

Maryland

UNIFORM APPLICATION FY 2008

SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT

OMB - Approved 09/20/2007 - Expires 09/30/2010

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Center for Substance Abuse Treatment
Division of State and Community Assistance

Introduction:

The SAPT Block Grant application format provides the means for States to comply with the reporting provisions of the Public Health Service Act (42 USC 300x-21-64), as implemented by the Interim Final Rule and the Tobacco Regulation for the SAPT Block Grant (45 CFR Part 96, parts XI and IV, respectively).

Public reporting burden for this collection of information is estimated to average 563 hours per response for sections I-III, 50 hours per response for Section IV-A and 42 hours per response for Section IV-B, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to SAMHSA Reports Clearance Officer; Paperwork Reduction Project (0930-0080); Room 16-105, Parklawn Building; 5600 Fishers Lane. Rockville. MD 20857.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-0080.

Form 1

State: Maryland

DUNS Number: 134104855-

Uniform Application for FY 2008 Substance Abuse Prevention and Treatment Block Grant

I. STATE AGENCY TO BE THE GRANTEE FOR THE BLOCK GRANT

Agency Name: Department of Health and Mental Hygiene

Organizational Unit: Alcohol and Drug Abuse Administration

Mailing Address: 55 Wade Avenue

City: Catonsville

Zip: 21228

II. CONTACT PERSON FOR THE GRANTEE FOR THE BLOCK GRANT

Name: Peter F. Luongo, PhD, Director

Agency Name: Alcohol and Drug Abuse Administration

Mailing Address: 55 Wade Avenue

City: Catonsville

Zip Code: 21228

Telephone: (410) 402-8600

FAX: (410) 402-8601

E-MAIL:

III. STATE EXPENDITURE PERIOD

From: 7/1/2005

To: 6/30/2006

IV. DATE SUBMITTED

Date: 10/1/2007 3:02:33 PM

Original

Revision

V. CONTACT PERSON RESPONSIBLE FOR APPLICATION SUBMISSION

Name: Steve Bocian

Telephone: (410) 402-8570

E-MAIL: bocians@dnhmh.state.md.us

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| UNIFORM APPLICATION FOR FY 2008 SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT Funding Agreements/Certifications as Required by the Public Health Service (PHS) Act | |
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| <i>The PHS Act, as amended, requires the chief executive officer (or an authorized designee) of the applicant organization to certify that the State will comply with the following specific citations as summarized and set forth below, and with any regulations or guidelines issued in conjunction with this Subpart except as exempt by statute.</i> | |
| We will accept a signature on this form as certification of agreement to comply with the cited provisions of the PHS Act. If signed by a designee, a copy of the designation must be attached. | |
| I. | Formula Grants to States, Section 1921 |
| Grant funds will be expended “only for the purpose of planning, carrying out, and evaluating activities to prevent and treat substance abuse and for related activities” as authorized. | |
| II. | Certain Allocations, Section 1922 |
| <ul style="list-style-type: none"> • Allocations Regarding Primary Prevention Programs, Section 1922(a) • Allocations Regarding Women, Section 1922(b) | |
| III. | Intravenous Drug Abuse, Section 1923 |
| <ul style="list-style-type: none"> • Capacity of Treatment Programs, Section 1923(a) • Outreach Regarding Intravenous Substance Abuse, Section 1923(b) | |
| IV. | Requirements Regarding Tuberculosis and Human Immunodeficiency Virus, Section 1924 |
| V. | Group Homes for Recovering Substance Abusers, Section 1925 |
| Optional beginning FY 2001 and subsequent fiscal years. Territories as described in Section 1925(c) are exempt. | |
| The State “has established, and is providing for the ongoing operation of a revolving fund” in accordance with Section 1925 of the PHS Act, as amended. This requirement is now optional. | |
| VI. | State Law Regarding Sale of Tobacco Products to Individuals Under Age of 18, Section 1926: |
| <ul style="list-style-type: none"> • The State has a law in effect making it illegal to sell or distribute tobacco products to minors as provided in Section 1926 (a)(1). • The State will enforce such law in a manner that can reasonably be expected to reduce the extent to which tobacco products are available to individuals under the age of 18 as provided in Section 1926 (b)(1). • The State will conduct annual, random unannounced inspections as prescribed in Section 1926 (b)(2). | |
| VII. | Treatment Services for Pregnant Women, Section 1927 |
| The State “...will ensure that each pregnant woman in the State who seeks or is referred for and would benefit from such services is given preference in admission to treatment facilities receiving funds pursuant to the grant.” | |
| VIII. | Additional Agreements, Section 1928 |
| <ul style="list-style-type: none"> • Improvement of Process for Appropriate Referrals for Treatment, Section 1928(a) • Continuing Education, Section 1928(b) • Coordination of Various Activities and Services, Section 1928(c) • Waiver of Requirement, Section 1928(d) | |

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| IX. Submission to Secretary of Statewide Assessment of Needs, Section 1929 |
| X. Maintenance of Effort Regarding State Expenditures, Section 1930 |
| With respect to the principal agency of a State, the State “will maintain aggregate State expenditures for authorized activities at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.” |
| XI. Restrictions on Expenditure of Grant, Section 1931 |
| XII. Application for Grant; Approval of State Plan, Section 1932 |
| XIII. Opportunity for Public Comment on State Plans, Section 1941 |
| The plan required under Section 1932 will be made “public in such a manner as to facilitate comment from any person (including any Federal person or any other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.” |
| XIV. Requirement of Reports and Audits by States, Section 1942 |
| XV. Additional Requirements, Section 1943 |
| XVI. Prohibitions Regarding Receipt of Funds, Section 1946 |
| XVII. Nondiscrimination, Section 1947 |
| XVIII. Services Provided By Nongovernmental Organizations, Section 1955 |
| I hereby certify that the State or Territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act, as amended, as summarized above, except for those Sections in the Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement. |
| State: Maryland |
| Name of Chief Executive Officer or Designee: John M. Colmers |
| Signature of CEO or Designee: |
| Title: Secretary, Maryland Department of Health and Mental Hygiene Date Signed: |
| If signed by a designee, a copy of the designation must be attached |

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| <p>1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION</p> <p>The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:</p> <ul style="list-style-type: none"> (a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency; (b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property; (c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and (d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default. <p>Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.</p> <p>The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion – Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with sub-grantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.</p> | <p>2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS</p> <p>The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 45 CFR Part 76 by:</p> <ul style="list-style-type: none"> (a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee’s workplace and specifying the actions that will be taken against employees for violation of such prohibition; (b) Establishing an ongoing drug-free awareness program to inform employees about – <ul style="list-style-type: none"> (1) The dangers of drug abuse in the workplace; (2) The grantee’s policy of maintaining a drug-free workplace; (3) Any available drug counseling, rehabilitation, and employee assistance programs; and (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace; (c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above; (d) Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will – <ul style="list-style-type: none"> (1) Abide by the terms of the statement; and (2) Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction; (e) Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant; |
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(f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted –

- (1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
- (2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

(g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
 Office of Grants Management
 Office of the Assistant Secretary for Management and Budget
 Department of Health and Human Services
 200 Independence Avenue, S.W., Room 517-D
 Washington, D.C. 20201

3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

- (1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the under signed, to any

person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

- (2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
- (3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

| | | |
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| <p>5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE</p> <p>Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children’s services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children’s services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.</p> <p>Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.</p> | <p>By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.</p> <p>The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children’s services and that all subrecipients shall certify accordingly.</p> <p>The Public Health Service strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.</p> | |
| <p>SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL</p> | <p>TITLE</p> <p>Secretary, DHMH</p> | |
| <p>APPLICANT ORGANIZATION</p> <p>ADAA, Maryland Department of Health and Mental Hygiene</p> | | <p>DATE SUBMITTED</p> |

| DISCLOSURE OF LOBBYING ACTIVITIES Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352 (See reverse for public burden disclosure.) | | |
|---|--|--|
| 1. Type of Federal Action: <input type="checkbox"/> a. contract <input type="checkbox"/> b. grant <input type="checkbox"/> c. cooperative agreement <input type="checkbox"/> d. loan <input type="checkbox"/> e. loan guarantee <input type="checkbox"/> f. loan insurance | 2. Status of Federal Action <input type="checkbox"/> a. bid/offer/application <input type="checkbox"/> b. initial award <input type="checkbox"/> c. post-award | 3. Report Type: <input type="checkbox"/> a. initial filing <input type="checkbox"/> b. material change For Material Change Only: Year _____ Quarter _____ date of last report _____ |
| 4. Name and Address of Reporting Entity: <input type="checkbox"/> Prime <input type="checkbox"/> Subawardee Tier _____, if known: _____ Congressional District, if known: _____ | 5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime: Congressional District, if known: _____ | |
| 6. Federal Department/Agency: | 7. Federal Program Name/Description: CFDA Number, if applicable: _____ | |
| 8. Federal Action Number, if known: | 9. Award Amount, if known: \$ _____ | |
| 10.a. Name and Address of Lobbying Entity <i>(if individual, last name, first name, MI):</i> | b. Individuals Performing Services <i>(including address if different from No. 10a.) (last name, first name, MI):</i> | |
| 11. Information requested through this form is authorized by title 31 U.S.C. Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure. | Signature: _____ Print Name: _____ Title: _____ Telephone No.: _____ Date: _____ | |
| Federal Use Only: | Authorized for Local Reproduction Standard Form - LLL (Rev. 7-97) | |

**DISCLOSURE OF LOBBYING ACTIVITIES
CONTINUATION SHEET**

Reporting Entity:

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of

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime Federal recipient, at the initiation or receipt of a covered Federal action, or a material change to a previous filing, pursuant to title 31 U.S.C. Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered Federal action. Use the SF-LLL-A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered Federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered Federal action.
2. Identify the status of the covered Federal action.
3. Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered Federal action.
4. Enter the full name, address, city, state and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants and contract awards under grants.
5. If the organization filing the report in item 4 checks "subawardee", then enter the full name, address, city, state and zip code of the prime Federal recipient. Include Congressional District, if known.
6. Enter the name of the Federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation, United States Coast Guard.
7. Enter the Federal program name or description for the covered Federal action (item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.
8. Enter the most appropriate Federal identifying number available for the Federal action identified in item 1 [e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract, grant, or loan award number; the application/proposal control number assigned by the Federal agency]. Include prefixes, e.g., "RFP-DE-90-001."
9. For a covered Federal action where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in item 4 or 5.
10. (a) Enter the full name, address, city, state and zip code of the lobbying entity engaged by the reporting entity identified in item 4 to influence the covered Federal action.

(b) Enter the full names of the individual(s) performing services, and include full address if different from 10(a). Enter Last Name, First Name, and Middle Initial (MI).
11. Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (item 4) to the lobbying entity (item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

According to the Paperwork Reduction Act, as amended, no persons are required to respond to a collection of information unless it displays a valid OMB Control Number. The valid OMB control number for this information collection is OMB No.0348-0046. Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0046), Washington, DC 20503.

ASSURANCES – NON-CONSTRUCTION PROGRAMS

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L.88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

| | | |
|--|--------------------------|----------------|
| SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL | TITLE Secretary, DHMH | |
| APPLICANT ORGANIZATION ADAA, Maryland Department of Health and Mental Hygiene | | DATE SUBMITTED |

| |
|---------------|
| State: |
| Maryland |

FY 2005 SAPT BLOCK GRANT

Your annual SAPT Block Grant Award for FY 2005 is reflected on Line 8 of the Notice of Block Grant Award

\$32,191,130

Maryland

Goal #1: Continuum of Substance Abuse Treatment Services

GOAL # 1. The State shall expend block grant funds to maintain a continuum of substance abuse treatment services that meet these needs for the services identified by the State. Describe the continuum of block grant-funded treatment services available in the State (See 42 U.S.C. 300x-21(b) and 45 C.F.R. 96.122(f)(g)).

FY 2005 (Compliance):

FY 2007 (Progress):

FY 2008 (Intended Use):

The Administration provided SAPT funding to maintain a continuum of substance abuse treatment services that met the need for the services identified by the State and Maryland jurisdictions in the amount of \$22,533,790. The State of Maryland's continuum of care offered various levels of care where individuals move from one level to another, based on their individual need. The levels of treatment care were based on the American Society of Addiction Medicine-Patient Placement Criteria, II or II-Revised (ASAM PPC II or II-R) and included outpatient, intensive outpatient, residential including halfway house, therapeutic community, extended care, intermediate care, medication assistance and detoxification services within various levels. 65,393 treatment episodes were provided within these modalities. Sixty-seven percent of these service episodes were provided to male patients and 33% to female patients.

Activities and allocation of service delivery units were in line with Administration parameters, based on historical, program specific and patient data. The Administration's Substance Abuse Management Information System (SAMIS) gathered demographic, as well as capacity and utilization data, in monitoring the treatment delivery system throughout the State of Maryland.

The following performance measures apply to SFY06 ADAA treatment grants:

1. 62% of patients in ADAA funded outpatient and halfway house programs are retained in treatment at least 90 days.
2. 50% of the patients completing ADAA funded intensive outpatient programs enter another level of treatment within thirty days of discharge.
3. 75% of patients completing ADAA funded detoxification programs enter another level of treatment within thirty days of discharge.
4. The number of patients using substances at completion of treatment will be reduced by at least 68% from the number of patients who were using substances at admission to treatment.
5. The number of employed patients at completion of treatment will increase by at least 29% from the number of patients who were employed at admission to treatment.
6. The average arrest rate per patient during treatment will decrease by at least 76%.

The Administration continues to provide SAPT level funding to maintain a continuum of substance abuse treatment services that meet the need for the services identified by the State of Maryland. The State of Maryland's continuum of care offers various levels of treatment care where individuals move from one level to another, based on their individual need. The levels of treatment care are based on the American Society of Addiction Medicine-Patient Placement Criteria II-Revised (ASAM PPC II-R) and include outpatient, intensive outpatient, residential including halfway house, therapeutic community, extended care, intermediate care, medication assistance and detoxification services within various modalities.

Activities and allocation of service delivery units were in line with Administration parameters, based on historical, program specific, and patient data. The Administration's Substance Abuse Management Information System (SAMIS) gathers demographic, as well as capacity and utilization data, in monitoring the treatment delivery system throughout the State of Maryland.

The following performance measures apply to SFY07 ADAA treatment grants:

1. 62% of patients in ADAA funded outpatient and halfway house programs are retained in treatment at least 90 days.
2. 50% of the patients completing ADAA funded intensive outpatient programs enter another level of treatment within thirty days of discharge.
3. 75% of patients completing ADAA funded detoxification programs enter another level of treatment within thirty days of discharge.
4. The number of patients using substances at completion of treatment will be reduced by at least 68% from the number of patients who were using substances at admission to treatment.
5. The number of employed patients at completion of treatment will increase by at least 29% from the number of patients who were employed at admission to treatment.
6. The average arrest rate per patient during treatment will decrease by at least 76%.

The Administration intends to provide SAPT level funding in maintaining a continuum of substance abuse treatment services that meet the need for the services identified by the State of Maryland.

The following performance measures apply to SFY08 ADAA treatment grants:

1. 62% of the patients in ADAA funded outpatient programs are retained in treatment at least 90 days.
2. 60% of patients in the ADAA funded halfway house programs are retained in treatment at least 90 days.
3. 50% of the patients completing ADAA funded intensive outpatient programs enter another level of treatment within thirty days of discharge.
4. 75% of the patients completing ADAA funded detoxification programs enter another level of treatment within 30 days of discharge.
5. The number of patients using substances at completion of treatment will be reduced by 85% among adolescents and 68% among adults from the number of patients who were using substances at admission to treatment.
6. The number of employed adult patients at completion of treatment will increase by 29% from the number of patients who were employed at admission to treatment.
7. The average arrest rate per patient during treatment will decrease by 65% among adolescents and 75% among adults.

Maryland

Goal #2: 20% for Primary Prevention

GOAL # 2. An agreement to spend not less than 20 percent on primary prevention programs for individuals who do not require treatment for substance abuse, specifying the activities proposed for each of the six strategies or by the Institute of Medicine Model of Universal, Selective, or Indicated as defined below: (See 42 U.S.C. 300x-22(a)(1) and 45 C.F.R. 96.124(b)(1)).

Institute of Medicine Classification: Universal Selective and Indicated:

- Universal: Activities targeted to the general public or a whole population group that has not been identified on the basis of individual risk.
 - o Universal Direct. Row 1—Interventions directly serve an identifiable group of participants but who have not been identified on the basis of individual risk (e.g., school curriculum, afterschool program, parenting class). This also could include interventions involving interpersonal and ongoing/repeated contact (e.g., coalitions)
 - o Universal Indirect. Row 2—Interventions support population-based programs and environmental strategies (e.g., establishing ATOD policies, modifying ATOD advertising practices). This also could include interventions involving programs and policies implemented by coalitions.
- Selective: Activities targeted to individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than average.
- Indicated: Activities targeted to individuals in high-risk environments, identified as having minimal but detectable signs or symptoms foreshadowing disorder or having biological markers indicating predisposition for disorder but not yet meeting diagnostic levels. (Adapted from The Institute of Medicine Model of Prevention)

FY 2005 (Compliance):

FY 2007 (Progress):

FY 2008 (Intended Use):

Primary prevention services on a statewide basis were supported by \$6,438,226 of FFY 2005 SAPT Block Grant funds. This amount represents 20% of the total SAPT allocation. An estimated 260,550 residents throughout the State of Maryland participated in prevention activities in Fiscal Year 2005 and over 92,294 youth were reached through prevention projects.

SAPT Block Grant funds enabled the Administration to support the Prevention Coordinators network. This statewide network utilized a community development model as its primary method of planning and implementing prevention services and for involving the residents within the State of Maryland in prevention goals and strategies. Through this community development model, 39 community-based prevention programs were developed, 27 of which focus on youth and other at risk groups.

The Administration maintained 612 community programs statewide. Additionally, SAPT funds were awarded to six subdivisions to target high-risk youth. A total of 3,112 children and families were served at 25 sites throughout these subdivisions. The Homeless Demonstration Grant provided a continuum of ATOD prevention activities for approximately 300 participants in Baltimore City. Activities include an after-school program, a health education program for adolescents and pregnant teens, a pre-school program, respite care for children whose mothers are in treatment for substance abuse, parenting groups and a mentoring program for school-aged children.

In FFY 2005, the Administration continued to fund four strategically located ATOD Prevention Centers in the central, eastern, southern and western regions of the State. These Centers are located at Towson University, the University of Maryland Eastern Shore, Bowie State University, and Frostburg State University respectively. A total of 427 events/activities that reached 42,018 individuals were sponsored by the ATOD Prevention Centers.

Utilizing SAPT Block Grant funds, the Administration's FFY 2005 prevention effort reached 260,554 individuals and represented a comprehensive approach in which a variety of strategies were employed to prevent alcohol, tobacco and other drug use. Strategies employed and individuals served included information dissemination (112,937), education (17,235), use alternatives (87,333), problem identification and referral (11,361), community-based process (27,343) and environmental improvements (4,345).

A minimum of 20% of the SAPT Block Grant funds supports primary prevention activities. An estimated 250,000 Maryland residents have or will participate in these activities. SAPT Block Grant funds enabled the Administration to support the Prevention Coordinators network. This statewide network utilizes a community development model as its primary method of planning and implementing prevention services and for involving the residents throughout the State of Maryland in prevention goals and strategies. Through this community development model, 450 community-based prevention programs are maintained. These programs expect to provide in excess of 3,000 prevention activities.

Additionally, SAPT Block Grant funds support six high-risk youth programs. Approximately 2,763 participants are expected to be served regionally throughout the State of Maryland. Each of the Pre-school programs use SAMHSA model programs targeted for the age group. Family management skills and child development education are central to the curriculum.

Four university campuses, regionally placed throughout the State of Maryland, continue to maintain Prevention Centers. At a cost of \$457,263 these centers expect to reach an estimated 30,000 participants. College students, faculty and staff actively participate in the program development, social norming, mentoring, classroom instruction, and campus-wide events.

Utilizing SAPT Block Grant funds, the Administration's FFY 2007 prevention efforts represent a comprehensive approach in which a variety of strategies and activities are employed to prevent ATOD use. College students were served through strategies that included information dissemination, education, use alternatives, problem identification and referral, community-based process, and environmental improvements.

The Administration's prevention goal is to utilize not less than 20% of the SAPT Block Grant funds to develop, implement, and oversee ATOD prevention programs and strategies. Direction and technical assistance is provided to the Prevention Network through communication, education, program development, coordination, cooperation, funding and advocacy. A community development model is used as one of the mechanisms for the Maryland prevention system. This model promotes the development of a system where all elements of the community have the capability to address ATOD prevention needs. Legislation in 2004 created a State Drug and Alcohol Council as well as Local Drug and Alcohol Councils located in every jurisdiction. These Councils will enhance the current system and create an environment of agency and community interaction in the process.

Objective: To develop, implement, maintain and evaluate community-based prevention programs that address ATOD issues.

Action: Maintain a statewide network to support various prevention programs and activities with information and materials.

Information Dissemination: Funds are provided to County Prevention Coordinators to establish mini-resource centers . They coordinate and provide speaker bureaus and develop and implement media campaigns.

Action: Develop and implement prevention training for agency and community representatives.

Community-Based Process: Administration staff maintains interaction with model program developers to remain current with evidence-based model programs. Training and technical assistance is provided to Prevention Coordinators, their staff and community representatives implementing model programs.

Education: Each of the County Prevention Coordinators is required to work with community groups and/or agencies to identify and institute AOD prevention training courses/seminars. Training for SAMHSA model program implementation is also provided. Peer leadership training programs are provided to middle and high school youth.

Action: Enhance the Administration's County Prevention Coordinator Network to provide additional SAMHSA Model Programs. Prevention Coordinators utilize a community development model as their primary method of planning and implementing services at local and community levels.

Alternative Activities: County Prevention Coordinators assist in the development and funding of Project Graduation activities and provide resources to community-based organizations to implement before and after-school ATOD prevention programs.

Problem Identification and Referral: Administration staff work collaboratively with the local health departments to provide student assistance programs, and education and referral programs that address drinking and driving issues.

Community-Based Process: County Prevention Coordinators provide resources to community-based groups and organizations to assist in the development of ATOD programs and activities. Technical assistance in the development of appropriate prevention programs/activities is provided. Coordinators work with county addiction coordinators and the Local Drug and Alcohol Councils to meet the AOD Prevention needs of their counties.

Environmental: Technical assistance is provided to community groups and organizations on how to develop appropriate legislative resources to address AOD issues.

Attachment A

| |
|---------------|
| State: |
| Maryland |

Attachment A: Prevention

Answer the following questions about the current year status of policies, procedures, and legislation in your State. Most of the questions are related to Healthy People 2010 objectives. References to these objectives are provided for each application question. To respond, check the appropriate box or enter numbers on the blanks provided. After you have completed your answers, copy the attachment and submit it with your application.

1. Does your State conduct sobriety checkpoints on major and minor thoroughfares on a periodic basis? (HP 26-25)

Yes No Unknown

2. Does your State conduct or fund prevention/education activities aimed at preschool children? (HP 26-9)

Yes No Unknown

3. Does your State alcohol and drug agency conduct or fund prevention/education activities in every school district aimed at youth grades K-12? (HP 26-9)

SAPT BLOCK GRANT

Yes
 No
 Unknown

OTHER STATE FUNDS

Yes
 No
 Unknown

DRUG FREE SCHOOLS

Yes
 No
 Unknown

4. Does your State have laws making it illegal to consume alcoholic beverages on the campuses of State colleges and universities? (HP 26-11)

Yes No Unknown

5. Does your State conduct prevention/education activities aimed at college students that include: (HP 26-11c)

Education Bureau? Yes No Unknown

Dissemination of materials? Yes No Unknown

Media campaigns? Yes No Unknown

Product pricing strategies? Yes No Unknown

Policy to limit access? Yes No Unknown

6. Does your State now have laws that provide for administrative suspension or revocation of drivers' licenses for those determined to have been driving under the influence of intoxicants? (HP 26-24)

Yes No Unknown

7. Has the State enacted and enforced new policies in the last year to reduce access to alcoholic beverages by minors such as: (HP 26-11c, 12, 23)

Restrictions at recreational and entertainment events at which youth made up a majority of participants/consumers,

Yes No Unknown

New product pricing,

Yes No Unknown

New taxes on alcoholic beverages,

Yes No Unknown

New Laws or enforcement of penalties and license revocation for sale of alcoholic beverages to minors,

Yes No Unknown

Parental responsibility laws for a child's possession and use of alcoholic beverages.

Yes No Unknown

8. Does your State provide training and assistance activities for parents regarding alcohol, tobacco, and other drug use by minors?

Yes No Unknown

9. What is the average age of first use for the following? (HP 26-9 and 27-4) (if available)

| | Age 0 - 5 | Age 6 - 11 | Age 12 - 14 | Age 15 - 18 |
|------------|--------------------------|--------------------------|-------------------------------------|-------------------------------------|
| Cigarettes | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| Alcohol | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Marijuana | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

10. What is your State's present legal alcohol concentration tolerance level for: (HP 26-25)

Motor vehicle drivers age 21 and older? .08

Motor vehicle drivers under age 21? .02

11. How many communities in your State have comprehensive, community-wide coalitions for alcohol and other drug abuse prevention (HP 26-3)?

40

12. Has your State enacted statutes to restrict promotion of alcoholic beverages and tobacco that are focused principally on young audiences (HP 26-11 and 26-16)?

Yes No Unknown

Maryland

Goal #3: Pregnant Women Services

GOAL # 3. An agreement to expend not less than an amount equal to the amount expended by the State for FY 1994 to establish new programs or expand the capacity of existing programs to make available treatment services designed for pregnant women and women with dependent children; and, directly or through arrangements with other public or nonprofit entities, to make available prenatal care to women receiving such treatment services, and, while the women are receiving services, child care (See 42 U.S.C. 300x-22(b)(1)(C) and 45 C.F.R. 96.124(c)(e)).

FY 2005 (Compliance):

FY 2007 (Progress):

FY 2008 (Intended Use):

The Administration expended \$4,121,210 to provide treatment services designed for pregnant women and women with dependent children. These expenditures included support for fifteen (15) gender-specific programs. Please refer to Attachment B for details. To ensure continued growth and awareness of service availability, the Administration published the Directory of Drug and Alcohol Treatment Services for Women, Infants and Children in Maryland, a comprehensive reference guide detailing type of patients served and services offered at all gender-specific addictions treatment programs. This directory is distributed to addictions programs, the Department of Human Resources (DHR), local Departments of Social Services (DSS), local hospitals, appropriate private agencies, and health professionals throughout the State of Maryland. Services provided by these gender-specific programs included substance abuse treatment, case management, parenting skills, educational and vocational services, prenatal, post-partum and gynecological health and child care referral services and family therapy.

The State of Maryland increased services to this population by expanding residential treatment slots for women as identified under Maryland Senate Bill 512 (Drug Affected Newborns) and Maryland House Bill 1160 (Welfare Innovation Act of 2000). Addictions specialists hired in local jurisdictions, as a result of these legislative initiatives, increased the identification and referral of women in need of substance abuse treatment.

ADAA Conditions of Award for SFY06 contained the following requirements:

If the program receives Block Grant funds set aside for pregnant women and women with dependent children (including women attempting to regain custody of their children), the program must adhere to items (1.) through (7.).

1. The program treats the family as a unit and, therefore, admits both women and their children into treatment services, if appropriate.
2. The program provides or arranges for primary medical care for women who are receiving substance abuse services, including prenatal care.
3. The program provides or arranges for child care while the women are receiving services.
4. The program provides or arranges for primary pediatric care for the women's children, including immunizations.
5. The program provides or arranges for gender-specific substance abuse treatment and other therapeutic interventions for women that may address issues of relationships, sexual abuse, physical abuse, and parenting.
6. The program provides or arranges for therapeutic interventions for children in custody of women in treatment which may, among other things, address the children's developmental needs and their issues of sexual abuse, physical abuse, and neglect.
7. The program provides or arranges for sufficient case management and transportation services to ensure that the women and their children have access to the services provided by (2.) through (6.) above.

The Administration provides categorical funds to support the continuum of treatment services for women, pregnant women, and women with children. Service provision includes but is not limited to substance abuse treatment, case management, parenting skills, educational and vocational services, prenatal, post-partum and gynecological health and child care referral services, and family therapy.

To ensure pregnant women and women with children continue to receive priority admission to treatment programs, the Administration includes this requirement in the conditions of grant award to local health departments and sub-contractors. Likewise, the Administration's funding commitment continues for the development of specialized gender-specific treatment services for women, pregnant women, and women with dependent children.

The Administration continues support for the development of ancillary services/activities that support gender-specific treatment. The Administration collaborates with the Department of Human Resources on the development of cross training for local Departments of Social Services personnel and substance abuse professionals.

ADAA Conditions of Award for SFY07 contained the following requirements:

If the program receives Block Grant funds set aside for pregnant women and women with dependent children (including women attempting to regain custody of their children), the program must adhere to items (1.) through (7.).

1. The program treats the family as a unit and, therefore, admits both women and their children into treatment services, if appropriate.
2. The program provides or arranges for primary medical care for women who are receiving substance abuse services, including prenatal care.
3. The program provides or arranges for child care while the women are receiving services.
4. The program provides or arranges for primary pediatric care for the women's children, including immunizations.
5. The program provides or arranges for gender-specific substance abuse treatment and other therapeutic interventions for women that may address issues of relationships, sexual abuse, physical abuse, and parenting.
6. The program provides or arranges for therapeutic interventions for children in custody of women in treatment which may, among other things, address the children's developmental needs and their issues of sexual abuse, physical abuse, and neglect.
7. The program provides or arranges for sufficient case management and transportation services to ensure that the women and their children have access to the services provided by (2.) through (6.) above.

Objective: To ensure that pregnant women continue to receive priority admission to substance abuse treatment programs.

Action: Include this requirement in the conditions of grant award to local health departments and sub-contractors.

Action: Review SAMIS generated utilization reports to measure and ensure compliance.

Objective: To continue the development of specialized gender-specific treatment services for women, pregnant women, and women with dependent children.

Action: Provide ongoing funding for gender-specific programs designed to meet the needs of this population.

Objective: To continue the development of ancillary services/activities that support gender-specific treatment.

Action: Collaborate with the Department of Human Resources on the provision of cross-training for Department of Social Services personnel and substance abuse professionals.

ADAA Conditions of Award for SFY08 contain the following requirements:

If the program receives Block Grant funds set aside for pregnant women and women with dependent children (including women attempting to regain custody of their children), the program must adhere to items (1.) through (7.).

1. The program treats the family as a unit and, therefore, admits both women and their children into treatment services, if appropriate.
2. The program provides or arranges for primary medical care for women who are receiving substance abuse services, including prenatal care.
3. The program provides or arranges for child care while the women are receiving services.
4. The program provides or arranges for primary pediatric care for the women's children, including immunizations.
5. The program provides or arranges for gender-specific substance abuse treatment and other therapeutic interventions for women that may address issues of relationships, sexual abuse, physical abuse, and parenting.
6. The program provides or arranges for therapeutic interventions for children in custody of women in treatment which may, among other things, address the children's developmental needs and their issues of sexual abuse, physical abuse, and neglect.
7. The program provides or arranges for sufficient case management and transportation services to ensure that the women and their children have access to the services provided by (2.) through (6.) above.

Maryland

Attachment B: Programs for Women

Attachment B: Programs for Pregnant Women and Women with Dependent Children
(See 42 U.S.C. 300x-22(b); 45 C.F.R. 96.124(c)(3); and 45 C.F.R. 96.122(f)(1)(viii))

For the fiscal year three years prior (FY 2005) to the fiscal year for which the State is applying for funds:
Refer back to your Substance Abuse Entity Inventory (Form 6). Identify those projects serving pregnant women and women with dependent children and the types of services provided in FY 2005. In a narrative of up to two pages, describe these funded projects.

Since 1990, the Administration maintains a specific policy requiring all programs to give priority admission to pregnant women. Women in need of services are defined as women who are using alcohol or drugs, with priority given to those who are pregnant. Our policy on the admission and retention of pregnant addicts is as follows:

A pregnant addicted female of any age, when pregnancy is confirmed by a valid provider, is to be admitted to and retained in treatment on a priority basis. Such a patient shall not be placed on the waiting list or be subject to involuntary termination. This policy applies to pregnant women who abuse alcohol as well as other drugs.

All programs which serve women incorporate gender-specific groups and activities. Pregnant women may be referred to any program statewide, whether it is a women only or mixed gender program. However, a variety of gender-specific programs have been developed including intensive outpatient, intermediate care, halfway house and therapeutic community services for pregnant women and women with dependent children. These projects are defined as those certified programs, which are designed specifically to treat only women, with or without their children in outpatient or residential settings.

As shown in the following table, the Administration uses federal SAPT funds to support 15 programs that provide gender-specific services to pregnant and post-partum women and their dependent children.

Pregnant Women and Women with Dependent Children Programs FFY 2005

WESTERN REGION

| PROGRAM | LOCATION | LEVEL OF CARE |
|-----------------------|--------------|---------------|
| Gale House | Frederick | Halfway |
| Massie Women's Unit | Cumberland | ICF |
| Safe Harbor | Emmitsburg | ICF |
| Shoemaker Women's Ctr | Westminister | ICF |
| W House | Hagerstown | Halfway |
| Avery House | Rockville | Halfway |

SOUTHERN REGION

| PROGRAM | LOCATION | LEVEL OF CARE |
|----------------------|-------------|----------------------|
| Prince George's Prog | Forestville | Intensive Outpatient |
| Chrysalis House | Crownsville | Halfway |
| Marcey House | Leonardtwn | Long Term |

CENTRAL REGION

| PROGRAM | LOCATION | LEVEL OF CARE |
|----------------------|------------------|----------------------|
| AWARE | Baltimore County | Intensive Outpatient |
| Center 4 Clean Start | Salisbury | Intensive Outpatient |

BALTIMORE CITY

| PROGRAM | LOCATION | LEVEL OF CARE |
|--------------------|----------------|----------------------|
| JHH Women's Center | North Broadway | Intensive Outpatient |
| Nilsson House | Purdue Ave. | Halfway House |
| Safe House | Randall Street | Halfway House |

Maryland

Attachment B: Programs for Women (contd.)

The PHS Act required the State to expend at least 5 percent of the FY 1993 and FY 1994 block grants to increase (relative to FY 1992 and FY 1993, respectively) the availability of treatment services designed for pregnant women and women with dependent children. In the case of a grant for any subsequent fiscal year, the State will expend for such services for such women not less than an amount equal to the amount expended by the State for fiscal year 1994.

In up to four pages, answer the following questions:

1. Identify the name, location (include sub-State planning area), Inventory of Substance Abuse Treatment Services (I-SATS) ID number (formerly the National Facility Register (NFR) number), level of care (refer to definitions in Section II.4), capacity, and amount of funds made available to each program designed to meet the needs of pregnant women and women with dependent children.
2. What did the State do to ensure compliance with 42 U.S.C. 300x-22(b)(1)(C) in spending FY 2005 block grant and/or State funds?
3. What special methods did the State use to monitor the adequacy of efforts to meet the special needs of pregnant women and women with dependent children?
4. What sources of data did the State use in estimating treatment capacity and utilization by pregnant women and women with dependent children?
5. What did the State do with FY 2005 block grant and/or State funds to establish new programs or expand the capacity of existing programs for pregnant women and women with dependent children?

1. Identify the name, location (include sub-State planning area), Inventory of Substance Abuse Treatment Services (I-SATS) ID number (formerly the National Facility Register (NFR) number), level of care (refer to definitions in Section II.4), capacity, and amount of funds made available to each program designed to meet the needs of pregnant women and women with dependent children.

Pregnant Women and Women with Dependent Children - Funded Programs FFY2005

| PROGRAM | LOCATION | NFR-ID | LEVEL OF CARE | FFY05 Funds | SLOTS |
|----------------|--------------|--------|---------------|-------------|-------|
| Gale House | Frederick | 750432 | Halfway House | \$191,123 | 12 |
| Massie Unit | Allegany | 103145 | ICF | \$167,67 | 14 |
| Safe Harbor | Frederick | 103137 | Detox, ICF | \$242,250 | 15 |
| Shoemaker | Carroll | 103129 | Detox, ICF | \$860,429 | 44 |
| W House | Washington | 101230 | Halfway House | \$215,875 | 17 |
| Avery House | Montgomery | 103392 | Halfway House | \$485,635 | 10 |
| P.G. Center | P.G. Co. | 103160 | IOP | \$218,812 | 125 |
| Marcy House | Leonardtwn | 101123 | Long Term | \$156,875 | 6 |
| A.W.A.R.E. | Baltimore Co | 101834 | IOP | \$370,784 | 40 |
| Chrysalis H | Crownsville | 903759 | Halfway House | \$188,121 | 20 |
| Center 4 Clean | Worcester Co | 103368 | IOP | \$273,686 | 34 |
| JHH Women's Ct | Baltimore | 101925 | IOP | \$501,204 | 85 |
| Nilsson House | Baltimore | 750036 | Halfway House | \$125,531 | 13 |
| Safe House | Baltimore | 903692 | Halfway House | \$123,214 | 8 |
| | | | | \$4,121,210 | |

2. What did the State do to ensure compliance with 42 U.S.C. 300x-22(b)(1)(C) in spending FY 2005 block grant and/or State funds?

During April, 2007, the Administration submitted a revision to last year's SAPT application to clarify the calculation method and to document compliance with the federal requirements. In consultation with SAMHSA, the Administration has revised its calculation method for documenting compliance with 42 U.S.C. 300x-22(b)(1)(C).

The base for Pregnant Women and Women with Dependent Children (PW/WDC) of \$5,032,564 was established by reviewing all grantees funded with FFY 1992 ADMS Block Grant funds which primarily provided treatment services designated for Pregnant Women and Women with Dependent Children that provided services consistent with those in 45 CFR 96.124. In FFY 1992, the Alcohol and Drug Abuse Administration (ADAA) calculated 5% of the FFY1992 SAPT Block Grant award (\$24,286,932 x 5% or \$1,214,347), plus \$513,146 in state general funds and established a base expenditure amount of \$1,727,493. ADAA then calculated 5% of the FFY1993 SAPT Block Grant award (\$22,226,407 x 5% or \$1,111,320), plus \$520,476 in state general funds to establish the FFY1993 base amount of \$1,631,796 and added this to the 1992 PW/WDC base (\$3,363,959). Finally, ADAA calculated 5% of the FFY1994 SAPT Block Grant award (\$22,989,174 x 5% or \$1,149,459), plus \$523,816 in state general funds to establish the FFY1994 base amount of \$1,673,275 and added this to the 1993 WDC base resulting in a FFY 1994 PW/WDC expenditure baseline amount of \$5,032,564.

3. What special methods did the State use to monitor the adequacy of efforts to meet the special needs of pregnant women and women with dependent children?

The Administration monitors treatment program performance in two ways. All programs submit treatment episode data to ADAA monthly. Programs are monitored by the Information Services Division analysts for anomalies in the reported data. These data are analyzed and compared to performance benchmarks of substance use, retention, arrests and employment. All funded programs are visited by the analysts on site for data reconciliation and validation. Programs that fall below the benchmarks or fail a data validation visit are

referred to the Regional Team Leaders for technical assistance.

In addition all programs receiving federal funds are monitored on site annually for treatment program performance and adherence to State COMAR regulations and federal conditions of award.

4. What sources of data did the State use in estimating treatment capacity and utilization by pregnant women and women with dependent children?

The sources of data are the State of Maryland Automated Record Tracking (SMART) system and the ADAA Funding Resource Allocation Network (FRAN) used in annual grant applications from the treatment providers. SMART is the electronic record used by all treatment providers to submit data to ADAA.

5. What did the State do with FY 2005 block grant and/or State funds to establish new programs or expand the capacity of existing programs for pregnant women and women with dependent children?

The State of Maryland expended \$4,121,210 in SAPT federal funds for 15 gender-specific programs in FFY 2005 focused on categorically maintaining and enhancing prevention activities and treatment services for pregnant women and women with dependent children. Programs are itemized in the following matrix.

Maryland

Goal #4: IVDU Services

GOAL # 4. An agreement to provide treatment to intravenous drug abusers that fulfills the 90 percent capacity reporting, 14-120 day performance requirement, interim services, outreach activities and monitoring requirements (See 42 U.S.C. 300x-23 and 45 C.F.R. 96.126).

FY 2005 (Compliance):

FY 2007 (Progress):

FY 2008 (Intended Use):

In FFY 2005, the Administration used its online data collection instruments, HATS and SMART to track Slots and admissions providing capacity level measurement. The Administration utilizes the SAMIS reporting process to identify patient census for all IVDU programs. All programs receiving state and/or federal funds must submit monthly Census and Waiting List Data to the MIS Section. This allows an ongoing count of slot availability. In addition, the Community Services Section provides technical assistance to local programs to develop plans in addressing utilization issues. To further enable admission to treatment for IVDUs within 10 days, the Administration continues to support the Baltimore City's Central Information and Referral Process to ensure methadone treatment admission availability to IVDUs. In addition, the Administration requires that any entity that receives federal funding for treatment services for IVDUs utilize effective outreach models to encourage persons in need of treatment to enter same. The Administration has strengthened the conditions of grant award language with local health departments and sub-contractors. In FFY 2004, the Administration conducted a statewide Management Conference for publicly funded service providers to include a focus point on this requirement, as well as other SAPT Block Grant fund requirements.

In FFY 2005 the Administration, as in prior fiscal years, required all programs receiving funding to submit monthly Client Census Data to the ADAA Management Information Services (MIS) section. It is through this system, in concert with program visits by Compliance Services Section staff, that a program serving intravenous drug users provides notification to the State when it reaches 90% capacity. In FFY 2005, funded programs reported this occurrence through this monitoring system. Program monthly Census and Waiting List Data are used to monitor program utilization. This requirement is in keeping with the Administration waiting list policy, that not only requires patients be placed on a waiting list if the time between initial contact and admission is longer than 10 days, but also requires that patients who must wait should be given interim counseling during the waiting period.

A pilot project by Baltimore City was begun with federal grant funds to provide interim methadone services as described in CFR 42 part 8. This pilot project ran successfully for one year. Patients that were served up to 4 months and remained active automatically were placed in the next traditional OMT treatment slot.

ADAA Conditions of Award for SFY07 contained the following requirements:

If the program treats individuals for intravenous substance abuse, the program must adhere to items (8.) through (15.).

8. Within 7 days of reaching 90 percent of its treatment capacity, the program notifies the State that 90 percent of the capacity has been reached.

9. The program admits each individual who requests and is in need of treatment for intravenous drug abuse not later than:

- (a.) 14 days after making the request or
- (b.) 120 days if the program has no capacity to admit the individual on the date of the request and, within 48 hours after the request, the program makes interim services available until the individual is admitted to a substance abuse treatment program

10. When applicable, the program offers interim services that include, at a minimum, the following:

- (a.) Counseling and education about HIV and tuberculosis (TB), the risks of needle-sharing, the risks of transmission to sexual partners and infants, and steps that can be taken to ensure that HIV and TB transmission do not occur
- (b.) Referral for HIV or TB treatment services, if necessary
- (c.) Counseling on the effects of alcohol and other drug use on the fetus for pregnant women and referrals for prenatal care for pregnant women

11. The program has established a waiting list that includes a unique patient identifier for each injecting drug abuser seeking treatment, including patients receiving interim services while awaiting admission.

12. The program has a mechanism that enables it to:

- (a.) Maintain contact with individuals awaiting admission
- (b.) Admit or transfer waiting list clients at the earliest possible time to an appropriate treatment program within a reasonable geographic area

13. The program takes clients awaiting treatment for intravenous substance abuse off the waiting list only when one of the following conditions exists:

- (a.) Such persons cannot be located for admission into treatment or
- (b.) Such persons refuse treatment

14. The program carries out activities to encourage individuals in need of treatment services for intravenous drug abuse to undergo such treatment by using scientifically sound outreach models such as those outlined below or, if no such models are applicable to the local situation, another approach which can reasonably be expected to be an effective outreach method:

- (a.) The standard intervention model as described in The NIDA Standard Intervention Model for Injection Drug Users: Intervention Manual, National AIDS Demonstration Research (NADR) Program, National Institute on Drug Abuse, (Feb. 1992)
- (b.) The health education model as described in Rhodes, F. Humfleet, G.L. et al., AIDS Intervention Program for Injection Drug Users: Intervention Manual, (Feb. 1992)
- (c.) The indigenous leader model as described in Wiebel, W., Levin, L.B., The Indigenous Leader Model: Intervention Manual, (Feb. 1992)

15. The program ensures that outreach efforts (have procedures for):

- (a.) Selecting, training, and supervising outreach workers
- (b.) Contacting, communicating, and following up with high-risk substance abusers, their associates and neighborhood residents within the constraints of Federal and State confidentially requirements
- (c.) Promoting awareness among injecting drug abusers about the relationship between injecting drug abuse and communicable diseases such as HIV

(d.) Recommending steps that can be taken to ensure that HIV transmission does not occur

The Baltimore City pilot project was converted to a standard protocol that is intended to be funded in Baltimore City with expansion expected to occur in Anne Arundel County.

ADAA Conditions of Award for SFY08 contain the following requirements:

If the program treats individuals for intravenous substance abuse, the program must adhere to items (8.) through (15.).

8. Within 7 days of reaching 90 percent of its treatment capacity, the program notifies the State that 90 percent of the capacity has been reached.

9. The program admits each individual who requests and is in need of treatment for intravenous drug abuse not later than:

(a.) 14 days after making the request or

(b.) 120 days if the program has no capacity to admit the individual on the date of the request and, within 48 hours after the request, the program makes interim services available until the individual is admitted to a substance abuse treatment program

10. When applicable, the program offers interim services that include, at a minimum, the following:

(a.) Counseling and education about HIV and tuberculosis (TB), the risks of needle-sharing, the risks of transmission to sexual partners and infants, and steps that can be taken to ensure that HIV and TB transmission do not occur

(b.) Referral for HIV or TB treatment services, if necessary

(c.) Counseling on the effects of alcohol and other drug use on the fetus for pregnant women and referrals for prenatal care for pregnant women

11. The program has established a waiting list that includes a unique patient identifier for each injecting drug abuser seeking treatment, including patients receiving interim services while awaiting admission.

12. The program has a mechanism that enables it to:

(a.) Maintain contact with individuals awaiting admission

(b.) Admit or transfer waiting list clients at the earliest possible time to an appropriate treatment program within a reasonable geographic area

13. The program takes clients awaiting treatment for intravenous substance abuse off the waiting list only when one of the following conditions exists:

(a.) Such persons cannot be located for admission into treatment or

(b.) Such persons refuse treatment

14. The program carries out activities to encourage individuals in need of treatment services for intravenous drug abuse to undergo such treatment by using scientifically sound outreach models such as those outlined below or, if no such models are applicable to the local situation, another approach which can reasonably be expected to be an effective outreach method:

(a.) The standard intervention model as described in The NIDA Standard Intervention Model for Injection Drug Users: Intervention Manual, National AIDS Demonstration Research (NADR) Program, National Institute on Drug Abuse, (Feb. 1992)

(b.) The health education model as described in Rhodes, F. Humfleet, G.L. et al., AIDS Intervention Program for Injection Drug Users: Intervention Manual, (Feb. 1992)

(c.) The indigenous leader model as described in Wiebel, W., Levin, L.B., The Indigenous Leader Model: Intervention Manual, (Feb. 1992)

15. The program ensures that outreach efforts (have procedures for):

(a.) Selecting, training, and supervising outreach workers

(b.) Contacting, communicating, and following up with high-risk substance abusers, their associates and neighborhood residents within the constraints of Federal and State confidentially requirements

(c.) Promoting awareness among injecting drug abusers about the relationship between injecting drug abuse and communicable diseases such as HIV

(d.) Recommending steps that can be taken to ensure that HIV transmission does not occur

Maryland

Attachment C: Programs for IVDU

Attachment C: Programs for Intravenous Drug Users (IVDUs)
(See 42 U.S.C. 300x-23; 45 C.F.R. 96.126; and 45 C.F.R. 96.122(f)(1)(ix))

For the fiscal year three years prior (FY 2005) to the fiscal year for which the State is applying for funds:

1. How did the State define IVDUs in need of treatment services?
2. 42 U.S.C. 300x-23(a)(1) requires that any program receiving amounts from the grant to provide treatment for intravenous drug abuse notify the State when the program has reached 90 percent of its capacity. Describe how the State ensured that this was done. Please provide a list of all such programs that notified the State during FY 2005 and include the program's I-SATS ID number (See 45 C.F.R. 96.126(a)).
3. 42 U.S.C. 300x-23(a)(2)(A)(B) requires that an individual who requests and is in need of treatment for intravenous drug abuse is admitted to a program of such treatment within 14-120 days. Describe how the State ensured that such programs were in compliance with the 14-120 day performance requirement (See 45 C.F.R. 96.126(b)).
4. 42 U.S.C. 300x-23(b) requires any program receiving amounts from the grant to provide treatment for intravenous drug abuse to carry out activities to encourage individuals in need of such treatment to undergo treatment. Describe how the State ensured that outreach activities directed toward IVDUs was accomplished (See 45 C.F.R. 96.126(e)).

1. How did the State define IVDUs in need of treatment services?

The State of Maryland defines IVDUs in need of services as any intravenous drug abuser who requests drug abuse treatment services. These services may be provided by Opioid Maintenance Treatment Programs, ASAM Level I/outpatient or Level III/residential treatment providers. All of our addictions treatment programs are mandated to provide HIV risk-reduction counseling to all patients as an integral part of the intake admission process.

2. 42 U.S.C. 300x-23(a)(1) requires that any program receiving amounts from the grant to provide treatment for intravenous drug abuse notify the State when the program has reached 90 percent of its capacity. Describe how the State ensured that this was done. Please provide a list of all such programs that notified the State during FY 2005 and include the program's I-SATS ID number (See 45 C.F.R. 96.126(a)).

The treatment service continuum in Maryland has been not only maintained but expanded by the use of SAPT Block Grant funds. The Administration supported 5,635 slots dedicated to opioid maintenance therapy (OMT) services. These services were provided in nine (9) of the jurisdictions: Allegany, Anne Arundel County, Baltimore City, Baltimore County, Frederick County, Harford County, Montgomery County, Prince George's County and Wicomico County. The treatment continuum in Maryland incorporates the ASAM PPC II-R levels of care. All treatment programs, including programs treating IVDU patients, uses the ADAA sponsored web enabled treatment episode reporting system. To specifically ensure compliance with 42 U.S.C. 300x-22(a)(2) and 300x-23 of the PHS Act the Administration requires each program to report monthly on admission and discharge activities. This information is collected and maintained on the Administration's centralized database and made available to the Information Services Division data analysis section, the Community Services Division, and the Compliance Section of the Quality Assurance Division. The online application provides reports to the programs for self-monitoring and quality improvement. Reports on program data are available to program staff at all times and provide instant feedback as to capacity status. In addition, all programs are required to submit a monthly Census and Waiting List (CWL) along with their monthly report on admissions and discharges. MIS staff monitor the CWL submissions and when anomalies appear they notify both Community Services Division and the Compliance Section of the Quality Assurance Division. Programs are called or visited to provide technical assistance to remedy the situation.

The following is a list of programs treating IVDUs and reported a 90% capacity during FFY 2005.

| I-SATS | FACILITY |
|--------|-------------------------------------|
| 43 | DEAF ADDICTION SERVICES |
| 484 | ALLEGANY HALFWAY HOUSE |
| 501 | CAMEO HOUSE |
| 541 | ALCOHOL AND DRUG INTERVENTION |
| 100083 | UNIV. OF MD. DRUG TREATMENT |
| 100091 | ADDICT REFERRAL & COUNSELING |
| 100141 | PRINCE GEORGE'S COUNTY HEALTH DEPT. |
| 100190 | REFLECTIVE TREATMENT CENTER |
| 100981 | HILLTOP RECOVERY |
| 101229 | BUILD FELLOWSHIP |
| 101258 | DRUID HEIGHTS |
| 101293 | JONES FALLS HALFWAY HOUSE |
| 101296 | JHH WILSON, FAITH HOUSES I AND II |
| 101818 | AWAKENINGS COUNSELING PROGRAM |
| 101834 | AWARE |
| 101891 | COUNSELING PLUS, INC. |

102147 IBR MOBILE HEALTH SERVICES
 102188 JUDE HOUSE
 102410 HOPE HOUSE EXTENDED
 103079 POWELL RECOVERY
 103137 SAFE HARBOR
 103145 ALLEGANY PREGNANT WOMEN'S SERV
 103889 SOUTH BALTIMORE FAMILY CENTER
 103491 ALLEGANY CTY JAIL SUB. ABUSE
 104135 RECOVERY NETWORK
 104143 ALLEGANY COUNTY IOP
 300014 JUNCTION, INC.
 301178 CALVERT NEW LEAF
 300329 SECOND GENESIS
 301350 GLENWOOD LIFE COUNSELING CTR.
 301459 ALLEGANY CHD - MASSIE UNIT
 301558 ALLEGANY CHD LOIS E. JACKSON
 750036 NILSSON HOUSE
 750283 MANN HOUSE
 750382 CAROLINE CHD
 750473 CHARLES CHD - OUTPATIENT
 750499 REALITY INC.
 750564 CARROLL CHD - OUTPATIENT
 750580 SAMARITAN HOUSE
 750614 BALTO. COUNTY HEALTH DEPT.
 900102 DAYBREAK REHABILITATION
 900128 MAN ALIVE
 900151 ADAPT CARES (PROJECT ADAPT)
 900169 SINAI HOSP. DRUG DEPENDANCY
 900227 ALLEGANY CHD OUTPATIENT
 900326 FIRST STEP
 900433 EPOCH COUNSELING CENTERS
 900441 HOWARD CHD - OUTPATIENT
 902140 TUERK HOUSE
 902280 REALITY HOUSE HALFWAY
 902314 AVERY ROAD TREATMENT CENTER
 902389 FRIENDSHIP HOUSE - HALFWAY
 902801 TOTAL HEALTH CARE

Also see ADAA Conditions of Award listed under Compliance and Intended Use sections of this Goal.

ADAA regulations and Conditions of Grant Award state that all patients must be seen within 10 working days from the date of first contact and a long standing policy that pregnant women, IV Drug Users, and HIV Positive patients are given priority status for admission to all funded programs.

The Quality Assurance Division, Compliance Section, conducts random compliance reviews with programs receiving federal funds to assure patients are seen for admission within 10 working days from date of first contact as required by Code of Maryland Regulations 10.47.01.04 A (1) (a).

Also see ADAA Conditions of Award listed under Compliance and Intended Use sections of this Goal.

ADAA directs local jurisdictions to provide outreach activities toward all drug users including IVDUs to increase awareness of treatment services available in their communities.

Also see ADAA Conditions of Award listed under Compliance and Intended Use sections of this Goal.

Maryland

Attachment D: Program Compliance Monitoring

Attachment D: Program Compliance Monitoring
(See 45 C.F.R. 96.122(f)(3)(vii))

The Interim Final Rule (45 C.F.R. Part 96) requires effective strategies for monitoring programs' compliance with the following sections of the PHS Act: 42 U.S.C. 300x-23(a); 42 U.S.C. 300x-24(a); and 42 U.S.C. 300x-27(b).

For the fiscal year two years prior (FY 2006) to the fiscal year for which the State is applying for funds:

In up to three pages provide the following:

- A description of the strategies developed by the State for monitoring compliance with each of the sections identified below; and
- A description of the problems identified and corrective actions taken:
 1. Notification of Reaching Capacity 42 U.S.C. 300x-23(a)
(See 45 C.F.R. 96.126(f) and 45 C.F.R. 96.122(f)(3)(vii));
 2. Tuberculosis Services 42 U.S.C. 300x-24(a)
(See 45 C.F.R. 96.127(b) and 45 C.F.R. 96.122(f)(3)(vii)); and
 3. Treatment Services for Pregnant Women 42 U.S.C. 300x-27(b)
(See 45 C.F.R. 96.131(f) and 45 C.F.R. 96.122(f)(3)(vii)).

1. Notification of Reaching Capacity 42 U.S.C. 300x-23(a)(See 45 C.F.R. 96.126(f) and 45 C.F.R. 96.122(f)(3)(vii));

Notification of program census throughout the State is accomplished through the use of the ADAA online data collection application and the submission of a Census and Waiting List (CWL). Programs use the application to submit a monthly report on admission and discharge activity. The online application also provides reports to the programs for self-monitoring and quality improvement. Reports on program data are available to programs staff at all times and provide instant feedback as to capacity status.

ADAA is exploring an automated notification of reaching capacity from its web based clinical record. When a treatment program's active client roster reaches 90% of its slot capacity a flag will be set and a notification sent to the State Methadone Authority (if it is an OMT program) and the appropriate Regional Services Manager from the Community Services Division. The Regional Managers provide technical services to assist the programs in managing their capacity.

All addictions treatment programs must, by State regulations, be certified and report to the Administration's online data collection application. The Administration has implemented regulation to ensure that any individual who requests and is in need of treatment be seen in the appropriate treatment within 10 days or be referred to another certified program.

2. Tuberculosis Services 42 U.S.C. 300x-24(a) (See 45 C.F.R. 96.127(b) and 45 C.F.R. 96.122(f)(3)(vii));

Administration policy mandates a screening for tuberculosis and referral to appropriate health services for substance abuse patients. All addiction treatment programs funded by the State shall directly or through arrangements with other public or non-profit entities routinely make available tuberculosis services to the admitted patients. Programs have implemented assessment, education and testing activities. Case management ensures that individuals needing TB services receive them, and treatment requirements are maintained and follow-up evaluations are performed. The Department of Health and Mental Hygiene, Office of Health Care Quality performs program compliance monitoring function biannually.

In addition ADAA's web-based clinical record tracks whether the patient received a TB Risk assessment and whether the patient was referred for testing.

The ADAA Conditions of Award for SFY07 contained the following requirements:

16. The program directly, or through arrangements with other public or nonprofit private entities, routinely makes available the following TB services to each individual receiving treatment for substance abuse:

- (a.) Counseling the individual with respect to TB
- (b.) Testing to determine whether the individual has been infected with mycobacteria TB to determine the appropriate form of treatment for the individual
- (c.) Providing for or referring the individuals infected by mycobacteria TB appropriate medical evaluation and treatment

17. For clients denied admission to the program on the basis of lack of capacity, the program refers such clients to other providers of TB services.

18. The program has implemented the infection control procedures that are consistent with those established by the Department to prevent the transmission of TB and that address the following:

- (a.) Screening patients and identification of those individuals who are at high risk of becoming infected.

(b.) Meeting all State reporting requirements while adhering to Federal and State confidentiality requirements, including 42 CFR part 2

(c.) Case management activities to ensure that individuals receive such services

19. The program reports all individuals with active TB to the local health department as required by State Law and in accordance with Federal and State confidentiality requirements, including 42 CFR part 2.

3. Treatment Services for Pregnant Women 42 U.S.C. 300x-27(b) (See 45 C.F.R. 96.131(f) and 45 C.F.R. 96.122(f)(3)(vii)).

Since 1990, the Administration has maintained a specific policy requiring all programs to give priority admission to pregnant women. (ADAA Policy Statement #27) on the admission and retention of pregnant addicts is as follows: A pregnant addicted female of any age when, pregnancy is confirmed by a valid provider, is to be admitted to and retained in treatment on a priority basis. Such a patient shall not be placed on the waiting list or be subject to involuntary termination. A variety of women's programs have been implemented over the past decade. These programs cover the continuum of addiction treatment. Additionally, wraparound services for this population include; child care, transportation, comprehensive prenatal care, pediatric care, GED, vocational assessment and training services, parenting education, treatment and/or referral for mental health issues, etc. Twelve-Step philosophies and community resources are also utilized.

Maryland

Goal #5: TB Services

GOAL # 5. An agreement, directly or through arrangements with other public or nonprofit private entities, to routinely make available tuberculosis services to each individual receiving treatment for substance abuse and to monitor such service delivery (See 42 U.S.C. 300x-24(a) and 45 C.F.R. 96.127).

FY 2005 (Compliance):

FY 2007 (Progress):

FY 2008 (Intended Use):

In FFY 2005, the Administration required a tuberculosis risk assessment (ADAA Policy Statement #39) be done on all patients receiving services. If the assessment indicated the patient at risk then skin testing on-site and/or by referral is required to be made available in Medication Assisted, Intermediate Care Facilities and Therapeutic Community programs, as well as referrals for services in outpatient settings. This requirement also stipulated that programs are to place the assessment and to note services or referrals in patient records. In meeting this objective, the State of Maryland's Department of Health and Mental Hygiene, Office of Health Care Quality and/or the Administration's Compliance Section reviewed tuberculosis assessment and referral services for patients during the annual/biannual certification process.

In FFY 2007, the Administration continues to require a tuberculosis risk assessment (ADAA Policy Statement #39) be done on all patients receiving services. For those individuals at risk, tuberculosis skin testing on-site and/or by referral be made available in Medication Assisted, Intermediate Care Facilities and Therapeutic Community programs, as well as referrals for services in outpatient settings. In meeting this objective, the State of Maryland's Department of Health and Mental Hygiene, Office of Health Care Quality and/or the Administration's Compliance Section reviews tuberculosis assessment and referral services for patients during the annual/biannual certification process.

In FFY 2008, the Administration intends to continue the requirement that a tuberculosis risk assessment (ADAA Policy Statement #39) be done on all patients receiving services. For those individuals at risk, tuberculosis skin testing on-site and/or by referral be made available in Medication Assisted, Intermediate Care Facilities and Therapeutic Community programs, as well as referrals for services in outpatient settings. In meeting this objective, the State of Maryland's Department of Health and Mental Hygiene, Office of Health Care Quality and/or the Administration's Compliance Section reviews tuberculosis assessment and referral services for patients during the annual/biannual certification process.

Maryland

Goal #6: HIV Services

GOAL # 6. An agreement, by designated States, to provide treatment for persons with substance abuse problems with an emphasis on making available within existing programs early intervention services for HIV in areas of the State that have the greatest need for such services and to monitor such service delivery (See 42 U.S.C. 300x-24(b) and 45 C.F.R. 96.128).

FY 2005 (Compliance):

FY 2007 (Progress):

FY 2008 (Intended Use):

As a designated state, Maryland expended \$1,609,557 of SAPT Block Grant funds on HIV early intervention services in FFY 2005. Activities included education, assessment and counseling services. As part of this statewide effort, four (4) programs were categorically funded to provide outreach, case management, assessment and referral services. These programs target the geographic areas that have the greatest need, most notably Baltimore City and Prince George's County.

In addition, all certified treatment programs were required, by policy, to have in place referral agreements for testing and therapeutic services. Recording of these services in patient records was mandatory. The State of Maryland Department of Health and Mental Hygiene, Office of Health Care Quality, reviewed the availability and referral of services for patients during the annual/biannual certification process.

As a designated state, Maryland continues to categorically expend SAPT Block Grant funds on HIV early intervention services. Activities include education, assessment and counseling services. As in prior years, these programs target geographic areas that have the greatest service need, most notably Baltimore City and Prince George's County.

In addition, all certified treatment programs are required, to conduct risk assessment , reduction and referral for testing and counseling for all patients. Recording of these services in patient records is mandatory. The State of Maryland's Department of Health and Mental Hygiene, Office of Health Care Quality reviews the availability and referral of services for patients during the annual/biannual certification process.

Objective: To assess and maintain categorical projects in geographic areas having the greatest need.

Action: Identify funding and program support for the continuation and enhancement of categorical projects.

Action: Coordinate funding commitments with the State of Maryland's AIDS Administration.

Objective: To ensure the availability of HIV prevention and education services, pre-test counseling, post-test counseling, and risk assessment on-site in all certified treatment programs, with testing and therapeutic services available through referral.

Action: Require, by policy, referral agreements for testing and therapeutic services.

Action: The State of Maryland's Department of Health and Mental Hygiene, Office of Health Care Quality shall review availability and referral of services for patients during the annual/biannual certification process.

Objective: To collaborate with the Maryland AIDS Administration regarding the training and implementation of the HIV rapid testing procedures.

Action: Alcohol and Drug Abuse Administration will identify key staff to collaborate with the AIDS Administration regarding training and implementation of procedures.

Maryland

Attachment E: TB and Early Intervention Svcs

Attachment E: Tuberculosis (TB) and Early Intervention Services for HIV
(See 45 C.F.R. 96.122(f)(1)(x))

For the fiscal year three years prior (FY 2005) to the fiscal year for which the State is applying for funds:

Provide a description of the State's procedures and activities and the total funds expended (or obligated if expenditure data is not available) for tuberculosis services. If a "designated State," provide funds expended (or obligated), for early intervention services for HIV.

Examples of procedures include, but are not limited to:

- development of procedures (and any subsequent amendments), for tuberculosis services and, if a designated State, early intervention services for HIV, e.g., Qualified Services Organization Agreements (QSOA) and Memoranda of Understanding (MOU);
- the role of the single State authority (SSA) for substance abuse prevention and treatment; and
- the role of the single State authority for public health and communicable diseases.

Examples of activities include, but are not limited to:

- the type and amount of training made available to providers to ensure that tuberculosis services are routinely made available to each individual receiving treatment for substance abuse;
- the number and geographic locations (include sub-State planning area) of projects delivering early intervention services for HIV;
- the linkages between IVDU outreach (See 42 U.S.C. 300x-23(b) and 45 C.F.R. 96.126(e)) and the projects delivering early intervention services for HIV; and
- technical assistance.

Tuberculosis (TB)

Administration policy mandates that all funded addictions treatment programs shall directly, or through arrangements with other public or non-profit private entities, routinely make available tuberculosis services for patients admitted for addictions treatment as well as for their employees. In addition, programs must meet all State reporting requirements outlined in COMAR 10.06.03. This requires that reportable diseases, such as active tuberculosis, be reported to the local Health Officer within 48 hours. The State of Maryland Department of Health and Mental Hygiene Office of Health Care Quality reviews compliance of tuberculosis assessment and referral services during the annual/biannual certification process.

Programs shall provide the following services to patients.

- A. Counseling and Education
- B. TB Risk Assessment and Referral
- C. Identification and Management of TB Suspects
- D. Case Management
- E. Record Keeping

Programs shall provide the following services to employees.

NOTE: ("Employee" refers to all persons working in an addictions program, including physicians, nurses, counselors, aides and persons not directly involved in patient care, such as; dietary, housekeeping, maintenance, clerical and janitorial staff.)

Employee TB Training: All employees shall receive TB infection control training within one month of employment and annually. Training shall be appropriate to the job category. Training shall be conducted before initial assignment and annually. Although the level and detail of this education may vary according to job description, the following elements shall be included in the education of all addictions employees.

1. The basic concepts of TB transmission, disease process, and diagnosis, including the difference between TB infection and active TB disease and the signs and symptoms of TB.
2. The potential for occupational exposure to persons with infectious TB in the addiction program.
3. The principles and practices of infection control that reduces the risk of transmission of TB.
4. The purpose of PPD testing, the significance of a positive result and the importance of participation in the skin test program
5. The principles of preventive therapy for latent TB infection and the potential adverse effects of the drugs.
6. The responsibility of the employee to seek medical evaluation promptly if symptoms develop that may be due to TB or if PPD test conversions occurs.
7. The principles of drug therapy for active TB.
8. The importance of notifying the program if the employee is diagnosed with active TB.
9. The responsibilities of the program to maintain the confidentiality of the employee while assuring that the employee with TB receives appropriate therapy and is non-infectious before returning to duty.
10. The higher risk posed by TB to individuals with HIV infection or other causes of immune suppression.
11. The potential for false-negative PPD skin tests as immune function declines.

Early Intervention Services for HIV

Prevention and treatment of AOD abuse and HIV disease require a

multi-disciplinary approach that relies on the strength of a variety of providers and treatment settings to provide a comprehensive range of effective services. Among substance abusers, specific practices such as needle sharing have been clearly identified as an important HIV risk behavior. Understanding the need to address methods in which we can prevent the spread of HIV/AIDS, the Administration has required all funded providers to provide HIV/AIDS education, assessment and counseling services to their patients.

Additionally and in support of this process, the following targeted projects detailed by region provide categorical early intervention services for HIV.

| Agency | Amount | Location |
|---|-----------|----------------|
| 1. Glenwood Life Counseling Center | \$50,468 | Baltimore City |
| 2. Health Care for the Homeless/PEP | \$107,549 | Baltimore City |
| 3. ADAA Program Manager, Program Evaluator and Partial Capacity Building Trainer salary & fringe benefits | \$166,500 | Baltimore City |
| 4. *RFP to be let in December | \$98,120 | Baltimore City |
| Total ADAA Funds | \$422,637 | |

Summary of Services:

| Agency | Activities | # Sessions | # Clients Served |
|---|----------------|------------|--|
| Glenwood Life Counseling Center | Group Sessions | 134 Groups | 133 |
| Health Care for the Homeless/PEP | Group Sessions | 148 Groups | 200 |
| Capacity Building and Training sessions targeted to Substance Abuse providers | Trainings | 9 Sessions | Over 200 Individualas participated in the following trainings: HIV101/Prevention Basics HIV & Substance Abuse and HIV Counseling & Testing |

The Maryland AIDS Administration will collaborate with the Baltimore City Health Department to let an RFP via BSAS for Substance Abuse Vendors to implement an HIV Prevention Intervention Curricula (Project SMART) within Substance Abuse Venues. The program Manager at the AIDS Administration will provide management for projects funded.

PROJECT SMART Curricula

Project SMART is a dual HIV risk reduction for Drug Users in short-term substance abuse treatment. The goals of the program are to reduce the incidence and transmission of HIV among IDUs and their networks. The curriculum includes an Informational Intervention as well as an Enhanced Intervention. The informational Intervention utilizes a cognitive-developmental approach to learning and consists of two 1-hour sessions that focus on HIV/AIDS information, AIDS antibody test, and condom use demonstration. The Enhanced intervention emphasizes a behavioral approach to education. The enhanced intervention include six group hours, plus ½ hour final one-on-one session to review a personal plan to reduce harm. Six 1-hour sessions focus on communicating about HIV/AIDS, dealing with difficult and harmful situations, and development of partner norms. Group discussion, experiential learning, and written homework enhance retention of program learning.

The total amount for HIV/AIDS early intervention and related services totaled \$1,609,557.

Provide a description of the State's procedures and activities and the total funds expended (or obligated if expenditure data is not available) for tuberculosis services. If a "designated State," provide funds expended (or obligated), for early intervention services for HIV.

Examples of procedures include, but are not limited to:

- development of procedures (and any subsequent amendments), for tuberculosis services and, if a designated State, early intervention services for HIV, e.g., Qualified Services Organization Agreements (QSOA) and Memoranda of Understanding (MOU);
- the role of the single State authority (SSA) for substance abuse prevention and treatment; and
- the role of the single State authority for public health and communicable diseases.

Examples of activities include, but are not limited to:

- the type and amount of training made available to providers to ensure that tuberculosis services are routinely made available to each individual receiving treatment for substance abuse;
- the number and geographic locations (include sub-State planning area) of projects delivering early intervention services for HIV;
- the linkages between IVDU outreach (See 42 U.S.C. 300x-23(b) and 45 C.F.R. 96.126(e)) and the projects delivering early intervention services for HIV;
- d
- technical assistance.

Maryland

Goal #7: Development of Group Homes

GOAL # 7. An agreement to continue to provide for and encourage the development of group homes for recovering substance abusers through the operation of a revolving loan fund (See 42 U.S.C. 300x-25). Effective FY 2001, the States may choose to maintain such a fund. If a State chooses to participate, reporting is required.

FY 2005 (Compliance): (participation OPTIONAL)

FY 2007 (Progress): (participation OPTIONAL)

FY 2008 (Intended Use): (participation OPTIONAL)

N/A

N/A

N/A

Maryland

Attachment F: Group Home Entities

Attachment F: Group Home Entities and Programs
(See 42 U.S.C. 300x-25)

If the State has chosen in Fiscal Year 2005 to participate and continue to provide for and encourage the development of group homes for recovering substance abusers through the operation of a revolving loan fund then Attachment F must be completed.

Provide a list of all entities that have received loans from the revolving fund during FY 2005 to establish group homes for recovering substance abusers. In a narrative of up to two pages, describe the following:

- the number and amount of loans made available during the applicable fiscal years;
- the amount available in the fund throughout the fiscal year;
- the source of funds used to establish and maintain the revolving fund;
- the loan requirements, application procedures, the number of loans made, the number of repayments, and any repayment problems encountered;
- the private, nonprofit entity selected to manage the fund;
- any written agreement that may exist between the State and the managing entity;
- how the State monitors fund and loan operations; and
- any changes from previous years' operations.

An agreement to continue the provision for and encourage the development of group homes for recovering substance abusers through the operation of a revolving loan fund is optional for States effective with FFY 2002. While the Administration continues to review the provision of substance free living environments as a critical component in sustaining recovery efforts, effective with FFY 2002 the Administration elected to discontinue the dedicated (set-aside) revolving loan fund in order to increase funding to the existing system of care. The Administration will consider other available options that are provided to identify funding for this effort. It is the intent of Administration management to also continue to strategically evaluate the service needs and available resources for those Maryland citizens in recovery.

Maryland

Goal #8: Tobacco Products

GOAL # 8. An agreement to continue to have in effect a State law that makes it unlawful for any manufacturer, retailer, or distributor of tobacco products to sell or distribute any such product to any individual under the age of 18; and, to enforce such laws in a manner that can reasonably be expected to reduce the extent to which tobacco products are available to individuals under age 18 (See 42 U.S.C. 300x-26 45 C.F.R. 96.130 and 45 C.F.R.96.122(d)).

- Is the State's FY 2008 Annual Synar Report included with the FY 2008 uniform application?
Yes No
- If No, please indicate when the State plans to submit the report:
mm/dd/2007

Note: The statutory due date is December 31, 2007.

- Is the State's FY 2008 Annual Synar Report included with the FY 2008 uniform application? NO
- If No, please indicate when the State plans to submit the report:
December 31, 2007

In FFY 2005, the State of Maryland maintained its established law prohibiting sale or distribution of tobacco products to individuals under the age of 18. No change in the law took place. Enforcement activities remained a unique local application of effort and strategy. Administration staff continued to conduct random unannounced inspections to ensure that retailers were not selling tobacco products to anyone under the age of 18 years. In addition, when the Administration found a retailer in non compliance during the non SYNAR period, the subdivisions was notified. This allowed all 24 subdivisions to utilize Administration inspection information to support their enforcements efforts. The non-compliance rate for 2005 was 8%, with 750 outlets inspected.

Objective: To assure adequate statutory prohibition against the sale of tobacco to persons under the age of 18.

Action: Participate with the Office of the Attorney General, Cancer Control, appropriate departmental, legislative committees and executive departments in reviewing and, if necessary, revising existing law.

Action: Testify at necessary bill hearings.

Objective: To strive to obtain a non-compliance rate equal to or below the required target of twenty percent (20%), as mandated by the Synar Amendment.

Action: Conduct random, unannounced inspections at selected outlet locations throughout the State of Maryland.

Action: Collaborate with the appropriate enforcement agencies at local, state and federal levels of government in developing enforcement methods.

Action: Utilize federal funding to provide enhanced infrastructure and programming related to effective enforcement activities aimed at reducing use of tobacco by youth.

Maryland

Goal #9: Pregnant Women Preferences

GOAL # 9. An agreement to ensure that each pregnant woman be given preference in admission to treatment facilities; and, when the facility has insufficient capacity, to ensure that the pregnant woman be referred to the State, which will refer the woman to a facility that does have capacity to admit the woman, or if no such facility has the capacity to admit the woman, will make available interim services within 48 hours, including a referral for prenatal care (See 42 U.S.C. 300x-27 and 45 C.F.R. 96.131).

FY 2005 (Compliance):

FY 2007 (Progress):

FY 2008 (Intended Use):

In FFY 2005, the State of Maryland continued to ensure pregnant women be given preference in admission to treatment. Please refer to Goal # 3 for compliance discussion for FFY 2004.

In FFY 2007, the State of Maryland continued to ensure that pregnant women be given preference in admission to treatment. Please refer to Goal # 3 for progress discussion for FFY 2006.

In FFY 2008, the State of Maryland shall continue to ensure that pregnant women be given preference in admission to treatment. Please refer to Goal # 3 for specific objectives and actions intended to provide continued compliance with the requirement that pregnant women be given preference in admission to treatment.

Maryland

Attachment G: Capacity Management

Attachment G: Capacity Management and Waiting List Systems
(See 45 C.F.R. 96.122(f)(3)(vi))

For the fiscal year two years prior (FY 2006) to the fiscal year for which the State is applying for funds:

In up to five pages, provide a description of the State's procedures and activities undertaken, and the total amount of funds expended (or obligated if expenditure data is not available), to comply with the requirement to develop capacity management and waiting list systems for intravenous drug users and pregnant women (See 45 C.F.R. 96.126(c) and 45 C.F.R. 96.131(c), respectively). This report should include information regarding the utilization of these systems. Examples of procedures may include, but not be limited to:

- development of procedures (and any subsequent amendments) to reasonably implement a capacity management and waiting list system;
- the role of the Single State Authority (SSA) for substance abuse prevention and treatment;
- the role of intermediaries (county or regional entity), if applicable, and substance abuse treatment providers; and
- the use of technology, e.g., toll-free telephone numbers, automated reporting systems, etc.

Examples of activities may include, but not be limited to:

- how interim services are made available to individuals awaiting admission to treatment;
- the mechanism(s) utilized by programs for maintaining contact with individuals awaiting admission to treatment; and
- technical assistance.

All addictions treatment programs must, by State regulations, be certified and report to the Administration's online data collection application. The ADAA Information Services Division gathers program census and wait list, demographic, drug use, and route of admission data on each patient accessing addictions treatment. Through reporting incidence data, length of time in treatment for each patient and an average retention rate across different levels of care and programs are computed. The Administration tracks and ensures Intravenous Drug Users (IVDUs) are admitted and retained in treatment as long as possible. Treatment programs are certified by the Department of Health and Mental Hygiene, Office of Health Care Quality on an annual or biannual basis. This certification process includes a thorough review of patient records, clinical and medical policies and procedures, and fiscal and personnel practices. All of these methods combine to ensure that the special needs of IVDUs are met. The Administration has issued and implemented a waiting list policy requiring patients be placed on a waiting list if the time between initial contact and admission is longer than 10 days or be referred to another program. Programs are encouraged to assist the persons on the wait list in finding another treatment option. All programs are required to submit a Census and Wait List report with their monthly submission of incidence data to the Administration.

Baltimore City has the highest incidence of IVDUs and opioid users in Maryland. Most OMT programs are at capacity and maintaining wait lists for this population is undesirable. In FFY 2005 Baltimore City ran a SAMHSA funded pilot program for Opioid Maintenance Therapy programs to begin using an Interim Maintenance protocol. Programs in the pilot, when capacity has been reached can offer the patient the option of entering an Interim Maintenance protocol. Patients come to the treatment program and receive daily doses of opioid maintenance medication for a period of no more than 120 days at which time the patient must be placed into a permanent treatment slot.

In SFY 2006 the Administration assumed funding for the Interim Methadone program in Baltimore City and began investigating expanding this practice to other jurisdictions.

In July 1989, the administration issued and implemented the pregnant Addict Policy; requiring pregnant addicts receive priority admission at all State certified treatment programs. The status of a treatment program's policy of admission of pregnant addict admissions is reviewed at every onsite certification visit.

All complaints from consumers and stakeholders about waiting lists and admission policies are examined by the Compliance Section of the Quality Assurance Division.

Maryland

Goal #10: Process for Referring

GOAL # 10. An agreement to improve the process in the State for referring individuals to the treatment modality that is most appropriate for the individual (See 42 U.S.C. 300x-28(a) and 45 C.F.R. 96.132(a)).

FY 2005 (Compliance):

FY 2007 (Progress):

FY 2008 (Intended Use):

In FFY 2005, All substance abuse treatment programs are required to utilize Administration approved assessment tools, which in the case of adults, is the Addictions Severity Index (ASI) and in the case of adolescents, the Problem Oriented Screening Instrument for Teenagers (POSIT). The instruments are provided through the Administration's online clinical record and training in their application is provided to the field through the Administrations Office of Education and Training for Addiction Services.

The State of Maryland Automated Record Tracking (SMART) application is a web based full clinical record based on the WITS platform. In the application two assessments are provide for the clinician. The ASI and the Treatment Assignment Protocol (TAP). The TAP provides questions based on the ASAM PPC II or II-R criteria and is very useful for determining the appropriate patient level of care placement. Once an appropriate level of care is determined, programs using the SMART application and electronically refer the patient to the appropriate treatment provider.

Provide Administration sponsored programming in SMART, trainings and technical assistance in best practice and specific application of screening, assessment and placement instruments. Training is offered through the Office on Education and Training for Addiction Services (OETAS).

SMART enhancements have included additional programming to provide instruments such as the Simple Screening Interview - Substance Abuse (SSI-SA) from the SAMHSA TAP 49.

Continue to provide Administration sponsored trainings and technical assistance in best practice and specific application of screening, assessment and placement instruments through the Office on Education and Training for Addiction Services (OETAS).

Continue to provide enhancement of SMART, to include additional screening, assessment and placement instruments.

Maryland

Goal #11: Continuing Education

GOAL # 11. An agreement to provide continuing education for the employees of facilities which provide prevention activities or treatment services (or both as the case may be) (See 42 U.S.C. 300x-28(b) and 45 C.F.R. 96.132(b)).

FY 2005 (Compliance):

FY 2007 (Progress):

FY 2008 (Intended Use):

In FFY 2005, the Administration continued to provide continuing education for the employees of facilities that provided prevention activities and treatment services. The Office of Education and Training (OETAS) within the Quality Assurance Division of the Administration was responsible for ensuring that continuing education courses were provided that met the needs of individuals providing addiction services.

The OETAS in collaboration with the Central East Addiction (CEATTC) and the Northeast Center for Applied Prevention Technology (NECAPT) provided year round training which met the needs of the addiction workforce. Training funds were allocated in all the programs funded by the State to afford the programs the opportunity to purchase training from OETAS or from other training venues which met their particular workforce needs.

However, most programs continued to select OETAS as their primary training provider and purchased training from OETAS. Student tuition was used to support the costs associated with the training such as instructional services, curriculum development, educational resources and materials.

There were three formats through which training was conveyed: commuter courses, residential training and customized training. Beginning in September of 2004 through May of 2005, OETAS, in cooperation with its federal partners offered 40 commuter courses and workshops at our central training location on the grounds of Spring Grove Hospital. In June, July and August of 2005 OETAS provided statewide residential training at Salisbury University located on the eastern shore of Maryland. During these three months, OETAS provided 24 twenty hour courses to 532 students. In addition, OETAS designed and provided customized continuing education activities to meet the specific workforce needs of various agencies' requesting this service. Instruction was provided at the work site to the staff of these addiction programs.

In 2001, Maryland required addiction counselor to be certified by the Maryland Board of Professional Counselors which stipulated the completion of basic addiction counseling courses at the college level. As a result, training and courses offered by OETAS were focused upon the acquisition of knowledge and skills of more advance counseling and prevention topics, such as motivational interviewing, cognitive behavior therapy, advance pharmacology, the strategic prevention framework and co-occurring disorders.

Finally, the ADAA hosted its statewide management conference for addiction program managers and prevention coordinators which comprise our State funded prevention, intervention and treatment addiction system.

In FFY 2007, the Administration continued to rely upon the Office of Education and Training (OETAS) to provide continuing education for the employees of facilities that provided prevention activities, intervention and treatment services. The Office continued to provide education opportunities through primary three methods of training services delivery: 1) centralized commuter training given from September to May at the training facility located at the ADAA at Spring Grove Hospital Center in Catonsville, Maryland, 2) statewide residential training at Salisbury University located in Salisbury, Maryland during the summer months of June, July and August, and 3) customized training to meet the workforce need of specific agencies. Utilizing these formats, OETAS will have provided 27 training opportunities through commuter classes and customized training and training to approximately 500 participants who attended the 25 (20) hour courses at our residential programs at Salisbury.

As stated earlier, funded program are provided training dollars through the State's grant funding process. Although OETAS remains the primary provider of training for addiction counselors in Maryland, addiction programs determine how to use their training dollars to purchase continuing education that best meets the needs of the program and its workforce. The training monies received by OETAS from training participants are used to support the continued training efforts of OETAS.

In the continuing education courses offered by OETAS there is emphasis placed upon advance addiction counseling and prevention subject matter that reiterates the vital need to integrate evidence based research into daily clinical processes and prevention activities.

ADAA hosted the fifth annual management conference which approximately 200 program managers, prevention coordinators and central administrators attended. The conference focused upon how the addiction service system must examine current business practices and reform them in order to better serve patients.

The Office of Education and Training for Addiction Services (OETAS) will continue with the responsibility of improving addiction treatment and prevention services by strengthening the knowledge, skills and attitudes of those providing substance abuse prevention and treatment services in Maryland. It is committed to improving the competency of current and future practitioners who comprise our prevention and treatment systems of care in Maryland.

The Office of Education for Addiction Service in collaboration with the Central East Technology Transfer Center and the Northeast Center for Applied Prevention Technologies will continue to create and deliver continuing education courses and assist higher education institutions in Maryland to develop addiction curriculum.

The Office of Education and Training will provide addiction training throughout the year. Beginning in September through May, the Office will provide addiction training in a commuter format for treatment and prevention service providers. During the months of June, July and August, the Office will provide each month a week of residential training with eight courses of twenty hour duration being offered at each session to serve approximately 500 participants. In addition, the Office will design and provide customized continuing education activities to meet the specific needs of an agency's workforce.

The training efforts of OETAS are supported by the student tuition fees charged by OETAS to the individual and/or his agency for participation in a course. It is through these funds that training activities are supported and sustained.

In October, the Office will host a statewide management conference for addictions program managers and prevention coordinators to be held in the Western region of our state.

WORKFORCE DEVELOPMENT

The Alcohol and Drug Abuse Administration has worked cooperatively with the Central East Addiction Technology Center to survey Maryland's entire addiction treatment field including funded and non funded programs. This extensive workforce survey, completed in 2006, has proved to be an invaluable tool for understanding current workforce needs and the critical issues that must be addressed to ensure an addiction field that will respond effectively to the needs of Maryland's citizens. The Administration is working to address workforce issues in a variety of ways.

The Administration recognized that in order to serve the increasing numbers of individuals who are seeking addiction services there is a need to examine work processes and business practices to ensure the efficient and effective provision of services. This was the focus of the Alcohol and Drug Abuse Administration's three day annual management conference. The conference, "The Business of Addiction" in October, 2006 provided an opportunity for the administration to examine with the managerial and program administrators of Maryland's publicly funded addiction treatment and prevention programs our internal and external business practices in order to achieve greater economy while increasing the quality of our services. The participants of the conference had the opportunity to hear from national leaders in the addiction treatment and prevention field such as Dr. Thomas McLellan of TRI and William Hansen of Tanglewood Research Inc. on how to be more effective providers of addiction services. Also, a unique feature of this conference was the inclusion of Dr. John Kimberly, Professor of Entrepreneurial Studies at the Wharton School of the University of Pennsylvania. Dr. Kimberly challenged the conference participants to think anew on how the business practices of successful private corporations could be infused and adapted to addiction practices in the public sector.

This year's management conference will continue to focus on the implementation

of sound business practices in our addiction services. The conference, "The Business of Addiction: The Workforce Connection" will directly link how management practices effect the retention of staff and workforce development.

Another component of Maryland's workforce development plan is the infusion of technology into our professional and clinical practices. For the past five years, the administration has devoted financial and staff resources to upgrading the hardware and software of the central administrative staff as well as the funded addiction programs. The Administration has purchased directly and have budgeted monies for the treatment system to acquire and utilize the most current technology. The upgrading of the technology hardware and the ability to use technology is integral to the successful migration of Maryland programs to using the web-based data reporting system, State of Maryland Automatic Record Tracking System (SMART). The Administration began the development of SMART approximately two and half years ago. During FY07, the introduction and implementation of SMART at the program level began and is projected to be completed during FY08. Extensive training of staff at all program levels accompanied the introduction of the new technology and is ongoing. Regional user groups provide the opportunity for counselors and other users of SMART to further refine their skills.

An important task of workforce development is the development of a strong cadre of individuals who will be able to provide leadership to the addiction field in the future. Recognizing this, the Administration in FY07 was actively involved in the Leadership Institute sponsored by the Central East Addiction Treatment Technology Center (CEATTC). Maryland selected four individuals from local addiction programs to be protégées in the program. It is an excellent year long mentoring program that provides an opportunity to develop and foster the future leaders of the addiction treatment system.

The essential ingredient to achieving a competent workforce who can assist individuals in their recovery is the adoption of evidenced based practices at all levels. The Office of Education and Training for Addiction Services (OETAS) is the unit within the Administration which is charged with the transfer of technology at all administrative and clinical levels. During FY07, OETAS offered courses on such management topics as clinical supervision, budgetary and fiscal processes, program management and human resource management to foster better management and leadership development. Courses on racial and ethnic diversity as well as professional development courses on ethics and confidentiality were offered to increase the professionalism of the addiction field. The emphasis in all the 20 hour courses that OETAS provides is the vital need to integrate evidence-based research into daily clinical and prevention practices.

Maryland

Goal #12: Coordinate Services

GOAL # 12. An agreement to coordinate ,prevention activities and treatment services with the provision of other appropriate services (See 42 U.S.C. 300x-28(c) and 45 C.F.R. 96.132(c)).

FY 2005 (Compliance):

FY 2007 (Progress):

FY 2008 (Intended Use):

In FFY 2005, the Administration coordinated a continuum of prevention and treatment services statewide with the provision of other appropriate services. Through participation with other involved State departments, local health departments and healthcare professionals coordination of other activities with treatment services was accomplished.

Examples of this coordination of activities include:

In partnership with the High Intensity Drug Trafficking Area (HIDTA) initiative, the Division of Parole and Probation, local health departments, and other appropriate agencies, the Administration has continued to implement improvements to the criminal justice and substance abuse treatment systems. The Administration continues to provide on-going training and technical assistance to the counties and Baltimore City regarding programmatic implementation and performance issues.

The Administration, the Department of Public Safety and Correctional Services, local corrections and health departments have collaborated to develop intensive therapeutic treatment programs that include inmate treatment services, post-release community based aftercare treatment, and close coordination between involved criminal justice and treatment agencies.

The Homeless Initiative provides comprehensive addiction and other auxiliary services needed to assist addicted and at-risk homeless individuals in regaining a stable and productive lifestyle. These services are located regionally.

In FFY 2007, the Administration continues to coordinate a continuum of prevention and treatment services statewide with the provisions of other appropriate services. Through participation with other involved State departments, local health departments and healthcare professionals coordination of other activities with treatment services continues to be accomplished.

Examples of this coordination of activities include:

The Administration, local corrections and health departments have collaborated to develop intensive therapeutic treatment programs that include inmate treatment services, post-release community based aftercare treatment, and close coordination between involved criminal justice and treatment agencies.

The Homeless Initiative provides comprehensive addiction and other auxiliary services needed to assist addicted and at-risk homeless individuals in regaining a stable and productive lifestyle. These services are coordinated regionally by Worcester, Prince George's, and Carroll Counties and Baltimore City.

Objective: To continue improving the coordination of prevention and treatment services with the provision of other appropriate services.

Action: Confer with other State departments/agencies, local health departments, education, legislative and community organizations to implement & coordinate programs that include prevention and treatment services.

Action: Collaborate with the Department of Human Resources to ensure integration of child welfare issues and treatment services for women.

Maryland

Goal #13: Assessment of Need

GOAL # 13. An agreement to submit an assessment of the need for both treatment and prevention in the State for authorized activities, both by locality and by the State in general (See 42 U.S.C. 300x-29 and 45 C.F.R. 96.133).

FY 2005 (Compliance):

FY 2007 (Progress):

FY 2008 (Intended Use):

In FFY 2005, the Administration continued its needs assessment analysis. Based on data from the Substance Abuse Management Information System (SAMIS), The Outlook and Outcomes FY 2005 Annual Report was produced and distributed statewide. This report and other selected patient-based data and treatment utilization reports provided details of treatment services delivered in every sector of the State, which facilitated informed targeting of resource needs.

The Administration continued to improve and enhance its electronic data collection and analysis capabilities with the service provider network, contributing to greater information accuracy and completeness for targeting available resources. The Administration continues to use the truncated Poisson probability distribution to estimate statewide and local need based on analysis of treatment episode data. All certified treatment programs in Maryland, both public and private, are required to report to the Substance Abuse Management Information System (SAMIS), so data represent the full spectrum of treatment in Maryland. It is estimated about 260,000 Maryland citizens, 5.3 percent of the population aged 10 and older, needed alcohol and drug abuse treatment. About one in five of those in need received treatment in Block Grant funded programs in FY 2005. ADAA has used this method to estimate need for each of the 24 Maryland subdivisions, and this information is used for preparation of budget requests, educating policy makers and the public, and allocating available resources to meet need. ADAA also continues to use results from the SAMHSA-funded State Need Assessment Program (STNAP).

The Maryland Alcohol and Drug Abuse Administration (ADAA) did not utilize SAPT Block Grant funds to conduct a Prevention Needs Assessment for FY2007. Although, the Maryland Alcohol and Drug Abuse Administration (ADAA) did not utilize SAPT Block Grant funds to conduct a Prevention Needs Assessment for FY2005 the ADAA applied for the Strategic Prevention Framework-State Incentive Grant in June, 2004 and was unsuccessful. The Administration has utilized concepts of the Strategic Prevention Framework (SPF) to educate members of the legislatively mandated Local Drug and Alcohol Councils in each of Maryland's 24 jurisdictions.

Local council members were provided regional trainings that focused on implementing a strategic planning process that used epidemiological data to make informed decisions regarding treatment, intervention and prevention programming needs.

During FFY 2007, the Administration continues to use the truncated Poisson probability distribution to estimate Statewide and local need-based on analysis of treatment episode data. It is estimated about 260,000 Maryland citizens, 5.3 percent of the population aged 10 and older, needed alcohol and drug abuse treatment. About one in five of those in need received treatment in Block Grant funded programs in FY2005. Work continued on an internet reporting initiative that shall facilitate patient-based data collection throughout the State, allow for enhanced needs assessment analysis, and promote the development of program performance standards. The ADAA Research Section focuses on developing new data analysis strategies, developing strategic planning and local needs assessment capabilities, and performance measurement. Reports have been developed that examine retention, progression from one level of care to another, reduction in substance use and arrests and improvement in employment and living situation by subdivision and for individual treatment programs. Program personnel are being trained in planning and utilizing data to enhance local treatment systems.

Objective: To continue existing needs assessment analysis as conducted by the Administration.

Action: Compile and generate Outlook and Outcomes reports, treatment utilization reports, team grant review reports, subdivision-level performance reports and other patient-based analyses of the treatment network.

Action: Implement conversion of the treatment network to web-based reporting and promote greater use of data by providers for program improvement, needs assessment and effective outreach.

Action: Partner with the Institute of Governmental Services and Research (IGSR), the Center for Substance Abuse Research (CESAR) to enhance performance measurement and develop resource allocation methodologies.

Action: Continue to provide technical assistance to the local councils to utilize data to identify gaps in the county/regional prevention/treatment system and to assess performance.

Maryland

Goal #14: Hypodermic Needle Program

GOAL # 14. An agreement to ensure that no program funded through the block grant will use funds to provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs (See 42 U.S.C. 300x-31(a)(1)(F) and 45 C.F.R. 96.135(a)(6)).

FY 2005 (Compliance):

FY 2007 (Progress):

FY 2008 (Intended Use):

In FFY 2005 ADAA conditions of grant award notified all programs that funds that support needle exchange were prohibited. No funds were utilized for that purpose.

As a condition of award, all programs were notified that funds to support needle exchange were prohibited. Local Health Officers sign an acknowledgement by which the jurisdiction accepts the conditions of the award. No funds were utilized for this purpose.

Objective: To ensure continued compliance of SAPT Block Grant fund restriction on use relating to provision of hypodermic needles or syringes.

Action: Notify sub-recipients of funds through grant conditions of award and technical assistance, as needed.

Maryland

Goal #15: Independent Peer Review

GOAL # 15. An agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers that receive funds from the block grant (See 42 U.S.C. 300x-53(a) and 45 C.F.R. 96.136).

FY 2005 (Compliance):

FY 2007 (Progress):

FY 2008 (Intended Use):

In FFY 2005, a total of four (4) independent peer reviews of treatment programs were conducted in the State of Maryland. The peer reviews were done to assess and improve the quality and appropriateness of treatment services delivered by funded providers.

In FFY 2007, the Administration conducted five (5) Independent Peer Reviews which have been conducted in treatment programs in Baltimore City, Montgomery County and Prince George's County. Reviews have been conducted in an interactive atmosphere in an effort to support and enhance effective quality treatment service delivery by funded providers.

Objective: To provide 5% of SAPT Block Grant funded programs with independent peer reviews that are helpful to the programs.

Action: Conduct independent peer reviews and distribute findings to programs for use in ongoing program improvement

Action: Provide peer review findings to Administration Regional Team Managers if technical assistance is needed or requested by the programs.

Action: Request feedback from programs that have participated in Peer Review to provide feedback about the experience and make any suggestions for changes in the process.

Maryland

Attachment H: Independent Peer Review

Attachment H: Independent Peer Review (See 45 C.F.R. 96.122(f)(3)(v))

In up to three pages provide a description of the State's procedures and activities undertaken to comply with the requirement to conduct independent peer review during FY 2006 (See 42 U.S.C. 300x-53(a)(1) and 45 C.F.R. 96.136).

Examples of procedures may include, but not be limited to:

- the role of the Single State Authority (SSA) for substance abuse prevention activities and treatment services in the development of operational procedures implementing independent peer review;
- the role of the State Medical Director for Substance Abuse Services in the development of such procedures;
- the role of the independent peer reviewers; and
- the role of the entity(ies) reviewed.

Examples of activities may include, but not be limited to:

- the number of entities reviewed during the applicable fiscal year;
- technical assistance made available to the entity(ies) reviewed; and
- technical assistance made available to the reviewers, if applicable.

The Administration tailors its Independent Peer Review process to be comprehensive and to highlight specific levels of treatment identified as priorities based on internal data and CSAT. In this past fiscal year, the peer review process focused on programs providing services in Baltimore City and an adjoining county. Reviews of programs providing medication assisted treatment were a large part of this fiscal year's reviews.

The Administration has designed its Independent Peer Review process to be an educational experience intended to provide feedback to addiction treatment programs for the enhancement of the quality of their services to patients. Each year a specific level of treatment will be reviewed based on internal and CSAT data.

During FFY 2005, a total of four (4) independent peer reviews of treatment programs were conducted in the State of Maryland. The Administration continues to assess its reviews by including the provision of a follow-up questionnaire to each program that has completed a review and received a final report supplied by the reviewer. This has allowed the Administration to increase the overall effectiveness of the independent review process. We anticipate maintaining full compliance with the peer review requirement. Accordingly, our progress to date indicates a strengthened process as we proceed forward with our FFY 2008 intended use planning.

In addition, the Administration provides information about the Independent Peer Review process to the field of addiction service providers. The areas of review include quality of services, appropriateness of services, efficacy of services and appropriateness of placement.

Role of the Treatment Program Peer Reviewers - IPR Credentialing and Procedures

Treatment program peer reviewers are selected from a pool of treatment professionals experienced in the field of addictions. The Administration's Quality Assurance Director reviews all applications and verifies applicants' credentials. The selected reviewers are placed on contract with the Administration.

Specifically, reviewers shall demonstrate experience as a treatment provider and have knowledge and experience with a variety of target groups; i.e., alcohol abuse, other drug abuse, co-occurring disorders, medication assisted treatment, youth, women, inner city/urban, rural, and criminal justice. The reviewer must have knowledge and experience with more than one of the following levels of care; residential, outpatient, intensive outpatient, and culturally specific programs. Experience as a treatment program Clinical Supervisor or Program Director is desired. The reviewer shall be a member of one of the following disciplines: Licensed Clinical Alcohol and Drug Counselor, Social Worker, Psychologist, Registered Nurse, Psychiatrist, or possess a Masters Degree in a Human Service discipline. The reviewer must have at least five (5) years of experience in the AOD field.

The Administration requires programs that receive federal funds to be available for Independent Peer Review if selected. The Peer Review Coordinator selects the program and schedules dates for the site review. During the site review, interviews are conducted with the Program Director, QA/QI Manager, Clinical Supervisor, and program staff. Personnel records and CQI/QA documentation are reviewed. A random sample of recently discharged patient records is examined for the following:

- Quality of the intake process and appropriateness of the admission;
- Quality of the assessment;
- Quality and appropriateness of the treatment plan, including referrals;

- Quality of the implementation of treatment services; and
- Quality and appropriateness of patient discharge.

Subsequently, reviewers and program staff participate in an oral exit interview to discuss the site visit results. It is stated at that time that the Administration will supply any technical assistance requested to improve identified program needs. The Peer Reviewer prepares a written summary of the peer review visit and submits it to the Administration within three weeks. The Administration maintains a copy in the master file and sends the final report to the treatment program's director. In addition, the Program Director is sent a follow-up questionnaire asking for feedback concerning the experience.

Maryland

Goal #16: Disclosure of Patient Records

GOAL # 16. An agreement to ensure that the State has in effect a system to protect patient records from inappropriate disclosure (See 42 U.S.C. 300x-53(b), 45 C.F.R. 96.132(e), and 42 C.F.R. Part 2).

FY 2005 (Compliance):

FY 2007 (Progress):

FY 2008 (Intended Use):

In FFY 2005 the Administration continued to provide counselor training on the subject of Federal Confidentiality Regulations and monitor program's compliance with the regulations. The Administration's Office of Education and Training for Addictions Services (OETAS) continued to provide patient confidentiality training to providers of addiction services in the State of Maryland. OETAS provided all-day trainings on a variety of treatment related topics throughout the year. During this time period, OETAS provided a three-day session on professional ethics that included patient confidentiality requirements. This twenty-hour training course was attended by twenty substance abuse treatment providers.

In FFY 2007 the Administration continues to monitor programs' compliance with Federal/State confidentiality rules. To ensure that substance abuse treatment programs continue to comply with the federal and state confidentiality regulations the Administration's Treatment Compliance Section, under the direction of the Quality Assurance Division routinely monitors Maryland's substance abuse treatment programs by conducting random program compliance reviews. The random reviews are conducted by the Section's Treatment Compliance Evaluators (TCE). The TCEs visit programs to review both administrative and clinical areas to determine compliance status. Programs that were deficient in the area of patient confidentiality were offered technical assistance and problem resolution by the administration. Any continued deficiencies may result in the substance abuse program losing its certification and its privilege to provide substance abuse services in the State of Maryland. It is expected that each program will be assessed for compliance by the Treatment Compliance Section bi-annually.

All certified substance abuse treatment programs in the State of Maryland must comply with federal and state confidentiality regulations as a condition of their certification. The Department of Health and Mental Hygiene's Office of Health Care Quality is the agency responsible for certifying substance abuse programs in Maryland. During the bi-annual certification program site visits policy and procedure manuals were checked for provisions regarding this issue. Patient records were also monitored for appropriate and accurate consent forms and patient rights statements that included these protections. Each substance abuse treatment program is required by regulation to have a statement of patient's rights and must provide a copy to each patient upon admission.

Objective: To maintain existing training activities through OETAS.

Action: Continue to provide counselor training that includes education regarding Federal Confidentiality Regulations.

Objective: To require programs to consistently apply Federal/State Confidentiality Regulations.

Action: Conduct regularly scheduled compliance reviews and complaint investigations to evaluate compliance with Federal/State confidentiality rules.

Action: Develop systems that will respond to reported breaches in Federal/State confidentiality rules.

Action: Continue to provide technical assistance and problem resolution to substance abuse treatment programs that are deficient in this area.

Maryland

Goal #17: Charitable Choice

GOAL # 17. An agreement to ensure that the State has in effect a system to comply with 42 U.S.C. 300x-65 and 42 C.F.R. part 54 (See 42 C.F.R. 54.8(b) and 54.8(c)(4), Charitable Choice Provisions and Regulations).

FY 2005 (Compliance):

FY 2007 (Progress):

FY 2008 (Intended Use):

Under Charitable Choice, States, local governments, and religious organizations, each as SAMHSA grant recipients, must: (1) ensure that religious organizations that are providers provide notice of their right to alternative services to all potential and actual program beneficiaries (services recipients); (2) ensure that religious organizations that are providers refer program beneficiaries to alternative services; and (3) fund and/or provide alternative services. The term "alternative services" means services determined by the State to be accessible and comparable and provided within a reasonable period of time from another substance abuse provider ("alternative provider") to which the program beneficiary ("services recipient") has no religious objection.

The purpose of Attachment I is to document how your State is complying with these provisions.

N/A

During FY2007, Maryland did not award SAPT Block Grant funds to recipients or sub-recipients ("program participants") that would be a "religious organization" under the Final Rule. In Maryland, the Alcohol and Drug Abuse Administration (ADAA) awards funds (including SAPT) for substance abuse prevention and treatment services to local health departments or other designated entities of local government. These recipients in turn provide or fund services via sub-grants or sub-contracts with direct service providers. The providers must be certified by the Department of Health and Mental Hygiene to provide services consistent with the specific level(s) of care for which they receive funds.

Under The Code of Maryland Regulations (COMAR), providers must be certified to provide Levels of Care that are consistent with the American Society of Addiction Medicine (ASAM) Patient Placement Criteria. A "religious organization" meeting that standard would certainly be eligible for funding; however, to date none have applied for funding. ADAA Regional Technical Assistance Team Leaders have surveyed their respective regions to verify this information.

In Maryland, the Alcohol and Drug Abuse Administration (ADAA) awards funds (including SAPT) for substance abuse prevention and treatment services to local health departments or other designated entities of local government. These recipients in turn provide or fund services via sub-grants or sub-contracts with direct service providers. The providers must be certified by the Department of Health and Mental Hygiene to provide services consistent with the specific level(s) of care for which they receive funds.

Under The Code of Maryland Regulations (COMAR), providers must be certified to provide Levels of Care that are consistent with the American Society of Addiction Medicine (ASAM) Patient Placement Criteria. A "religious organization" meeting that standard would certainly be eligible for funding; however, to date none have applied for funding. ADAA Regional Technical Assistance Team Leaders have surveyed their respective regions to verify this information.

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Attachment I

| |
|---------------|
| State: |
| Maryland |

Attachment I

Under Charitable Choice, States, local governments, and religious organizations, each as SAMHSA grant recipients, must: (1) ensure that religious organizations that are providers provide notice of their right to alternative services to all potential and actual program beneficiaries (services recipients); (2) ensure that religious organizations that are providers refer program beneficiaries to alternative services; and (3) fund and/or provide alternative services. The term "alternative services" means services determined by the State to be accessible and comparable and provided within a reasonable period of time from another substance abuse provider ("alternative provider") to which the program beneficiary ("services recipient") has no religious objection.

The purpose of Attachment I is to document how your State is complying with these provisions.

Attachment I - Charitable Choice

For the fiscal year prior (FY 2007) to the fiscal year for which the State is applying for funds provide a description of the State's procedures and activities undertaken to comply with the provisions.

Notice to Program Beneficiaries - Check all that apply:

- Use model notice provided in final regulations.
- Use notice developed by State (attached copy).
- State has disseminated notice to religious organizations that are providers.
- State requires these religious organizations to give notice to all potential beneficiaries.

Referrals to Alternative Services - Check all that apply:

- State has developed specific referral system for this requirement.
- State has incorporated this requirement into existing referral system(s).
- SAMHSA's Treatment Facility Locator is used to help identify providers.
- Other networks and information systems are used to help identify providers.
- State maintains record of referrals made by religious organizations that are providers.
- 0 Enter total number of referrals necessitated by religious objection to other substance abuse providers ('alternative providers'), as define above, made in previous fiscal year. Provide total ONLY; no information on specific referrals required.

Brief description (one paragraph) of any training for local governments and faith-based and community organizations on these requirements.

Attachment I Footnotes

During FY2005, Maryland did not award SAPT Block Grant funds to recipients or sub-recipients ("program participants") that would be a "religious organization" under the Final Rule. In Maryland, the Alcohol and Drug Abuse Administration (ADAA) awards funds (including SAPT) for substance abuse prevention and treatment services to local health departments or other designated entities of local government. These recipients in turn award to or contract for services with local programs or vendors (sub-recipients).

Under The Code of Maryland Regulations (COMAR), providers must be certified to provide Levels of Care that are consistent with the American Society of Addiction Medicine (ASM) Patient Placement Criteria. A "religious organization" meeting that standard would certainly be eligible for funding; however, to date none have applied for funding. ADAA Regional Technical Assistance Team Leaders have surveyed their respective regions to verify this information.

| |
|---------------|
| State: |
| Maryland |

Attachment J

If your State plans to apply for any of the following waivers, check the appropriate box and submit the request for a waiver at the earliest possible date.

- To expend not less than an amount equal to the amount expended by the State for FY 1994 to establish new programs or expand the capacity of existing programs to make available treatment services designed for pregnant women and women with dependent children (See 42 U.S.C. 300x-22(b)(2) and 45 C.F.R. 96.124(d))
- Rural area early intervention services HIV requirements (See 42 U.S.C. 300x-24(b)(5)(B) and 45 C.F.R. 96.128(d))
- Improvement of process for appropriate referrals for treatment, continuing education, or coordination of various activities and services (See 42 U.S.C. 300x-28(d) and 45 C.F.R. 96.132(d))
- Statewide maintenance of effort (MOE) expenditure levels (See 42 U.S.C. 300x-30(c) and 45 C.F.R. 96.134(b))
- Construction/rehabilitation (See 42 U.S.C. 300x-31(c) and 45 C.F.R. 96.135(d))

If your State proposes to request a waiver at this time for one or more of the above provisions, include the waiver request as an attachment to the application, if possible. The Interim Final Rule, 45 C.F.R. 96.124(d), 96.128(d), 96.132(d), 96.134(b), and 96.135(d), contains information regarding the criteria for each waiver, respectively. A formal waiver request must be submitted to SAMHSA at some point in time if not included as an attachment to the application.

Maryland

Attachment J: Waivers

Attachment J: Waivers

If your State proposes to request a waiver at this time for one or more of the above provisions, include the waiver request as an attachment to the application, if possible. The Interim Final Rule, 45 C.F.R. 96.124(d), 96.128(d), 96.132(d), 96.134(b), and 96.135(d), contains information regarding the criteria for each waiver, respectively. A formal waiver request must be submitted to SAMHSA at some point in time if not included as an attachment to the application.

The State of Maryland does not intend to file any waiver applications for FFY 2008.

SUBSTANCE ABUSE STATE AGENCY SPENDING REPORT

State:
Maryland

Dates of State Expenditure Period:
From 7/1/2005 to 6/30/2006

| Activity | A. SAPT Block Grant FY 2005 Award (Spent) | B. Medicaid (Federal, State and Local) | C. Other Federal Funds (e.g., Medicare, other public welfare) | D. State Funds | E. Local Funds (excluding local Medicaid) | F. Other |
|---|---|--|---|----------------|---|-------------|
| 1. Substance Abuse Prevention* and Treatment | \$22,533,790 | \$1,086,422 | \$ | \$65,719,508 | \$5,922,087 | \$8,297,057 |
| 2. Primary Prevention | \$6,438,226 | | \$ | \$ | \$ | \$ |
| 3. Tuberculosis Services | \$ | \$ | \$ | \$ | \$ | \$ |
| 4. HIV Early Intervention Services | \$1,609,557 | \$ | \$ | \$ | \$ | \$ |
| 5. Administration (excluding program/provider level) | \$1,609,557 | | \$ | \$5,121,208 | \$ | \$137,580 |
| 6. Column Total | \$32,191,130 | \$1,086,422 | \$ | \$70,840,716 | \$5,922,087 | \$8,434,637 |

* Prevention other than Primary Prevention

Form 4ab

| |
|---------------|
| State: |
| Maryland |

Form 4a. Primary Prevention Expenditures Checklist

| | Block Grant FY 2005 | Other Federal | State | Local | Other |
|--|------------------------|---------------|-------|-------|-------|
| Information Dissemination | \$1,480,792 | \$ | \$ | \$ | \$ |
| Education | \$2,317,761 | \$ | \$ | \$ | \$ |
| Alternatives | \$1,030,116 | \$ | \$ | \$ | \$ |
| Problem Identification & Referral | \$386,294 | \$ | \$ | \$ | \$ |
| Community-Based Process | \$965,734 | \$ | \$ | \$ | \$ |
| Environmental | \$257,529 | \$ | \$ | \$ | \$ |
| Other | \$ | \$ | \$ | \$ | \$ |
| Section 1926 - Tobacco | \$ | \$ | \$ | \$ | \$ |
| TOTAL | \$6,438,226 | \$ | \$ | \$ | \$ |

Form 4b. Primary Prevention Expenditures Checklist

| | Block Grant FY 2005 | Other Federal | State | Local | Other |
|---------------------------|------------------------|---------------|-------|-------|-------|
| Universal Indirect | \$2,510,908 | \$ | \$ | \$ | \$ |
| Universal Direct | \$1,480,792 | \$ | \$ | \$ | \$ |
| Selective | \$1,609,557 | \$ | \$ | \$ | \$ |
| Indicated | \$836,969 | \$ | \$ | \$ | \$ |
| TOTAL | \$6,438,226 | \$ | \$ | \$ | \$ |

Resource Development Expenditure Checklist

| |
|---------------|
| State: |
| Maryland |

Did your State fund resource development activities from the FY 2005 block grant?

Yes No

| | Column 1 Treatment | Column 2 Prevention | Column 3 Additional Combined | Total |
|--|-----------------------|------------------------|------------------------------------|------------------|
| Planning, Coordination and Needs Assessment | \$ | \$ | \$ | \$ |
| Quality Assurance | \$ | \$ | \$ | \$ |
| Training (post-employment) | \$41,250 | \$26,450 | \$ | \$67,700 |
| Education (pre-employment) | \$40,100 | \$29,250 | \$ | \$69,350 |
| Program Development | \$ | \$ | \$ | \$ |
| Research and Evaluation | \$ | \$ | \$ | \$ |
| Information Systems | \$ | \$ | \$ | \$ |
| TOTAL | \$81,350 | \$55,700 | \$ | \$137,050 |

Expenditures on Resource Development Activities are:

Actual Estimated

SUBSTANCE ABUSE ENTITY INVENTORY

| |
|---------------|
| State: |
| Maryland |

| 1. Entity Number | 2. National Register (I-SATS) ID (Mark [X] box if no ID) | 3. Area Served | 4. State Funds (Spent during State Expenditure Period) | FISCAL YEAR 2005 | | | |
|------------------|--|---------------------|--|---|---|--|---|
| | | | | 5. SAPT Block Grant Funds for Substance Abuse Prevention (other than primary prevention) and Treatment Services | 5.a. SAPT Block Grant Funds for Services for Pregnant Women and Women with Dependent Children | 6. SAPT Block Grant Funds for Primary Prevention | 7. SAPT Block Grant Funds for Early Intervention Services for HIV (if applicable) |
| 101001 | 900227 | Allegany County | \$828,067 | \$329,697 | \$167,671 | \$415,549 | \$26,795 |
| 102001 | 100182 | Anne Arundel County | \$1,199,263 | \$1,558,533 | \$188,121 | \$302,460 | \$93,678 |
| 103001 | 750614 | Baltimore County | \$3,147,202 | \$1,675,157 | \$370,784 | \$691,621 | \$94,925 |
| 104001 | 902512 | Calvert County | \$446,236 | \$254,500 | \$ | \$172,499 | \$15,787 |
| 105001 | 750382 | Caroline County | \$335,472 | \$120,915 | \$ | \$94,352 | \$2,700 |
| 106001 | 750564 | Carroll County | \$875,693 | \$318,521 | \$860,429 | \$163,949 | \$61,275 |
| 107001 | 900375 | Cecil County | \$800,061 | \$237,518 | \$ | \$88,083 | \$15,995 |
| 108001 | 750473 | Charles County | \$1,081,120 | \$268,382 | \$ | \$245,027 | \$13,916 |
| 109001 | 902199 | Dorchester County | \$693,457 | \$215,127 | \$ | \$242,844 | \$2,700 |
| 110001 | 750424 | Frederick County | \$1,310,090 | \$461,016 | \$433,373 | \$309,766 | \$72,906 |
| 111001 | 901209 | Garrett County | \$715,055 | \$83,125 | \$ | \$398,240 | \$3,531 |
| 112001 | 903817 | Harford County | \$1,043,022 | \$318,248 | \$ | \$128,711 | \$20,771 |

| |
|---------------|
| State: |
| Maryland |

| | | | | FISCAL YEAR 2005 | | | |
|------------------|--|------------------------|--|---|---|--|---|
| 1. Entity Number | 2. National Register (I-SATS) ID (Mark [X] box if no ID) | 3. Area Served | 4. State Funds (Spent during State Expenditure Period) | 5. SAPT Block Grant Funds for Substance Abuse Prevention (other than primary prevention) and Treatment Services | 5.a. SAPT Block Grant Funds for Services for Pregnant Women and Women with Dependent Children | 6. SAPT Block Grant Funds for Primary Prevention | 7. SAPT Block Grant Funds for Early Intervention Services for HIV (if applicable) |
| 113001 | 900441 | Howard County | \$977,559 | \$172,300 | \$ | \$150,687 | \$10,800 |
| 114001 | 301293 | Kent County | \$441,562 | \$99,439 | \$ | \$124,010 | \$24,302 |
| 115001 | 902967 | Montgomery County | \$2,583,988 | \$715,333 | \$485,635 | \$580,363 | \$40,503 |
| 116001 | 300030 | Prince George's County | \$5,154,033 | \$1,672,773 | \$218,812 | \$493,825 | \$25,135 |
| 117001 | 750325 | Queen Anne's County | \$460,569 | \$161,236 | \$ | \$76,980 | \$3,531 |
| 118001 | 901779 | St Mary's County | \$1,614,716 | \$464,557 | \$156,875 | \$116,058 | \$15,786 |
| 119001 | 103608 | Somerset County | \$487,268 | \$88,051 | \$ | \$288,998 | \$7,685 |
| 120001 | 750390 | Talbot County | \$507,007 | \$160,817 | \$ | \$124,532 | \$1,870 |
| 121001 | 301400 | Washington County | \$2,172,452 | \$744,958 | \$215,875 | \$297,273 | \$22,017 |
| 122001 | 900300 | Wicomico County | \$1,147,052 | \$367,568 | \$ | \$277,152 | \$18,486 |
| 123001 | 901845 | Worcester County | \$1,268,403 | \$714,458 | \$273,686 | \$122,303 | \$32,195 |
| 130001 | 100091 | Baltimore City | \$25,837,860 | \$9,305,680 | \$749,949 | \$532,944 | \$920,370 |

| |
|---------------|
| State: |
| Maryland |

| FISCAL YEAR 2005 | | | | | | | |
|------------------|--|---------------------|--|---|---|--|---|
| 1. Entity Number | 2. National Register (I-SATS) ID (Mark [X] box if no ID) | 3. Area Served | 4. State Funds (Spent during State Expenditure Period) | 5. SAPT Block Grand Funds for Substance Abuse Prevention (other than primary prevention) and Treatment Services | 5.a. SAPT Block Grant Funds for Services for Pregnant Women and Women with Dependent Children | 6. SAPT Block Grant Funds for Primary Prevention | 7. SAPT Block Grant Funds for Early Intervention Services for HIV (if applicable) |
| 135001 | X | Statewide Contracts | \$10,592,301 | \$2,025,881 | \$ | \$ | \$61,898 |
| TOTAL | | | \$65,719,508 | \$22,533,790 | \$4,121,210 | \$6,438,226 | \$1,609,557 |

PROVIDER ADDRESS TABLE

| |
|---------------|
| State: |
| Maryland |

| Provider ID | Description | Provider Address |
|-------------|-----------------|---|
| 135001 | Provider 135001 | 55 Wade Avenus, Catonsville, MD, 21228, 410-402-8600, |

Prevention Strategy Report

| |
|---------------|
| State: |
| Maryland |

| Column A (Risks) | Column B (Strategies) | Column C (Providers) |
|-------------------------------------|--|----------------------|
| Children of Substance Abusers [1] | Brochures [4] | 31 |
| | Speaking engagements [6] | 28 |
| | Health fairs and other health promotion, e.g., conferences, meetings, seminars [7] | 33 |
| | Parenting and family management [11] | 22 |
| | Peer leader/helper programs [13] | 19 |
| | Education programs for youth groups [14] | 18 |
| | Mentors [15] | 12 |
| | Preschool ATOD prevention programs [16] | 6 |
| | Drug free dances and parties [21] | 17 |
| | Youth/adult leadership activities [22] | 27 |
| | Community service activities [24] | 14 |
| | Recreation activities [26] | 29 |
| | Student Assistance Programs [32] | 12 |
| | Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41] | 9 |
| Community team-building [44] | 7 | |
| Pregnant Women/Teens [2] | Brochures [4] | 22 |
| | Speaking engagements [6] | 28 |
| | Health fairs and other health promotion, e.g., conferences, meetings, seminars [7] | 10 |
| | Parenting and family management [11] | 22 |
| | Community service activities [24] | 13 |
| Violent and Delinquent Behavior [4] | Brochures [4] | 16 |
| | Speaking engagements [6] | 22 |

Form 6a: Risk - Strategies (...continued)

| |
|---------------|
| State: |
| Maryland |

| Column A (Risks) | Column B (Strategies) | Column C (Providers) |
|---|--|----------------------|
| (cont...) Violent and Delinquent Behavior [4] | Health fairs and other health promotion, e.g., conferences, meetings, seminars [7] | 2 |
| | Peer leader/helper programs [13] | 15 |
| | Education programs for youth groups [14] | 19 |
| | Community team-building [44] | 5 |
| Mental Health Problems [5] | Brochures [4] | 18 |
| | Speaking engagements [6] | 12 |
| | Health fairs and other health promotion, e.g., conferences, meetings, seminars [7] | 22 |
| Economically Disadvantaged [6] | Brochures [4] | 19 |
| | Speaking engagements [6] | 2 |
| | Health fairs and other health promotion, e.g., conferences, meetings, seminars [7] | 10 |
| | Parenting and family management [11] | 19 |
| | Education programs for youth groups [14] | 10 |
| | Mentors [15] | 7 |
| | Youth/adult leadership activities [22] | 9 |
| | Community service activities [24] | 5 |
| | Recreation activities [26] | 19 |
| Physically Disabled [7] | Speaking engagements [6] | 6 |
| | Ongoing classroom and/or small group sessions [12] | 1 |
| | Youth/adult leadership activities [22] | 4 |
| | Recreation activities [26] | 5 |
| Already Using Substances [9] | Brochures [4] | 18 |
| | Speaking engagements [6] | 22 |

Form 6a: Risk - Strategies (...continued)

| |
|---------------|
| State: |
| Maryland |

| Column A (Risks) | Column B (Strategies) | Column C (Providers) |
|--|--|----------------------|
| (cont...) Already Using Substances [9] | Health fairs and other health promotion, e.g., conferences, meetings, seminars [7] | 8 |
| | Parenting and family management [11] | 18 |
| | Education programs for youth groups [14] | 13 |
| Homeless and/or Run away Youth [10] | Peer leader/helper programs [13] | 11 |
| Parents [11] | Brochures [4] | 32 |
| | Speaking engagements [6] | 27 |
| | Health fairs and other health promotion, e.g., conferences, meetings, seminars [7] | 10 |
| | Parenting and family management [11] | 29 |
| | Peer leader/helper programs [13] | 16 |
| | Mentors [15] | 12 |
| | Drug free dances and parties [21] | 2 |
| | Youth/adult leadership activities [22] | 29 |
| | Community service activities [24] | 12 |
| Preschool [12] | Brochures [4] | 6 |
| | Speaking engagements [6] | 6 |
| | Parenting and family management [11] | 6 |
| | Preschool ATOD prevention programs [16] | 6 |

TREATMENT UTILIZATION MATRIX

| |
|---------------|
| State: |
| Maryland |

| |
|---|
| Dates of State Expenditure Period: |
| From 7/1/2005 to 6/30/2006 (Same as Form 1) |

| | | | Costs Per Person | | |
|--------------------------------------|-------------------------|-----------------------------|--------------------------|----------------------------|-------------------------------|
| Level of Care | A. Number of Admissions | B. Number of Persons Served | C. Mean Cost of Services | D. Median Cost of Services | E. Standard Deviation of Cost |
| Detoxification (24 hour Care) | | | | | |
| 1. Hospital Inpatient | | | \$0.00 | \$0.00 | \$0.00 |
| 2. Free-standing Residential | 1,971 | 1,853 | \$3,514.00 | \$0.00 | \$0.00 |
| Rehabilitation / Residential | | | | | |
| 3. Hospital Inpatient | | | \$0.00 | \$0.00 | \$0.00 |
| 4. Short-term (up to 30 days) | 8,492 | 7,667 | \$2,002.00 | \$0.00 | \$0.00 |
| 5. Long-term (over 30 days) | 3,053 | 2,762 | \$7,890.00 | \$0.00 | \$0.00 |
| Ambulatory (Outpatient) | | | | | |
| 6. Outpatient | 21,543 | 19,983 | \$1,546.00 | \$0.00 | \$0.00 |
| 7. Intensive Outpatient | 8,139 | 7,446 | \$1,479.00 | \$0.00 | \$0.00 |
| 8. Detoxification | 824 | 754 | \$1,112.00 | \$0.00 | \$0.00 |
| 9. Opioid Replacement Therapy | | | | | |
| 9. Opioid Replacement Therapy | 3,036 | 2,608 | \$8,156.00 | \$0.00 | \$0.00 |

Number Of Persons Served (Unduplicated Count) For Alcohol And Other Drug Use In State-Funded Services By Age, Sex, And Race/Ethnicity

| |
|---------------|
| State: |
| Maryland |

| AGE GROUP | A. TOTAL | B. White | | C. Black or African American | | D. Native Hawaiian / Other Pacific Islander | | E. Asian | | F. American Indian / Alaska Native | | G. More than one race reported | | H. Unknown | | I. Not Hispanic or Latino | | J. Hispanic or Latino | |
|-------------------|----------|----------|-------|------------------------------|-------|---|---|----------|----|------------------------------------|----|--------------------------------|---|------------|-----|---------------------------|-----|-----------------------|--------|
| | | M | F | M | F | M | F | M | F | M | F | M | F | M | F | M | F | M | F |
| 1. 17 and under | 5,155 | 2,083 | 865 | 1,576 | 429 | | | 23 | 8 | 8 | 1 | | | 115 | 47 | 136 | 45 | 3,662 | 1,305 |
| 2. 18-24 | 9,004 | 4,213 | 1,794 | 1,981 | 577 | | | 64 | 20 | 21 | 9 | | | 284 | 41 | 353 | 53 | 6,196 | 2,384 |
| 3. 25-44 | 26,609 | 7,780 | 4,127 | 8,668 | 5,112 | | | 94 | 26 | 57 | 31 | | | 619 | 95 | 837 | 169 | 16,373 | 9,207 |
| 4. 45-64 | 11,261 | 2,980 | 1,273 | 4,618 | 2,173 | | | 19 | 6 | 28 | 7 | | | 127 | 30 | 197 | 53 | 7,578 | 3,437 |
| 5. 65 and over | 231 | 95 | 24 | 93 | 13 | | | 2 | | 1 | | | | 3 | | 4 | | 189 | 37 |
| 6. Total | 52,260 | 17,151 | 8,083 | 16,936 | 8,304 | | | 202 | 60 | 115 | 48 | | | 1,148 | 213 | 1,527 | 320 | 33,998 | 16,370 |
| 7. Pregnant Women | 547 | | 297 | | 236 | | | | 3 | | | | | 11 | | 11 | | | 536 |

Did the values reported by your State on Forms 7a and 7b come from a client-based system(s) with unique client identifiers?

Yes **No**

Numbers of Persons Served who were admitted in a period prior to the 12 month reporting period: 18,027

Form 7b Footnotes

Column H (Unknown) consists of persons reported as "Other" Race, primarily Hispanics reported neither as white nor black.

Maryland

Description of Calculations

Description of Calculations

If revisions or changes are necessary to prior years' description of the following, please provide: a brief narrative describing the amounts and methods used to calculate the following: (a) the base for services to pregnant women and women with dependent children as required by 42 U.S.C. 300x-22(b)(1); and, for 1994 and subsequent fiscal years report the Federal and State expenditures for such services; (b) the base and Maintenance of Effort (MOE) for tuberculosis services as required by 42 U.S.C. 300x-24(d); and, (c) for designated States, the base and MOE for HIV early intervention services as required by 42 U.S.C. 300x-24(d) (See 45 C.F.R. 96.122(f)(5)(ii)(A)(B)(C)).

Description of Calculations:

In a brief narrative, provide a description of the amounts and methods used to calculate the following: (a) the base for services to pregnant women and women with dependent children as required by section 1922(c)(1); and, for 1994 and subsequent fiscal years report the Federal and State expenditures for such services; (b) the base and Maintenance of Effort (MOE) for tuberculosis services as required by section 1924(d); and, (c) for designated States, the base and MOE for HIV early intervention services as required by section 1924(d) (See 42 U.S.C. 300x-52 and 45 C.F.R. 96.122(f)(5)(ii)(A)(B)(C)).

Base Development

96.124 - Pregnant Woman and Women With Dependent Children

The State of Maryland's Alcohol and Drug Abuse Administration reviewed those addictions services provisions that were available to pregnant women and women with dependent children. It was determined that for Fiscal Year 1994 those provisions consisted of limited resources in both programming and form with a total Women's Base of \$5,032,564 (Refer to MOE Table IV). As demonstrated in subsequent years, service resources for this target group have continued to grow. Historical trends reflect total expenditures of \$13,228,678 in 2003, \$13,294,821 in 2004 and \$13,294,821 projected in 2005.

96.127 - Tuberculosis Services

The State of Maryland's Alcohol and Drug Abuse Administration has reviewed the epidemiological and disease control programming specifically targeted for tuberculosis services within the State. This activity falls under the Community Health Administration (CHA) which is charged with controlling all communicable diseases in the State of Maryland. Services provided include treatment, as well as preventive measures related to controlling tuberculosis infection. Based on information provide by CHA, the Fiscal Year 1991 and 1992 totals of all State funds spent on tuberculosis services were \$596,143 and \$649,086, respectively. State addiction program directors were polled by the Administration as to incidence and prevalence of tuberculosis within their modalities. It was estimated that 2% of the treatment population received services.

96.128 - HIV Early Intervention Services

The State of Maryland, under Section 1924 (b)(2), is a designated state. Using the definition of early intervention services for HIV, the Administration reviewed its substance abuse treatment sites and determined 1992 base expenditures of \$1,272,808 in calculating the MOE level.

| |
|---------------|
| State: |
| Maryland |

SSA (MOE Table I)

Total Single State Agency (SSA) Expenditures for Substance Abuse (Table I)

| PERIOD (A) | EXPENDITURES (B) | B1(2005) + B2(2006) / 2 (C) |
|--------------|------------------|-----------------------------|
| SFY 2005 (1) | \$64,805,532 | |
| SFY 2006 (2) | \$65,681,041 | \$65,243,287 |
| SFY 2007 (3) | \$71,133,248 | |

Are the expenditure amounts reported in Columns B "actual" expenditures for the State fiscal years involved?

FY 2005 Yes No

FY 2006 Yes No

FY 2007 Yes No

If estimated expenditures are provided, please indicate when "actual" expenditure data will be submitted to SAMHSA(mm/dd/yyyy):

The MOE for State fiscal year(SFY) 2007 is met if the amount in Box B3 is greater than or equal to the amount in Box C2 assuming the State complied with MOE requirements in these previous years.

The State may request an exclusion of certain non-recurring expenditures for a singular purpose from the calculation of the MOE, provided it meets CSAT approval based on review of the following information:

Did the State have any non-recurring expenditures for a specific purpose which were not included in the MOE calculation?

Yes No If yes, specify the amount and the State fiscal year:

Did the State include these funds in previous year MOE calculations? Yes No

When did the State submit a request to the SAMHSA Administration to exclude these funds from the MOE calculations(Date)?

TB (MOE Table II)

| |
|---------------|
| State: |
| Maryland |

Statewide Non-Federal Expenditures for Tuberculosis Services
to Substance Abusers in Treatment (Table II)

(BASE TABLE)

| PERIOD | Total of All State Funds Spent on TB Services (A) | % of TB Expenditures Spent on Clients who were Substance Abusers in Treatment (B) | Total State Funds Spent on Clients who were Substance Abusers in Treatment (A x B) (C) | Average of Columns C1 and C2 C1 + C2 / 2 MOE BASE (D) |
|--------------|--|--|--|--|
| SFY 1991 (1) | \$596,143 | 1% | \$5,961 | |
| SFY 1992 (2) | \$649,086 | 1% | \$6,491 | \$6,226 |

(MAINTENANCE TABLE)

| PERIOD | Total of All State Funds Spent on TB Services (A) | % of TB Expenditures Spent on Clients who were Substance Abusers in Treatment (B) | Total State Funds Spent on Clients who were Substance Abusers in Treatment (A x B) |
|--------------|--|--|---|
| SFY 2007 (3) | \$918,054 | 2% | \$18,361 |

HIV (MOE Table III)

| |
|---------------|
| State: |
| Maryland |

Statewide Non-Federal Expenditures for HIV Early Intervention Services to Substance Abusers in Treatment (Table III)

(BASE TABLE)

| PERIOD | Total of All State Funds Spent on Early Intervention Services for HIV* (A) | Average of Columns A1 and A2 A1 + A2 / 2 MOE BASE (B) |
|-------------|---|--|
| SFY1991 (1) | \$989,864 | |
| SFY1992 (2) | \$1,555,753 | \$1,272,809 |

(MAINTENANCE TABLE)

| PERIOD | Total of All State Funds Spent on Early Intervention Services for HIV* (A) |
|--------------|---|
| SFY 2007 (3) | \$3,516,155 |

* Provided to substance abusers at the site at which they receive substance abuse treatment

Womens (MOE TABLE IV)

| |
|---------------|
| State: |
| Maryland |

Expenditures for Services to Pregnant Women and
Women with Dependent Children (Table IV)

(MAINTENANCE TABLE)

| PERIOD | Total Women's BASE (A) | Total Expenditures (B) |
|--------|------------------------------|------------------------------|
| 1994 | \$5,032,564 | |
| 2005 | | \$13,294,821 |
| 2006 | | \$13,294,821 |
| 2007 | | \$13,294,821 |

Enter the amount the State plans to expend in FY 2008 for services for pregnant women and women with dependent children (amount entered must be not less than amount entered in Table IV Maintenance - Box A {1994}): \$13,295,000

Maryland

1. Planning

1. Planning

This item addresses compliance of the State's planning procedures with several statutory requirements. It requires completion of narratives and a checklist.

These are the statutory requirements:

- 42 U.S.C. 300x-29, 45 C.F. R. 96.133 and 45 C.F.R. 96.122(g)(13) require the State to submit a Statewide assessment of need for both treatment and prevention.

In a narrative of up to three pages, describe how your State carries out sub-State area planning and determines which areas have the highest incidence, prevalence, and greatest need. Include a definition of your State's sub-State planning areas. Identify what data is collected, how it is collected, and how it is used in making these decisions. If there is a State, regional, or local advisory council, describe their composition and their role in the planning process. Describe the monitoring process the State will use to assure that funded programs serve communities with the highest prevalence and need. Those States that have a State Epidemiological Workgroup or a State Epidemiological Outcomes Workgroup, must describe its composition and its contribution to needs assessment, planning, and evaluation processes for primary prevention and treatment planning. States are encouraged to utilize the epidemiological analyses and profiles to establish substance abuse prevention and treatment goals at the State level.

- 42 U.S.C. 300x-51 and 45 C.F. R. 96.123(a)(13) require the State to make the State plan public in such a manner as to facilitate public comment from any person during the development of the plan.

In a narrative of up to two pages, describe the process your State used to facilitate public comment in developing the State's plan and its FY 2008 application for SAPT Block Grant funds.

The legislation proposed by Governor Robert L. Ehrlich and signed into law on May 11, 2004 established a mandate that all twenty-four political subdivisions (23 counties and Baltimore City) in Maryland develop Drug and Alcohol Advisory Councils. The law requires that certain agency representatives be appointed to each local Advisory Council. All twenty-four jurisdictions have a Local Council, with the required membership and structure. The Local Councils have reported progress to the ADAA and sent the first local strategic plans.

The Alcohol and Drug Abuse Administration provided technical assistance to local councils, by providing data to assist in needs assessments and outcome evaluations. Allocations from the Maryland Substance Abuse Fund, created under the Governor's legislation, help defray the cost of local council operations as well as the associated cost of technical assistance from ADAA.

These comprehensive plans included the strategies and priorities of the jurisdiction for meeting the identified needs of the general public and the criminal justice system for alcohol and other drug evaluation, prevention, intervention and treatment services. The plan should also include the mission, principles, goals, and values of each council. Priority and target populations were included and were checked for compliance with state and federal block grant requirements. These included pregnant and post-partum women and women with children, persons with HIV, and injecting drug users. Each jurisdiction attempted to assess the ability of the local treatment system to identify and treat persons with co-occurring mental health and substance abuse disorders. Each council met the mandate to submit a comprehensive plan for prevention, intervention and treatment services in their jurisdictions to the Governor or his designee due by July 1, 2005. The Councils are further mandated to submit plans every two years thereafter, and report on progress toward implementation of the plans to the Alcohol and Drug Abuse Administration every six months.

All twenty-four jurisdiction's initial two year strategic plans along with a local surveys of prevention, intervention and treatment resources were reviewed by ADAA. Feedback was provided by the ADAA Regional Team Leaders acknowledging the plans and providing suggestions or comments regarding implementation. Jurisdictions were then asked to establish priority areas, an action plan including measurable outcomes and connections to targeted outcomes from their initial strategic plan, along with a budget for any new or expanded initiatives. This document served as the required six month update to the initial plan.

By Executive Order, Governor Robert L. Ehrlich established a Maryland State Drug and Alcohol Abuse Council. The objectives of the State Council are to develop a comprehensive, coordinated and collaborative approach to the use of for prevention, intervention and treatment of drug and alcohol abuse among the citizens of the state; to promote the coordinated planning and delivery of state drug and alcohol abuse prevention, intervention, evaluation and treatment resources; and, to promote collaboration and coordination by state substance abuse programs with local Drug and Alcohol Abuse Councils, local health systems and private drug and alcohol abuse service providers.

The Council is charged with identifying, developing and recommending implementation of comprehensive systemic improvements in prevention, intervention and treatment services, preparing and updating a 2-year plan establishing priorities and strategies for funding and delivery of services, reviewing plans submitted by local Drug and Alcohol Abuse Councils and coordinating with the state plan, coordinating with the Governor's Grants Office to seek funds and advise local councils of funding opportunities, and receiving and reviewing studies and evaluations of state and local substance abuse programs and other relevant materials. An initial report was prepared and delivered to the Governor on September 9th, 2005.

The Council met four times during the year, pursuant to the terms of the

Executive Order. During this time, the Planning and Coordination subcommittee met six times from November, 2004 through June, 2005. The committee focused on defining the task, reviewing existing national and local area strategic plans, and developing and approving uniform language and mechanisms for each selected State department or agency to utilize in reporting resources. This committee also conducted an internal State government survey of resources, a process that was mirrored in the twenty four local subdivisions in their local planning process. The survey was designed to identify all State resources, including federal funds, used in the areas of: Prevention (reducing rates of first-time use of illicit substances by adolescents or adults, underage use of alcohol and tobacco), Intervention (identifying and moving individuals to care), and Treatment (reducing rates of substance abuse and addiction in adults or adolescents).

Alcohol and Drug Abuse Administration staff provided technical assistance and guidance during this information collection process. The Department of Budget and Management staff analysts facilitated the collection of fiscal information within departments. Surveys have been collected and are under being reviewed by the committee prior to presentation to the full Council.

In determining areas of high incidence and prevalence along with other indicators of highest need, the State of Maryland employs a multi-faceted monitoring and information gathering system. The first and foremost component of this system is the Administration's Substance Abuse Management Information System (SAMIS). Its purpose is to obtain, process, analyze, report and monitor demographic and other statistical data generated from the state's alcohol and drug abuse treatment services network along with other aspects of AOD problems throughout the State of Maryland. Information from this system is distributed statewide to treatment and prevention programs, interested agencies and the public. This system collects pertinent data contained on approximately 80,000 admission reports, 80,000 discharge reports and 3,600 program-level reports yearly from 150 funded and 220 non-funded treatment programs. Additional data sets and data systems maintained by SAMIS such as the DWI Assessment System, which consists of data containing 20,000 assessment reports annually. Categorical database information is maintained for pregnancy, adolescent, prevention, certification, and capacity/waiting list thereby supplementing SAMIS's capabilities and output. As an adjunct to this statewide data gathering effort, the Administration is in frequent contact with the federal Substance Abuse and Mental Health Services Administration (SAMHSA) in regard to data reporting requirements for the National Survey of Substance Abuse Services (N-SSATS), The Treatment Episode Data Set (TEDS) and the Inventory of Substance Abuse Treatment Services (I-SATS). Information gathered from the Drug Abuse Warning Network (DAWN), The Maryland Adolescent Survey (MAS) and Uniform Crime Reporting System (UCRS) also provides statewide data links, that when incorporated with SAMIS data serves to assess and indicate areas of greatest need. The Administration also documents need through its annual Statewide Outlook and Outcomes Alcohol and Drug Abuse Treatment Report. The Administration's ability in this area has also been enhanced by the results of the State Needs Assessment Grant that was provided through SAMHSA. This study generated regional and statewide projections of the number of Maryland residents in need of treatment.

ADAA obtains state and sub-state estimates of alcohol and drug dependence and abuse and unmet treatment need from SAMHSA's National Survey on Drug Use and Health (NSDUH). ADAA has worked with the SAMHSA Office of Applied Studies (OAS) to plan for sub-state estimates of substance abuse measures for the following regions, dictated somewhat by sample size, which should be available in the coming year:

- Anne Arundel County
- Baltimore City
- Central Maryland - (Baltimore, Howard and Harford counties)

- Rural Maryland - (Calvert, Caroline, Cecil, Charles, Dorchester, Kent, Queen Anne's, St. Mary's, Somerset, Talbot, Wicomico, and Worcester counties)
- Montgomery County
- Prince George's County
- Western Maryland - (Allegany, Carroll, Garrett, Frederick and Washington counties)

Besides its data systems base, the State system also gathers pertinent information through its Quality and Treatment and Prevention Divisions. Staffs from these prevention and treatment offices serve as the major liaison between the Administration and the AOD treatment and prevention providers throughout the State of Maryland. Information gathered by these offices on abuse trends and targeted populations serve as an important mechanism complementing the sometimes more formalized data collection systems.

The massive amount of information and data contribute to formulation of the local and state alcohol and drug abuse plans. Additional public comment is generated through the state Legislature process and the House of Delegates Committee on Alcohol and Drug.

The local state and local advisory councils, with ADAA support, assure that funded programs serve those areas with the highest prevalence and need. Various process and outcome data reports provide oversight by which the Administration can assure service provision. Providers and local councils will be trained and facilitated in utilizing the electronic data system to generate many of their own pertinent reports.

| |
|---------------|
| State: |
| Maryland |

Criteria for Allocating Funds

Use the following checklist to indicate the criteria your State will use in deciding how to allocate FY 2008 block grant funds. Mark all criteria that apply. Indicate the priority of the criteria by placing numbers in the boxes. For example, if the most important criterion is 'incidence and prevalence levels', put a '1' in the box beside that option. If two or more criteria are equal, assign them the same number.

4 Population levels, Specify formula:

1 Incidence and prevalence levels

2 Problem levels as estimated by alcohol/drug-related crime statistics

2 Problem levels as estimated by alcohol/drug-related health statistics

 Problem levels as estimated by social indicator data

3 Problem levels as estimated by expert opinion

 Resource levels as determined by (specific method)

 Size of gaps between resources (as measured by)

and needs (as estimated by)

 Other (specify):

Treatment Needs Assessment Summary Matrix

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| State: | | Calendar Year: | | | | | | | | | | | | |
|----------------------------|---------------------|-------------------------------|------------------------------|-------------------------------|------------------------------|-------------------------------|------------------------------|--|-----------------------------------|-----------|---------------------------------------|-------------------|---------------------------|--|
| Maryland | | 2006 | | | | | | | | | | | | |
| | | 3. Total Population in need | | 4. Number of IVDUs in need | | 5. Number of women in need | | 6. Prevalence of substance-related criminal activity | | | 7. Incidence of communicable diseases | | | |
| 1. Substate Planning Area | 2. Total Population | A. Needing treatment services | B. That would seek treatment | A. Needing treatment services | B. That would seek treatment | A. Needing treatment services | B. That would seek treatment | A. Number of DWI arrests | B. Number of drug-related arrests | C. Other: | A. Hepatitis B / 100,000 | B. AIDS / 100,000 | C. Tuberculosis / 100,000 | |
| Allegany County | 73,245 | 4,039 | 710 | 710 | 126 | 1,194 | 205 | 481 | 854 | 0 | 1 | 7 | 0 | |
| Anne Arundel County | 509,397 | 23,137 | 4,168 | 3,888 | 649 | 6,010 | 1,026 | 2,671 | 2,626 | 0 | 8 | 13 | 4 | |
| Baltimore County | 783,405 | 38,461 | 7,267 | 8,056 | 1,468 | 11,769 | 2,158 | 1,986 | 4,537 | 0 | 7 | 19 | 2 | |
| Calvert County | 87,622 | 4,439 | 752 | 276 | 47 | 1,011 | 215 | 803 | 715 | 0 | 1 | 8 | 0 | |

Treatment Needs Assessment Summary Matrix

| State: | | Calendar Year: | | | | | | | | | | | |
|---------------------------|---------------------|-------------------------------|------------------------------|-------------------------------|------------------------------|-------------------------------|------------------------------|--|-----------------------------------|-----------|---------------------------------------|-------------------|---------------------------|
| Maryland | | 2006 | | | | | | | | | | | |
| | | 3. Total Population in need | | 4. Number of IVDUs in need | | 5. Number of women in need | | 6. Prevalence of substance-related criminal activity | | | 7. Incidence of communicable diseases | | |
| 1. Substate Planning Area | 2. Total Population | A. Needing treatment services | B. That would seek treatment | A. Needing treatment services | B. That would seek treatment | A. Needing treatment services | B. That would seek treatment | A. Number of DWI arrests | B. Number of drug-related arrests | C. Other: | A. Hepatitis B / 100,000 | B. AIDS / 100,000 | C. Tuberculosis / 100,000 |
| Caroline County | 31,805 | 2,473 | 468 | 74 | 12 | 508 | 89 | 334 | 144 | 0 | 0 | 7 | 7 |

| 1. Substate Planning Area | 2. Total Population | A. Needing treatment services | B. That would seek treatment | A. Needing treatment services | B. That would seek treatment | A. Needing treatment services | B. That would seek treatment | A. Number of DWI arrests | B. Number of drug-related arrests | C. Other: | A. Hepatitis B / 100,000 | B. AIDS / 100,000 | C. Tuberculosis / 100,000 |
|---------------------------|---------------------|-------------------------------|------------------------------|-------------------------------|------------------------------|-------------------------------|------------------------------|--------------------------|-----------------------------------|-----------|--------------------------|-------------------|---------------------------|
| Carroll County | 168,397 | 7,038 | 1,277 | 1,312 | 225 | 2,305 | 418 | 691 | 730 | 0 | 0 | 3 | 3 |

| 1. Substate Planning Area | 2. Total Population | A. Needing treatment services | B. That would seek treatment | A. Needing treatment services | B. That would seek treatment | A. Needing treatment services | B. That would seek treatment | A. Number of DWI arrests | B. Number of drug-related arrests | C. Other: | A. Hepatitis B / 100,000 | B. AIDS / 100,000 | C. Tuberculosis / 100,000 |
|---------------------------|---------------------|-------------------------------|------------------------------|-------------------------------|------------------------------|-------------------------------|------------------------------|--------------------------|-----------------------------------|-----------|--------------------------|-------------------|---------------------------|
| Cecil County | 97,474 | 5,487 | 1,024 | 860 | 148 | 1,589 | 282 | 907 | 717 | 0 | 19 | 8 | 6 |

| 1. Substate Planning Area | 2. Total Population | A. Needing treatment services | B. That would seek treatment | A. Needing treatment services | B. That would seek treatment | A. Needing treatment services | B. That would seek treatment | A. Number of DWI arrests | B. Number of drug-related arrests | C. Other: | A. Hepatitis B / 100,000 | B. AIDS / 100,000 | C. Tuberculosis / 100,000 |
|---------------------------|---------------------|-------------------------------|------------------------------|-------------------------------|------------------------------|-------------------------------|------------------------------|--------------------------|-----------------------------------|-----------|--------------------------|-------------------|---------------------------|
| Charles County | 138,106 | 7,346 | 1,388 | 312 | 53 | 1,585 | 288 | 912 | 961 | 0 | 1 | 6 | 3 |

Treatment Needs Assessment Summary Matrix

| State: | | Calendar Year: | | | | | | | | | | | |
|---------------------------|-----------------------------|-------------------------------|------------------------------|-------------------------------|------------------------------|-------------------------------|--|--------------------------|-----------------------------------|---------------------------------------|--------------------------|-------------------|---------------------------|
| Maryland | | 2006 | | | | | | | | | | | |
| | 3. Total Population in need | | 4. Number of IVDUs in need | | 5. Number of women in need | | 6. Prevalence of substance-related criminal activity | | | 7. Incidence of communicable diseases | | | |
| 1. Substate Planning Area | 2. Total Population | A. Needing treatment services | B. That would seek treatment | A. Needing treatment services | B. That would seek treatment | A. Needing treatment services | B. That would seek treatment | A. Number of DWI arrests | B. Number of drug-related arrests | C. Other: | A. Hepatitis B / 100,000 | B. AIDS / 100,000 | C. Tuberculosis / 100,000 |
| Dorchester County | 31,351 | 2,275 | 408 | 91 | 18 | 593 | 103 | 339 | 478 | 0 | 0 | 3 | 3 |
| Frederick County | 220,409 | 8,909 | 1,621 | 1,115 | 208 | 2,319 | 406 | 1,102 | 1,150 | 0 | 1 | 10 | 4 |
| Garrett County | 29,863 | 1,183 | 199 | 95 | 16 | 320 | 53 | 297 | 178 | 0 | 0 | 0 | 0 |
| Harford County | 238,850 | 12,608 | 2,503 | 1,687 | 313 | 3,381 | 657 | 1,150 | 1,115 | 0 | 3 | 16 | 1 |

Treatment Needs Assessment Summary Matrix

| State: | | Calendar Year: | | | | | | | | | | | |
|---------------------------|---------------------|-------------------------------|------------------------------|-------------------------------|------------------------------|-------------------------------|------------------------------|--|-----------------------------------|-----------|---------------------------------------|-------------------|---------------------------|
| Maryland | | 2006 | | | | | | | | | | | |
| 1. Substate Planning Area | 2. Total Population | 3. Total Population in need | | 4. Number of IVDUs in need | | 5. Number of women in need | | 6. Prevalence of substance-related criminal activity | | | 7. Incidence of communicable diseases | | |
| | | A. Needing treatment services | B. That would seek treatment | A. Needing treatment services | B. That would seek treatment | A. Needing treatment services | B. That would seek treatment | A. Number of DWI arrests | B. Number of drug-related arrests | C. Other: | A. Hepatitis B / 100,000 | B. AIDS / 100,000 | C. Tuberculosis / 100,000 |
| Howard County | 269,174 | 6,446 | 1,223 | 900 | 159 | 1,682 | 306 | 1,402 | 1,080 | 0 | 0 | 8 | 2 |

| 1. Substate Planning Area | 2. Total Population | A. Needing treatment services | B. That would seek treatment | A. Needing treatment services | B. That would seek treatment | A. Needing treatment services | B. That would seek treatment | A. Number of DWI arrests | B. Number of drug-related arrests | C. Other: | A. Hepatitis B / 100,000 | B. AIDS / 100,000 | C. Tuberculosis / 100,000 |
|---------------------------|---------------------|-------------------------------|------------------------------|-------------------------------|------------------------------|-------------------------------|------------------------------|--------------------------|-----------------------------------|-----------|--------------------------|-------------------|---------------------------|
| Kent County | 19,908 | 1,741 | 315 | 116 | 22 | 444 | 75 | 106 | 192 | 0 | 0 | 5 | 5 |

| 1. Substate Planning Area | 2. Total Population | A. Needing treatment services | B. That would seek treatment | A. Needing treatment services | B. That would seek treatment | A. Needing treatment services | B. That would seek treatment | A. Number of DWI arrests | B. Number of drug-related arrests | C. Other: | A. Hepatitis B / 100,000 | B. AIDS / 100,000 | C. Tuberculosis / 100,000 |
|---------------------------|---------------------|-------------------------------|------------------------------|-------------------------------|------------------------------|-------------------------------|------------------------------|--------------------------|-----------------------------------|-----------|--------------------------|-------------------|---------------------------|
| Montgomery County | 927,405 | 18,530 | 3,228 | 1,530 | 269 | 4,219 | 718 | 4,076 | 2,953 | 0 | 1 | 23 | 7 |

| 1. Substate Planning Area | 2. Total Population | A. Needing treatment services | B. That would seek treatment | A. Needing treatment services | B. That would seek treatment | A. Needing treatment services | B. That would seek treatment | A. Number of DWI arrests | B. Number of drug-related arrests | C. Other: | A. Hepatitis B / 100,000 | B. AIDS / 100,000 | C. Tuberculosis / 100,000 |
|---------------------------|---------------------|-------------------------------|------------------------------|-------------------------------|------------------------------|-------------------------------|------------------------------|--------------------------|-----------------------------------|-----------|--------------------------|-------------------|---------------------------|
| Prince George's County | 842,764 | 21,734 | 4,146 | 2,037 | 403 | 4,553 | 829 | 1,663 | 3,180 | 0 | 3 | 47 | 9 |

Treatment Needs Assessment Summary Matrix

| State: | | Calendar Year: | | | | | | | | | | | |
|---------------------------|-----------------------------|-------------------------------|------------------------------|-------------------------------|------------------------------|-------------------------------|--|--------------------------|-----------------------------------|---------------------------------------|--------------------------|-------------------|---------------------------|
| Maryland | | 2006 | | | | | | | | | | | |
| | 3. Total Population in need | | 4. Number of IVDUs in need | | 5. Number of women in need | | 6. Prevalence of substance-related criminal activity | | | 7. Incidence of communicable diseases | | | |
| 1. Substate Planning Area | 2. Total Population | A. Needing treatment services | B. That would seek treatment | A. Needing treatment services | B. That would seek treatment | A. Needing treatment services | B. That would seek treatment | A. Number of DWI arrests | B. Number of drug-related arrests | C. Other: | A. Hepatitis B / 100,000 | B. AIDS / 100,000 | C. Tuberculosis / 100,000 |
| Queen Anne's County | 45,469 | 2,768 | 504 | 243 | 43 | 674 | 116 | 441 | 426 | 0 | 0 | 7 | 0 |
| St Mary's County | 96,868 | 6,141 | 1,176 | 237 | 46 | 1,362 | 253 | 793 | 701 | 0 | 0 | 3 | 2 |
| Somerset County | 25,666 | 2,232 | 414 | 123 | 21 | 487 | 83 | 132 | 217 | 0 | 4 | 24 | 12 |
| Talbot County | 35,630 | 1,951 | 345 | 129 | 23 | 459 | 77 | 493 | 364 | 0 | 0 | 12 | 0 |

Treatment Needs Assessment Summary Matrix

| State: | | Calendar Year: | | | | | | | | | | | |
|---------------------------|-----------------------------|-------------------------------|------------------------------|-------------------------------|------------------------------|-------------------------------|--|--------------------------|-----------------------------------|---------------------------------------|--------------------------|-------------------|---------------------------|
| Maryland | | 2006 | | | | | | | | | | | |
| | 3. Total Population in need | | 4. Number of IVDUs in need | | 5. Number of women in need | | 6. Prevalence of substance-related criminal activity | | | 7. Incidence of communicable diseases | | | |
| 1. Substate Planning Area | 2. Total Population | A. Needing treatment services | B. That would seek treatment | A. Needing treatment services | B. That would seek treatment | A. Needing treatment services | B. That would seek treatment | A. Number of DWI arrests | B. Number of drug-related arrests | C. Other: | A. Hepatitis B / 100,000 | B. AIDS / 100,000 | C. Tuberculosis / 100,000 |
| Washington County | 141,563 | 7,269 | 1,316 | 812 | 149 | 1,989 | 353 | 843 | 805 | 0 | 0 | 21 | 2 |
| Wicomico County | 90,252 | 5,416 | 910 | 397 | 63 | 1,624 | 261 | 408 | 1,067 | 0 | 6 | 26 | 6 |
| Worcester County | 48,599 | 4,347 | 790 | 166 | 27 | 1,156 | 209 | 782 | 1,112 | 0 | 0 | 9 | 4 |
| Baltimore City | 636,377 | 73,427 | 12,494 | 27,144 | 4,764 | 28,342 | 4,693 | 363 | 28,896 | 0 | 0 | 167 | 5 |

Treatment Needs by Age, Sex, and Race/Ethnicity

State:
Maryland

Substate Planning Area [95]:
State Total

| AGE GROUP | A. TOTAL | B. WHITE | | C. BLACK OR AFRICAN AMERICAN | | D. NATIVE HAWAIIAN / OTHER PACIFIC ISLANDER | | E. ASIAN | | F. AMERICAN INDIAN / ALASKA NATIVE | | G. MORE THAN ONE RACE REPORTED | | H. UNKNOWN | | I. NOT HISPANIC OR LATINO | | J. HISPANIC OR LATINO | |
|-----------------|----------|----------|--------|------------------------------|--------|---|---|----------|-----|------------------------------------|-----|--------------------------------|---|------------|-------|---------------------------|--------|-----------------------|-------|
| | | M | F | M | F | M | F | M | F | M | F | M | F | M | F | M | F | M | F |
| 1. 17 and under | 26,320 | 8,394 | 3,521 | 9,887 | 2,572 | 0 | 0 | 127 | 46 | 0 | 0 | 0 | 0 | 1,283 | 490 | 17,806 | 5,926 | 1,223 | 374 |
| 2. 18 - 24 | 50,001 | 22,995 | 9,020 | 11,389 | 2,526 | 0 | 0 | 908 | 140 | 263 | 90 | 0 | 0 | 2,246 | 424 | 33,557 | 11,323 | 3,067 | 896 |
| 3. 25 - 44 | 123,950 | 42,939 | 19,816 | 34,143 | 17,964 | 0 | 0 | 871 | 276 | 425 | 206 | 0 | 0 | 6,581 | 729 | 76,634 | 37,488 | 9,054 | 1,539 |
| 4. 45 - 64 | 56,853 | 18,517 | 7,591 | 19,763 | 8,611 | 0 | 0 | 456 | 73 | 172 | 94 | 0 | 0 | 1,425 | 151 | 37,826 | 15,985 | 2,320 | 445 |
| 5. 65 and over | 1,621 | 465 | 438 | 657 | 61 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1,622 | 309 | 0 | 0 |
| 6. Total | 258,745 | 93,310 | 40,386 | 75,839 | 31,734 | | | 2,362 | 535 | 860 | 390 | | | 11,535 | 1,794 | 167,445 | 71,031 | 15,664 | 3,254 |

Form 9 Footnotes

Column H (Unknown) consists of cases reported as "Other" race - primarily Hispanics not reported as either White or Black.

Many of the cells with zeroes, in particular the oldest age groups for Asians, American Indian/Alaskan Native and Unknown Race and Hispanics, had insufficient numbers for estimation.

Maryland

How your State determined the estimates for Form 8 and Form 9

How your State determined the estimates for Form 8 and Form 9

Under 42 U.S.C. 300x-29 and 45 C.F.R. 96.133, States are required to submit annually a needs assessment. This requirement is not contingent on the receipt of Federal needs assessment resources. States are required to use the best available data. Using up to three pages, explain what methods your State used to estimate the numbers of people in need of substance abuse treatment services, the biases of the data, and how the State intends to improve the reliability and validity of the data. Also indicate the sources and dates or timeframes for the data used in making these estimates reported in both Forms 8 and 9. In addition, provide any necessary explanation of the way your State records data or interprets the indices in columns 6 and 7.

The estimates of treatment need presented in Forms 08 and 09 were generated from treatment data available through the Substance Abuse Management Information System (SAMIS) using the truncated Poisson Probability Model. This is an inexpensive method that uses the numbers of episodes individual patients have experienced during the year to estimate the truncated portion of the prevalence pool - those in need of treatment who had no treatment episodes during the year. A drawback to using the Poisson model is that it requires some difficult assumptions about the treatment data:

- 1) the probability of treatment admission is the same for the substance users and at all times;
- 2) treatment admissions are randomly distributed over time; and,
- 3) the treatment population is homogenous with respect to factors associated with the likelihood of entering treatment.

However, given its ease of use, the nature of the population and the difficulty in obtaining data on injecting drug users anywhere but in treatment, we believe the estimates are reasonable.

Use of the Poisson Model to estimate treatment need requires availability of a unique identifier in the treatment data. ADAA bases its unique identifier on the last four digits of Social Security Number (SSN) combined with the full date of birth. Adjustments were made for cases missing part of the unique identifier, which comprised less than 5 percent of the cases. Two figures were generated for each selected sub-population - the actual counts of unduplicated individuals receiving treatment during the year, and the estimated untreated portion of the need pool. The estimates of those who would seek treatment were derived by taking 25 percent of this latter group.

| |
|---------------|
| State: |
| Maryland |

INTENDED USE PLAN

(Include ONLY Funds to be spent by the agency administering the block grant. Estimated data are acceptable on this form)

SOURCE OF FUNDS

(24 Month Projection)

| Activity (see instructions for using Row 1) | A. FY 2008 SAPT Block Grant | B. Medicaid (Federal, State and Local) | C. Other Federal Funds (e.g., Medicare, other public welfare) | D. State Funds | E. Local Funds (excluding local Medicaid) | F. Other |
|--|-----------------------------|--|---|----------------|---|--------------|
| 1. Substance abuse treatment and rehabilitation | \$22,308,244 | \$1,782,112 | \$0 | \$145,732,601 | \$11,456,676 | \$15,998,778 |
| 2. Primary Prevention | \$6,373,784 | | \$0 | \$0 | \$0 | \$0 |
| 3. Tuberculosis Services | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| 4. HIV Early Intervention Services | \$1,593,446 | \$0 | \$0 | \$0 | \$0 | \$0 |
| 5. Administration (excluding program/provider level) | \$1,593,446 | | \$0 | \$9,355,597 | \$0 | \$275,160 |
| 6. Column Total | \$31,868,920 | \$1,782,112 | \$ | \$155,088,198 | \$11,456,676 | \$16,273,938 |

Form 11ab

| |
|---------------|
| State: |
| Maryland |

Form 11a: Primary Prevention Planned Expenditures Checklist

| | Block Grant FY 2008 | Other Federal | State | Local | Other |
|--|------------------------|------------------|-------|-------|-------|
| Information Dissemination | \$1,529,708 | \$ | \$ | \$ | \$ |
| Education | \$2,549,514 | \$ | \$ | \$ | \$ |
| Alternatives | \$1,147,281 | \$ | \$ | \$ | \$ |
| Problem Identification & Referral | \$318,689 | \$ | \$ | \$ | \$ |
| Community-Based Process | \$701,116 | \$ | \$ | \$ | \$ |
| Environmental | \$127,476 | \$ | \$ | \$ | \$ |
| Other | \$ | \$ | \$ | \$ | \$ |
| Section 1926 - Tobacco | \$ | \$ | \$ | \$ | \$ |
| TOTAL | \$6,373,784 | \$ | \$ | \$ | \$ |

Form 11b: Primary Prevention Planned Expenditures Checklist

| | Block Grant FY 2008 | Other Federal | State | Local | Other |
|---------------------------|------------------------|------------------|-------|-------|-------|
| Universal Direct | \$1,912,135 | \$ | \$ | \$ | \$ |
| Universal Indirect | \$1,912,135 | \$ | \$ | \$ | \$ |
| Selective | \$1,274,757 | \$ | \$ | \$ | \$ |
| Indicated | \$1,274,757 | \$ | \$ | \$ | \$ |
| TOTAL | \$6,373,784 | \$ | \$ | \$ | \$ |

State:

Maryland

Resource Development Planned Expenditure Checklist

Does your State plan to fund resource development activities with FY 2008 funds?

 Yes No

| | Treatment | Prevention | Additional Combined | Total |
|---|-----------------|-----------------|---------------------|------------------|
| Planning, Coordination and Needs Assessment | \$ | \$ | \$ | \$ |
| Quality Assurance | \$ | \$ | \$ | \$ |
| Training (post-employment) | \$43,000 | \$25,000 | \$ | \$68,000 |
| Education (pre-employment) | \$42,000 | \$30,000 | \$ | \$72,000 |
| Program Development | \$ | \$ | \$ | \$ |
| Research and Evaluation | \$ | \$ | \$ | \$ |
| Information Systems | \$ | \$ | \$ | \$ |
| TOTAL | \$85,000 | \$55,000 | \$ | \$140,000 |

| |
|---------------|
| State: |
| Maryland |

TREATMENT CAPACITY MATRIX

This form contains data covering a 24-month projection for the period during which your principal agency of the State is permitted to spend the FY 2008 block grant award.

| Level of Care | A. Number of Admissions | B. Number of Persons Served |
|---------------------------------------|--------------------------------|------------------------------------|
| Detoxification (24 hour Care) | | |
| 1. Hospital Inpatient | | |
| 2. Free-standing Residential | 3,942 | 3,706 |
| Rehabilitation / Residential | | |
| 3. Hospital Inpatient | | |
| 4. Short-term (up to 30 days) | 16,984 | 15,334 |
| 5. Long-term (over to 30 days) | 6,106 | 5,524 |
| Ambulatory (Outpatient) | | |
| 6. Outpatient | 43,086 | 39,966 |
| 7. Intensive Outpatient | 16,278 | 14,892 |
| 8. Detoxification | 1,648 | 1,508 |
| | | |
| 9. Opioid Replacement Therapy | 6,072 | 5,216 |

| |
|---------------|
| State: |
| Maryland |

Purchasing Services

Methods for Purchasing

This item requires completing two checklists

There are many methods the State can use to purchase substance abuse services. Use the following checklist to describe how your State will purchase services with the FY 2008 block grant award. Indicate the proportion of funding that is expended through the applicable procurement mechanism.

- | | |
|--|-------------------------|
| <input type="checkbox"/> Competitive grants | Percent of Expense: % |
| <input checked="" type="checkbox"/> Competitive contracts | Percent of Expense: 6% |
| <input checked="" type="checkbox"/> Non-competitive grants | Percent of Expense: 49% |
| <input checked="" type="checkbox"/> Non-competitive contracts | Percent of Expense: 19% |
| <input type="checkbox"/> Statutory or regulatory allocation to governmental agencies serving as umbrella agencies that purchase or directly operate services | Percent of Expense: % |
| <input type="checkbox"/> Other | Percent of Expense: % |
| (The total for the above categories should equal 100 percent.) | |
| <input checked="" type="checkbox"/> According to county or regional priorities | Percent of Expense: 26% |

Methods for Determining Prices

There are also alternative ways a State can decide how much it will pay for services. Use the following checklist to describe how your State pays for services. Complete any that apply. In addressing a States allocation of resources through various payment methods, a State may choose to report either the proportion of expenditures or proportion of clients served through these payment methods. Estimated proportions are acceptable.

- | | |
|--|--|
| <input type="checkbox"/> Line item program budget | Percent of Clients Served: % Percent of Expenditures: % |
| <input type="checkbox"/> Price per slot | Percent of Clients Served: % Percent of Expenditures: % |
| Rate: | Type of slot: |
| Rate: | Type of slot: |
| Rate: | Type of slot: |
| <input type="checkbox"/> Price per unit of service | Percent of Clients Served: % Percent of Expenditures: % |
| Unit: | Rate: |
| Unit: | Rate: |
| Unit: | Rate: |

PAGE 2 - Purchasing Services Checklist

Per capita allocation (Formula):

Percent of Clients Served: %
Percent of Expenditures: %

Price per episode of care:

Percent of Clients Served: %
Percent of Expenditures: %

Rate: Diagnostic Group:

Rate: Diagnostic Group:

Rate: Diagnostic Group:

| |
|---------------|
| State: |
| Maryland |

Program Performance Monitoring

- On-site inspections
 - (Frequency for treatment:) Quarterly
 - (Frequency for prevention:) Quarterly
- Activity Reports
 - (Frequency for treatment:) Quarterly
 - (Frequency for prevention:) Quarterly
- Management information System
- Patient/participant data reporting system
 - (Frequency for treatment:) Monthly
 - (Frequency for prevention:) Monthly
- Performance Contracts
- Cost reports
- Independent Peer Review
- Licensure standards - programs and facilities
 - (Frequency for treatment:) Anually
 - (Frequency for prevention:)
- Licensure standards - personnel
 - (Frequency for treatment:) Anually
 - (Frequency for prevention:)
- Other (Specify):

Form T1 was pre-populated with the following Data Source: Discharges in CY 2006

EMPLOYMENT/EDUCATION STATUS (From Admission to Discharge)

| Short-term Residential(SR) | | |
|--|--|-------------------------------------|
| Employment/Education - Clients employed (full-time and part-time) or student at admission vs. discharge | At Admission (T₁) | At Discharge (T₂) |
| Number of clients employed (full-time and part-time) or student [numerator] | 1,689 | 1,678 |
| Total number of clients with non-missing values on employment status [denominator] | 6,694 | 6,694 |
| Percent of clients employed (full-time and part-time) or student | 25.2% | 25.1% |
| Percent of clients employed (full-time and part-time) or student at discharge minus percent of clients employed or student at admission. | Absolute Change [%T ₂ - %T ₁] -0.1% | |

| Notes (for this level of care): | |
|---|--------------|
| Number of CY 2006 admissions submitted: | 7,913 |
| Number of CY 2006 discharges submitted: | 7,505 |
| Number of CY 2006 discharges linked to an admission: | 7,461 |
| Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated): | 7,438 |
| Number of CY 2006 linked discharges eligible for this calculation (non-missing values): | 6,694 |
| Source: SAMHSA/OAS TEDS CY 2006 admissions file and CY 2006 linked discharge file [Records received through 5/14/2007] | |

Long-term Residential(LR)

| Employment/Education - Clients employed (full-time and part-time) or student at admission vs. discharge | At Admission (T₁) | At Discharge (T₂) |
|--|--|-------------------------------------|
| Number of clients employed (full-time and part-time) or student [numerator] | 349 | 1,005 |
| Total number of clients with non-missing values on employment status [denominator] | 1,978 | 1,978 |
| Percent of clients employed (full-time and part-time) or student | 17.6% | 50.8% |
| Percent of clients employed (full-time and part-time) or student at discharge minus percent of clients employed or student at admission. | Absolute Change [%T ₂ - %T ₁] 33.2% | |

Notes (for this level of care):

| | |
|---|--------------|
| Number of CY 2006 admissions submitted: | 3,070 |
| Number of CY 2006 discharges submitted: | 2,228 |
| Number of CY 2006 discharges linked to an admission: | 2,200 |
| Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated): | 2,170 |
| Number of CY 2006 linked discharges eligible for this calculation (non-missing values): | 1,978 |

**Source: SAMHSA/OAS TEDS CY 2006 admissions file and CY 2006 linked discharge file
[Records received through 5/14/2007]**

Intensive Outpatient (IO)

| Employment/Education - Clients employed (full-time and part-time) or student at admission vs. discharge | At Admission (T₁) | At Discharge (T₂) |
|--|---|-------------------------------------|
| Number of clients employed (full-time and part-time) or student [numerator] | 1,982 | 2,612 |
| Total number of clients with non-missing values on employment status [denominator] | 6,916 | 6,916 |
| Percent of clients employed (full-time and part-time) or student | 28.7% | 37.8% |
| Percent of clients employed (full-time and part-time) or student at discharge minus percent of clients employed or student at admission. | Absolute Change [%T ₂ - %T ₁] 9.1% | |

Notes (for this level of care):

| | |
|---|--------------|
| Number of CY 2006 admissions submitted: | 8,152 |
| Number of CY 2006 discharges submitted: | 7,383 |
| Number of CY 2006 discharges linked to an admission: | 7,343 |
| Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated): | 7,129 |
| Number of CY 2006 linked discharges eligible for this calculation (non-missing values): | 6,916 |

**Source: SAMHSA/OAS TEDS CY 2006 admissions file and CY 2006 linked discharge file
[Records received through 5/14/2007]**

Outpatient (OP)

| Employment/Education - Clients employed (full-time and part-time) or student at admission vs. discharge | At Admission (T₁) | At Discharge (T₂) |
|--|---|-------------------------------------|
| Number of clients employed (full-time and part-time) or student [numerator] | 8,937 | 10,167 |
| Total number of clients with non-missing values on employment status [denominator] | 15,274 | 15,274 |
| Percent of clients employed (full-time and part-time) or student | 58.5% | 66.6% |
| Percent of clients employed (full-time and part-time) or student at discharge minus percent of clients employed or student at admission. | Absolute Change [%T ₂ - %T ₁] 8.1% | |

Notes (for this level of care):

| | |
|---|---------------|
| Number of CY 2006 admissions submitted: | 21,124 |
| Number of CY 2006 discharges submitted: | 18,337 |
| Number of CY 2006 discharges linked to an admission: | 18,178 |
| Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated): | 15,602 |
| Number of CY 2006 linked discharges eligible for this calculation (non-missing values): | 15,274 |

**Source: SAMHSA/OAS TEDS CY 2006 admissions file and CY 2006 linked discharge file
[Records received through 5/14/2007]**

Form T1 Footnotes

The pre-populated data represent about two-thirds of the final CY 2006 totals. Also, about a third of the pre-populated data came from private, non-block-grant-funded treatment programs.

Form T2 was pre-populated with the following Data Source: Discharges in CY 2006

STABLE HOUSING SITUATION (From Admission to Discharge)

| Short-term Residential(SR) | | |
|--|---|-------------------------------------|
| Clients with stable housing (independent or dependent living/not homeless) at admission vs. discharge | At Admission (T₁) | At Discharge (T₂) |
| Number of clients with stable housing [numerator] | 6,470 | 6,879 |
| Total number of clients with non-missing values on living arrangements [denominator] | 7,291 | 7,291 |
| Percent of clients with stable housing | 88.7% | 94.3% |
| Percent of clients with stable housing at discharge minus percent of clients with stable housing at admission. | Absolute Change [%T ₂ – %T ₁] 5.6% | |

| Notes (for this level of care): | |
|---|--------------|
| Number of CY 2006 admissions submitted: | 7,913 |
| Number of CY 2006 discharges submitted: | 7,505 |
| Number of CY 2006 discharges linked to an admission: | 7,461 |
| Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated): | 7,438 |
| Number of CY 2006 linked discharges eligible for this calculation (non-missing values): | 7,291 |
| Source: SAMHSA/OAS TEDS CY 2006 admissions file and CY 2006 linked discharge file [Records received through 5/14/2007] | |

Long-term Residential(LR)

| Clients with stable housing (independent or dependent living/not homeless) at admission vs. discharge | At Admission (T₁) | At Discharge (T₂) |
|--|--|-------------------------------------|
| Number of clients with stable housing [numerator] | 1,564 | 1,830 |
| Total number of clients with non-missing values on living arrangements [denominator] | 2,123 | 2,123 |
| Percent of clients with stable housing | 73.7% | 86.2% |
| Percent of clients with stable housing at discharge minus percent of clients with stable housing at admission. | Absolute Change [%T ₂ - %T ₁] 12.5% | |

Notes (for this level of care):

| | |
|---|--------------|
| Number of CY 2006 admissions submitted: | 3,070 |
| Number of CY 2006 discharges submitted: | 2,228 |
| Number of CY 2006 discharges linked to an admission: | 2,200 |
| Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated): | 2,170 |
| Number of CY 2006 linked discharges eligible for this calculation (non-missing values): | 2,123 |

Source: SAMHSA/OAS TEDS CY 2006 admissions file and CY 2006 linked discharge file
[Records received through 5/14/2007]

Intensive Outpatient (IO)

| Clients with stable housing (independent or dependent living/not homeless) at admission vs. discharge | At Admission (T₁) | At Discharge (T₂) |
|--|---|-------------------------------------|
| Number of clients with stable housing [numerator] | 6,517 | 6,801 |
| Total number of clients with non-missing values on living arrangements [denominator] | 7,002 | 7,002 |
| Percent of clients with stable housing | 93.1% | 97.1% |
| Percent of clients with stable housing at discharge minus percent of clients with stable housing at admission. | Absolute Change [%T ₂ - %T ₁] 4.0% | |

Notes (for this level of care):

| | |
|---|--------------|
| Number of CY 2006 admissions submitted: | 8,152 |
| Number of CY 2006 discharges submitted: | 7,383 |
| Number of CY 2006 discharges linked to an admission: | 7,343 |
| Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated): | 7,129 |
| Number of CY 2006 linked discharges eligible for this calculation (non-missing values): | 7,002 |

**Source: SAMHSA/OAS TEDS CY 2006 admissions file and CY 2006 linked discharge file
[Records received through 5/14/2007]**

Outpatient (OP)

| Clients with stable housing (independent or dependent living/not homeless) at admission vs. discharge | At Admission (T₁) | At Discharge (T₂) |
|--|---|-------------------------------------|
| Number of clients with stable housing [numerator] | 15,054 | 15,096 |
| Total number of clients with non-missing values on living arrangements [denominator] | 15,425 | 15,425 |
| Percent of clients with stable housing | 97.6% | 97.9% |
| Percent of clients with stable housing at discharge minus percent of clients with stable housing at admission. | Absolute Change [%T ₂ - %T ₁] 0.3% | |

Notes (for this level of care):

| | |
|---|---------------|
| Number of CY 2006 admissions submitted: | 21,124 |
| Number of CY 2006 discharges submitted: | 18,337 |
| Number of CY 2006 discharges linked to an admission: | 18,178 |
| Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated): | 15,602 |
| Number of CY 2006 linked discharges eligible for this calculation (non-missing values): | 15,425 |

**Source: SAMHSA/OAS TEDS CY 2006 admissions file and CY 2006 linked discharge file
[Records received through 5/14/2007]**

Form T2 Footnotes

The pre-populated data represent about two-thirds of the final CY 2006 totals. Also, about a third of the pre-populated data came from private, non-block-grant-funded treatment programs.

Form T3 was pre-populated with the following Data Source: Discharges in CY 2006

CRIMINAL JUSTICE INVOLVEMENT - NO ARRESTS (From Admission to Discharge)

| Short-term Residential(SR) | | |
|---|---|-------------------------------------|
| Criminal Justice Involvement – Clients with no arrests (any charge) (prior 30 days) at admission vs. discharge | At Admission (T₁) | At Discharge (T₂) |
| Number of clients with no arrests [numerator] | 6,779 | 7,264 |
| Total number of clients with non-missing values on arrests [denominator] | 7,311 | 7,311 |
| Percent of clients with no arrests | 92.7% | 99.4% |
| Percent of clients with no arrests at discharge minus percent of clients with no arrests at admission. | Absolute Change [%T ₂ – %T ₁] 6.7% | |

| Notes (for this level of care): | |
|---|--------------|
| Number of CY 2006 admissions submitted: | 7,913 |
| Number of CY 2006 discharges submitted: | 7,505 |
| Number of CY 2006 discharges linked to an admission: | 7,461 |
| Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths): | 7,460 |
| Number of CY 2006 linked discharges eligible for this calculation (non-missing values): | 7,311 |
| Source: SAMHSA/OAS TEDS CY 2006 admissions file and CY 2006 linked discharge file [Records received through 5/14/2007] | |

Long-term Residential(LR)

| Criminal Justice Involvement – Clients with no arrests (any charge) (prior 30 days) at admission vs. discharge | At Admission (T₁) | At Discharge (T₂) |
|---|---|-------------------------------------|
| Number of clients with no arrests [numerator] | 1,931 | 2,049 |
| Total number of clients with non-missing values on arrests [denominator] | 2,084 | 2,084 |
| Percent of clients with no arrests | 92.7% | 98.3% |
| Percent of clients with no arrests at discharge minus percent of clients with no arrests at admission. | Absolute Change [%T ₂ – %T ₁] 5.6% | |

Notes (for this level of care):

| | |
|---|--------------|
| Number of CY 2006 admissions submitted: | 3,070 |
| Number of CY 2006 discharges submitted: | 2,228 |
| Number of CY 2006 discharges linked to an admission: | 2,200 |
| Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths): | 2,199 |
| Number of CY 2006 linked discharges eligible for this calculation (non-missing values): | 2,084 |

**Source: SAMHSA/OAS TEDS CY 2006 admissions file and CY 2006 linked discharge file
[Records received through 5/14/2007]**

Intensive Outpatient (IO)

| Criminal Justice Involvement – Clients with no arrests (any charge) (prior 30 days) at admission vs. discharge | At Admission (T₁) | At Discharge (T₂) |
|---|---|-------------------------------------|
| Number of clients with no arrests [numerator] | 6,373 | 6,944 |
| Total number of clients with non-missing values on arrests [denominator] | 7,119 | 7,119 |
| Percent of clients with no arrests | 89.5% | 97.5% |
| Percent of clients with no arrests at discharge minus percent of clients with no arrests at admission. | Absolute Change [%T ₂ – %T ₁] 8.0% | |

Notes (for this level of care):

| | |
|---|--------------|
| Number of CY 2006 admissions submitted: | 8,152 |
| Number of CY 2006 discharges submitted: | 7,383 |
| Number of CY 2006 discharges linked to an admission: | 7,343 |
| Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths): | 7,329 |
| Number of CY 2006 linked discharges eligible for this calculation (non-missing values): | 7,119 |

**Source: SAMHSA/OAS TEDS CY 2006 admissions file and CY 2006 linked discharge file
[Records received through 5/14/2007]**

Outpatient (OP)

| Criminal Justice Involvement – Clients with no arrests (any charge) (prior 30 days) at admission vs. discharge | At Admission (T₁) | At Discharge (T₂) |
|---|---|-------------------------------------|
| Number of clients with no arrests [numerator] | 13,666 | 14,559 |
| Total number of clients with non-missing values on arrests [denominator] | 14,973 | 14,973 |
| Percent of clients with no arrests | 91.3% | 97.2% |
| Percent of clients with no arrests at discharge minus percent of clients with no arrests at admission. | Absolute Change [%T ₂ – %T ₁] 5.9% | |

Notes (for this level of care):

| | |
|---|---------------|
| Number of CY 2006 admissions submitted: | 21,124 |
| Number of CY 2006 discharges submitted: | 18,337 |
| Number of CY 2006 discharges linked to an admission: | 18,178 |
| Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths): | 16,119 |
| Number of CY 2006 linked discharges eligible for this calculation (non-missing values): | 14,973 |

Source: SAMHSA/OAS TEDS CY 2006 admissions file and CY 2006 linked discharge file [Records received through 5/14/2007]

Form T3 Footnotes

The pre-populated data represent about two-thirds of the final CY 2006 totals. Also, about a third of the pre-populated data came from private, non-block-grant-funded treatment programs.

Form T4 was pre-populated with the following Data Source: Discharges in CY 2006

ALCOHOL ABSTINENCE

| Short-term Residential(SR) | | |
|--|--|-------------------------------------|
| A. ALCOHOL ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge) | | |
| Denominator = All clients | | |
| Alcohol Abstinence – Clients with no alcohol use at admission vs. discharge, as a percent of all clients (regardless of primary problem) | At Admission (T₁) | At Discharge (T₂) |
| Number of clients abstinent from alcohol [numerator] | 3,992 | 6,506 |
| All clients with non-missing values on at least one substance/frequency of use [denominator] | 7,390 | 7,390 |
| Percent of clients abstinent from alcohol | 54.0% | 88.0% |
| Percent of clients abstinent from alcohol at discharge minus percent of clients abstinent from alcohol at admission. | Absolute Change [%T ₂ – %T ₁] 34.0% | |
| B. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL USERS AT ADMISSION | | |
| Denominator = Clients using at admission | | |
| Clients abstinent from alcohol at discharge among clients using alcohol at admission (regardless of primary problem) | At Admission (T₁) | At Discharge (T₂) |
| Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator] | | 2,562 |
| Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator] | 3,398 | |
| Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T ₂ / #T ₁ x 100] | | 75.4% |
| C. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL ABSTINENT AT ADMISSION | | |
| Denominator = Clients abstinent at admission | | |
| Clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission (regardless of primary problem) | At Admission (T₁) | At Discharge (T₂) |
| Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator] | | 3,944 |
| Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator] | 3,992 | |
| Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T ₂ / #T ₁ x 100] | | 98.8% |
| Notes (for this level of care): | | |
| Number of CY 2006 admissions submitted: | | 7,913 |
| Number of CY 2006 discharges submitted: | | 7,505 |
| Number of CY 2006 discharges linked to an admission: | | |

| | |
|---|--------------|
| | 7,461 |
| Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths): | 7,460 |
| Number of CY 2006 linked discharges eligible for this calculation (non-missing values): | 7,390 |
| Source: SAMHSA/OAS TEDS CY 2006 admissions file and CY 2006 linked discharge file [Records received through 5/14/2007] | |

Long-term Residential(LR)

A. ALCOHOL ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)

Denominator = All clients

| Alcohol Abstinence – Clients with no alcohol use at admission vs. discharge, as a percent of all clients (regardless of primary problem) | At Admission (T ₁) | At Discharge (T ₂) |
|--|---|--------------------------------|
| Number of clients abstinent from alcohol [numerator] | 1,546 | 1,989 |
| All clients with non-missing values on at least one substance/frequency of use [denominator] | 2,137 | 2,137 |
| Percent of clients abstinent from alcohol | 72.3% | 93.1% |
| Percent of clients abstinent from alcohol at discharge minus percent of clients abstinent from alcohol at admission. | Absolute Change [%T ₂ – %T ₁] 20.8% | |

B. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL USERS AT ADMISSION

Denominator = Clients using at admission

| Clients abstinent from alcohol at discharge among clients using alcohol at admission (regardless of primary problem) | At Admission (T ₁) | At Discharge (T ₂) |
|---|--------------------------------|--------------------------------|
| Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator] | | 506 |
| Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator] | 591 | |
| Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T ₂ / #T ₁ x 100] | | 85.6% |

C. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL ABSTINENT AT ADMISSION

Denominator = Clients abstinent at admission

| Clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission (regardless of primary problem) | At Admission (T ₁) | At Discharge (T ₂) |
|--|--------------------------------|--------------------------------|
| Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator] | | 1,483 |
| Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator] | 1,546 | |
| Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T ₂ / #T ₁ x 100] | | 95.9% |

Notes (for this level of care):

| | |
|---|-------|
| Number of CY 2006 admissions submitted: | 3,070 |
| Number of CY 2006 discharges submitted: | 2,228 |
| Number of CY 2006 discharges linked to an admission: | 2,200 |
| Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths): | 2,199 |

Number of CY 2006 linked discharges eligible for this calculation (non-missing values):

2,137

**Source: SAMHSA/OAS TEDS CY 2006 admissions file and CY 2006 linked discharge file
[Records received through 5/14/2007]**

Intensive Outpatient (IO)

A. ALCOHOL ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)

Denominator = All clients

| Alcohol Abstinence – Clients with no alcohol use at admission vs. discharge, as a percent of all clients (regardless of primary problem) | At Admission (T ₁) | At Discharge (T ₂) |
|--|---|--------------------------------|
| Number of clients abstinent from alcohol [numerator] | 4,511 | 6,069 |
| All clients with non-missing values on at least one substance/frequency of use [denominator] | 6,789 | 6,789 |
| Percent of clients abstinent from alcohol | 66.4% | 89.4% |
| Percent of clients abstinent from alcohol at discharge minus percent of clients abstinent from alcohol at admission. | Absolute Change [%T ₂ – %T ₁] 23.0% | |

B. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL USERS AT ADMISSION

Denominator = Clients using at admission

| Clients abstinent from alcohol at discharge among clients using alcohol at admission (regardless of primary problem) | At Admission (T ₁) | At Discharge (T ₂) |
|---|--------------------------------|--------------------------------|
| Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator] | | 1,681 |
| Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator] | 2,278 | |
| Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T ₂ / #T ₁ x 100] | | 73.8% |

C. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL ABSTINENT AT ADMISSION

Denominator = Clients abstinent at admission

| Clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission (regardless of primary problem) | At Admission (T ₁) | At Discharge (T ₂) |
|--|--------------------------------|--------------------------------|
| Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator] | | 4,388 |
| Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator] | 4,511 | |
| Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T ₂ / #T ₁ x 100] | | 97.3% |

Notes (for this level of care):

| | |
|---|-------|
| Number of CY 2006 admissions submitted: | 8,152 |
| Number of CY 2006 discharges submitted: | 7,383 |
| Number of CY 2006 discharges linked to an admission: | 7,343 |
| Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths): | 7,329 |

Number of CY 2006 linked discharges eligible for this calculation (non-missing values):

6,789

**Source: SAMHSA/OAS TEDS CY 2006 admissions file and CY 2006 linked discharge file
[Records received through 5/14/2007]**

Outpatient (OP)

A. ALCOHOL ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)

Denominator = All clients

| Alcohol Abstinence – Clients with no alcohol use at admission vs. discharge, as a percent of all clients (regardless of primary problem) | At Admission (T ₁) | At Discharge (T ₂) |
|--|---|--------------------------------|
| Number of clients abstinent from alcohol [numerator] | 9,494 | 13,790 |
| All clients with non-missing values on at least one substance/frequency of use [denominator] | 15,283 | 15,283 |
| Percent of clients abstinent from alcohol | 62.1% | 90.2% |
| Percent of clients abstinent from alcohol at discharge minus percent of clients abstinent from alcohol at admission. | Absolute Change [%T ₂ – %T ₁] 28.1% | |

B. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL USERS AT ADMISSION

Denominator = Clients using at admission

| Clients abstinent from alcohol at discharge among clients using alcohol at admission (regardless of primary problem) | At Admission (T ₁) | At Discharge (T ₂) |
|---|--------------------------------|--------------------------------|
| Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator] | | 4,553 |
| Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator] | 5,789 | |
| Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T ₂ / #T ₁ x 100] | | 78.6% |

C. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL ABSTINENT AT ADMISSION

Denominator = Clients abstinent at admission

| Clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission (regardless of primary problem) | At Admission (T ₁) | At Discharge (T ₂) |
|--|--------------------------------|--------------------------------|
| Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator] | | 9,237 |
| Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator] | 9,494 | |
| Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T ₂ / #T ₁ x 100] | | 97.3% |

Notes (for this level of care):

| | |
|---|--------|
| Number of CY 2006 admissions submitted: | 21,124 |
| Number of CY 2006 discharges submitted: | 18,337 |
| Number of CY 2006 discharges linked to an admission: | 18,178 |
| Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths): | 16,119 |

Number of CY 2006 linked discharges eligible for this calculation (non-missing values):

15,283

**Source: SAMHSA/OAS TEDS CY 2006 admissions file and CY 2006 linked discharge file
[Records received through 5/14/2007]**

Form T4 Footnotes

The pre-populated data represent about two-thirds of the final CY 2006 totals. Also, about a third of the pre-populated data came from private, non-block-grant-funded treatment programs.

Form T5 was pre-populated with the following Data Source: Discharges in CY 2006

DRUG ABSTINENCE

| Short-term Residential(SR) | | |
|--|--|-------------------------------------|
| A. DRUG ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge) | | |
| Denominator = All clients | | |
| Drug Abstinence – Clients with no drug use (all clients regardless of primary problem) at admission vs. discharge. | At Admission (T₁) | At Discharge (T₂) |
| Number of clients abstinent from drugs [numerator] | 1,615 | 5,667 |
| All clients with non-missing values on at least one substance/frequency of use [denominator] | 7,390 | 7,390 |
| Percent of clients abstinent from drugs | 21.9% | 76.7% |
| Percent of clients abstinent from drugs at discharge minus percent of clients abstinent from drugs at admission. | Absolute Change [%T ₂ – %T ₁] 54.8% | |
| B. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG USERS AT ADMISSION | | |
| Denominator = Clients using at admission | | |
| Clients abstinent from drugs at discharge among clients using drugs at admission (regardless of primary problem) | At Admission (T₁) | At Discharge (T₂) |
| Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator] | | 4,094 |
| Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator] | 5,775 | |
| Percent of clients abstinent from drugs at discharge among clients using drugs at admission [#T ₂ / #T ₁ x 100] | | 70.9% |
| C. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG ABSTINENT AT ADMISSION | | |
| Denominator = Clients abstinent at admission | | |
| Clients abstinent from drugs at discharge among clients abstinent from drugs at admission (regardless of primary problem) | At Admission (T₁) | At Discharge (T₂) |
| Number of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [numerator] | | 1,573 |
| Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator] | 1,615 | |
| Percent of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [#T ₂ / #T ₁ x 100] | | 97.4% |
| Notes (for this level of care): | | |
| Number of CY 2006 admissions submitted: | | 7,913 |
| Number of CY 2006 discharges submitted: | | 7,505 |
| Number of CY 2006 discharges linked to an admission: | | |

| | |
|---|--------------|
| | 7,461 |
| Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths): | 7,460 |
| Number of CY 2006 linked discharges eligible for this calculation (non-missing values): | 7,390 |
| Source: SAMHSA/OAS TEDS CY 2006 admissions file and CY 2006 linked discharge file [Records received through 5/14/2007] | |

Long-term Residential(LR)

A. DRUG ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)

Denominator = All clients

| Drug Abstinence – Clients with no drug use (all clients regardless of primary problem) at admission vs. discharge. | At Admission (T ₁) | At Discharge (T ₂) |
|--|---|--------------------------------|
| Number of clients abstinent from drugs [numerator] | 1,230 | 1,771 |
| All clients with non-missing values on at least one substance/frequency of use [denominator] | 2,137 | 2,137 |
| Percent of clients abstinent from drugs | 57.6% | 82.9% |
| Percent of clients abstinent from drugs at discharge minus percent of clients abstinent from drugs at admission. | Absolute Change [%T ₂ – %T ₁] 25.3% | |

B. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG USERS AT ADMISSION

Denominator = Clients using at admission

| Clients abstinent from drugs at discharge among clients using drugs at admission (regardless of primary problem) | At Admission (T ₁) | At Discharge (T ₂) |
|---|--------------------------------|--------------------------------|
| Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator] | | 679 |
| Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator] | 907 | |
| Percent of clients abstinent from drugs at discharge among clients using drugs at admission [#T ₂ / #T ₁ x 100] | | 74.9% |

C. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG ABSTINENT AT ADMISSION

Denominator = Clients abstinent at admission

| Clients abstinent from drugs at discharge among clients abstinent from drugs at admission (regardless of primary problem) | At Admission (T ₁) | At Discharge (T ₂) |
|--|--------------------------------|--------------------------------|
| Number of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [numerator] | | 1,092 |
| Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator] | 1,230 | |
| Percent of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [#T ₂ / #T ₁ x 100] | | 88.8% |

Notes (for this level of care):

| | |
|---|-------|
| Number of CY 2006 admissions submitted: | 3,070 |
| Number of CY 2006 discharges submitted: | 2,228 |
| Number of CY 2006 discharges linked to an admission: | 2,200 |
| Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths): | 2,199 |

Number of CY 2006 linked discharges eligible for this calculation (non-missing values):

2,137

**Source: SAMHSA/OAS TEDS CY 2006 admissions file and CY 2006 linked discharge file
[Records received through 5/14/2007]**

Intensive Outpatient (IO)

A. DRUG ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)

Denominator = All clients

| Drug Abstinence – Clients with no drug use (all clients regardless of primary problem) at admission vs. discharge. | At Admission (T ₁) | At Discharge (T ₂) |
|--|---|--------------------------------|
| Number of clients abstinent from drugs [numerator] | 3,202 | 5,312 |
| All clients with non-missing values on at least one substance/frequency of use [denominator] | 6,789 | 6,789 |
| Percent of clients abstinent from drugs | 47.2% | 78.2% |
| Percent of clients abstinent from drugs at discharge minus percent of clients abstinent from drugs at admission. | Absolute Change [%T ₂ – %T ₁] 31.0% | |

B. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG USERS AT ADMISSION

Denominator = Clients using at admission

| Clients abstinent from drugs at discharge among clients using drugs at admission (regardless of primary problem) | At Admission (T ₁) | At Discharge (T ₂) |
|---|--------------------------------|--------------------------------|
| Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator] | | 2,331 |
| Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator] | 3,587 | |
| Percent of clients abstinent from drugs at discharge among clients using drugs at admission [#T ₂ / #T ₁ x 100] | | 65.0% |

C. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG ABSTINENT AT ADMISSION

Denominator = Clients abstinent at admission

| Clients abstinent from drugs at discharge among clients abstinent from drugs at admission (regardless of primary problem) | At Admission (T ₁) | At Discharge (T ₂) |
|--|--------------------------------|--------------------------------|
| Number of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [numerator] | | 2,981 |
| Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator] | 3,202 | |
| Percent of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [#T ₂ / #T ₁ x 100] | | 93.1% |

Notes (for this level of care):

| | |
|---|-------|
| Number of CY 2006 admissions submitted: | 8,152 |
| Number of CY 2006 discharges submitted: | 7,383 |
| Number of CY 2006 discharges linked to an admission: | 7,343 |
| Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths): | 7,329 |

Number of CY 2006 linked discharges eligible for this calculation (non-missing values):

6,789

**Source: SAMHSA/OAS TEDS CY 2006 admissions file and CY 2006 linked discharge file
[Records received through 5/14/2007]**

Outpatient (OP)

A. DRUG ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)

Denominator = All clients

| Drug Abstinence – Clients with no drug use (all clients regardless of primary problem) at admission vs. discharge. | At Admission (T ₁) | At Discharge (T ₂) |
|--|---|--------------------------------|
| Number of clients abstinent from drugs [numerator] | 9,392 | 12,752 |
| All clients with non-missing values on at least one substance/frequency of use [denominator] | 15,283 | 15,283 |
| Percent of clients abstinent from drugs | 61.5% | 83.4% |
| Percent of clients abstinent from drugs at discharge minus percent of clients abstinent from drugs at admission. | Absolute Change [%T ₂ – %T ₁] 21.9% | |

B. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG USERS AT ADMISSION

Denominator = Clients using at admission

| Clients abstinent from drugs at discharge among clients using drugs at admission (regardless of primary problem) | At Admission (T ₁) | At Discharge (T ₂) |
|---|--------------------------------|--------------------------------|
| Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator] | | 3,887 |
| Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator] | 5,891 | |
| Percent of clients abstinent from drugs at discharge among clients using drugs at admission [#T ₂ / #T ₁ x 100] | | 66.0% |

C. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG ABSTINENT AT ADMISSION

Denominator = Clients abstinent at admission

| Clients abstinent from drugs at discharge among clients abstinent from drugs at admission (regardless of primary problem) | At Admission (T ₁) | At Discharge (T ₂) |
|--|--------------------------------|--------------------------------|
| Number of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [numerator] | | 8,865 |
| Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator] | 9,392 | |
| Percent of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [#T ₂ / #T ₁ x 100] | | 94.4% |

Notes (for this level of care):

| | |
|---|--------|
| Number of CY 2006 admissions submitted: | 21,124 |
| Number of CY 2006 discharges submitted: | 18,337 |
| Number of CY 2006 discharges linked to an admission: | 18,178 |
| Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths): | 16,119 |

Number of CY 2006 linked discharges eligible for this calculation (non-missing values):

15,283

**Source: SAMHSA/OAS TEDS CY 2006 admissions file and CY 2006 linked discharge file
[Records received through 5/14/2007]**

Form T5 Footnotes

The pre-populated data represent about two-thirds of the final CY 2006 totals. Also, about a third of the pre-populated data came from private, non-block-grant-funded treatment programs.

Performance Measure Data Collection
Interim Standard – Percentage Point Change in Social Support of Recovery

GOAL To improve clients’ participation in social support of recovery activities to reduce substance abuse to protect the health, safety, and quality of life for all.

MEASURE The change in *all clients receiving treatment* who reported participation in one or more social and or recovery support activity at discharge.

DEFINITIONS Change in *all clients receiving treatment* who reported participation in one or more social and recovery support activities at discharge equals clients reporting participation at admission subtracted from clients reporting participation at discharge.

| | | |
|---|----------------------------|--------------------------|
| Most recent year for which data are available | From: <input type="text"/> | To: <input type="text"/> |
|---|----------------------------|--------------------------|

| Social Support of Recovery – Clients participating in self-help groups, support groups (e.g., AA, NA, etc.) (prior 30 days) at admission vs. discharge | Admission Clients (T₁) | Discharge Clients (T₂) |
|---|---|--|
| Number of clients with one or more such activities (AA NA meetings attended, etc.) [numerator] | <input type="text" value="0"/> | <input type="text" value="0"/> |
| Total number of Admission and Discharge clients with non-missing values on social support activities [denominator] | <input type="text" value="0"/> | <input type="text" value="0"/> |
| Percent of clients participating in social support activities | | |
| Percent of clients participating in social support of recovery activities in prior 30 days at discharge minus percent of clients participating in social support of recovery activities in prior 30 days at admission. (Positive percent change values indicate increased participation in social support of recovery activities.) | Absolute Change [%T ₂ -%T ₁] 0.00% / 0.00% | |

State Description of Employment Status Data Collection (Form T6)

| | |
|--|--|
| STATE CONFORMANCE TO INTERIM STANDARD | States should detail exactly how this information is collected. Where data and methods vary from interim standard, variance should be described |
|--|--|

| | |
|--------------------|--|
| DATA SOURCE | What is the source of data for table T6? (Select all that apply) <input type="checkbox"/> Client Self Report Client self-report confirmed by another source: <input type="checkbox"/> Collateral source <input type="checkbox"/> Administrative data source <input type="checkbox"/> Other: Specify <input type="text"/> |
|--------------------|--|

| | |
|--|--|
| | |
|--|--|

EPISODE OF CARE

How is the admission/discharge basis defined for table T6? (Select one)

- Admission is on the first date of service, prior to which no service has been received for 30 days AND discharge is on the last date of service, subsequent to which no service has been received for 30 days
- Admission is on the first date of service in a Program/Service Delivery Unit and Discharge is on the last date of service in a Program/Service Delivery Unit
- Other, Specify:

DISCHARGE DATA COLLECTION

How was discharge data collected for table T6? (Select all that apply)

- Not applicable, data reported on form is collected at time period other than discharge
Specify:
 - In-Treatment data days post admission
 - Follow-up data months post
 - Other, Specify:
- Discharge data is collected for the census of all (or almost all) clients who were admitted to treatment
- Discharge data is collected for a sample of all clients who were admitted to treatment
- Discharge records are directly collected (or in the case of early dropouts) are created for all (or almost all) clients who were admitted to treatment
- Discharge records are not collected for approximately % of clients who were admitted for treatment

RECORD LINKING

Was the admission and discharge data linked for table T6? (Select all that apply)

- Yes, all clients at admission were linked with discharge data using an Unique Client Identifier (UCID)
Select type of UCID:
 - Master Client Index or Master Patient Index, centrally assigned
 - Social Security Number (SSN)
 - Unique client ID based on fixed client characteristics (such as date of birth, gender, partial SSN, etc.)
 - Some other Statewide unique ID
 - Provider-entity-specific unique ID
- No, State Management Information System does not utilize UCID that allows comparison of admission and discharge data on a client specific basis (data developed on a cohorts basis) or State relied on other data sources for post admission data
- No, admission and discharge records were matched using probabilistic record matching

IF DATA IS UNAVAILABLE

If data is not reported, why is State unable to report? (Select all that apply)

- Information is not collected at admission
- Information is not collected at discharge
- Information is not collected by the categories requested
- State collects information on the indicator area but utilizes a different measure.

DATA PLANS IF DATA IS NOT AVAILABLE

State must provide time-framed plans for capturing social support of recovery data on all clients, if data is not currently available. Plans should also discuss barriers, resource

needs and estimates of cost.

Form T7 was pre-populated with the following Data Source: Discharges in CY 2006

Length of Stay (in Days) of All Discharges

| Level of Care | Length of Stay (in Days) | | | |
|---|--------------------------|-----------------|--------------------------|-----------------|
| | Average (Mean) | 25th Percentile | 50th Percentile (Median) | 75th Percentile |
| Detoxification (24-Hour Care) | | | | |
| 1. Hospital Inpatient | 6 | 1 | 6 | 10 |
| 2. Free-standing Residential | 9 | 4 | 6 | 8 |
| Rehabilitation / Residential | | | | |
| 3. Hospital Inpatient | 17 | 5 | 13 | 25 |
| 4. Short-term (up to 30 days) | 21 | 9 | 20 | 28 |
| 5. Long-term (over 30 days) | 86 | 27 | 53 | 135 |
| Ambulatory (Outpatient) | | | | |
| 6. Outpatient | 126 | 43 | 100 | 185 |
| 7. Intensive Outpatient | 76 | 27 | 52 | 101 |
| 8. Detoxification | 16 | 5 | 6 | 6 |
| Opioid Replacement Therapy (ORT) | | | | |
| 9. ORT Detoxification (any setting) | 337 | 98 | 168 | 468 |
| 10. ORT Outpatient | 534 | 119 | 316 | 759 |

| Notes: | | |
|--|-----------------------------------|-----------------------------------|
| Level of Care | 2006 TEDS discharge record counts | |
| | Discharges submitted | Discharges linked to an admission |
| Total count, all levels of care..... | 38,200 | 37,912 |
| Detoxification (24-Hour Care) - Hospital Inpatient | 4 | 4 |
| Detoxification (24-Hour Care) - Free-standing Residential | 2,127 | 2,114 |
| Rehabilitation / Residential - Hospital Inpatient | 22 | 21 |
| Rehabilitation / Residential - Short-term (up to 30 days) | 7,505 | 7,461 |
| Rehabilitation / Residential - Long-term (over 30 days) | 2,228 | 2,200 |
| Ambulatory (Outpatient) - Outpatient | 18,337 | 16,147 |
| Ambulatory (Outpatient) - Intensive Outpatient | 7,383 | 7,343 |
| Ambulatory (Outpatient) - Detoxification | 594 | 518 |
| Opioid Replacement Therapy (ORT) - ORT Detoxification (any setting) | Not Available | 73 |
| Opioid Replacement Therapy (ORT) - ORT Outpatient | Not Available | 2,031 |
| Source: SAMHSA/OAS TEDS CY 2006 linked discharge file [Records received through 5/14/2007] | | |

Form T7 Footnotes

The pre-populated data represent about two-thirds of the final CY 2006 totals. Also, about a third of the pre-populated data came from private, non-block-grant-funded treatment programs.

Maryland

INSERT OVERALL NARRATIVE:

INSERT OVERALL NARRATIVE:

The State should address as many of these questions as possible and may provide other relevant information if so desired. Responses to questions that are already provided in other sections of the application (e.g., planning, needs assessment) should be referenced whenever possible.

State Performance Management and Leadership

Describe the Single State Authority capacity and capability to make data driven decisions based on performance measures? Describe any potential barriers and necessary changes that would enhance the SSA's leadership role in this capacity.

Describe the types of regular and ad hoc reports generated by the State and identify to whom they are distributed and how.

If the State sets benchmarks, performance targets or quantified objectives, what methods are used by the State in setting these values?

What actions does the State take as a result of analyzing performance management data?

Has the State developed evidence-based practices (EBPs) or programs and, if so, does the State require that providers use these EBPs?

Provider Involvement

What actions does the State expect the provider or intermediary to take as a result of analyzing performance management data?

If the SSA has a regular training program for State and provider staff that collect and report client information, describe the training program, its participants and frequency.

Do workforce development plans address NOMs implementation and performance-based management practices?

Does the State require providers to supply information about the intensity or number of services received?

The Maryland Alcohol and Drug Abuse Administration utilizes its web-based clinical record (State of Maryland Automated Record Tracking [SMART]) application to provide real time data. The Administration obtains data on a monthly basis by virtue of a data download procedure; however, SMART provides on-demand reports and raw data as an Excel export. These data are then available for any secondary analysis needed.

The ADAA also utilizes the CSAP developed Minimum Data Set (MDS) tool to collect prevention program data on all of its funded prevention providers. The MDS is a web-based client-server data collection system that uses internet technology. While the MDS is able to identify and provide basic demographic information (i.e. persons served, age, gender, race and ethnicity), other potential data sources for needs assessment and outcome evaluations will have to be considered and implemented if we are to be able to demonstrate effective prevention services. ADAA applied for and received funds to establish the Maryland State Epidemiology Outcomes Workgroup (MdSEOW) to oversee the collection of data for state and local indicators and to identify community needs and target populations. The (MdSEOW) will provide the data structure for the Maryland Strategic Prevention Framework.

Training for providers on how to use these applications is ongoing. The Administration has two full-time trainers who, in concert with the Prevention Database Administrator and Analyst, provide training on the MDS. In addition to the in-house trainers, the University of Maryland Institute for Governmental Services and Research, ADAA's partner in the development of SMART, provides four trainers for SMART. ADAA has established a computer training lab where training occurs on both a regular and ad hoc basis. The training covers basic navigation within the application, integration of clinical training, use of an electronic treatment plan module, and how to export and use clinical data in day to day operations.

ADAA has a regional team structure that provides leadership and technical assistance to the Local Drug and Alcohol Abuse Councils and Service Providers. These teams consist of members of the Administration's four Divisions: Information Services, Community Services, Quality Assurance, and Management Services.

ADAA has established performance measures for the local jurisdictions based on its TOPPS II research results and the National Outcome Measures (NOMs). These performance targets are established in each jurisdiction's yearly grant application.

The Information Services Division provides bi-annual reports on the performance measures for local planners at both the jurisdictional (county or Baltimore City) and the individual provider levels. These reports are also reviewed by the ADAA regional teams. When a jurisdiction or individual provider is found to be falling short of the projected performance targets, the team will work with the jurisdiction to identify problems and recommend resolutions that are based on best practice.

ADAA has recently begun to pilot a "pay for performance" incentive program as well. Performance standards were set for outpatient services and if the jurisdiction met or exceeded the standards they received additional funds to be used in the jurisdiction where needed.

Form P1

NOMs Domain: Reduced Morbidity—Abstinence from Drug Use/Alcohol Use Measure: 30-Day Use

| A. Measure | B. Question/Response | C. Pre-Populated Data | D. Approved Substitute Data |
|---|---|---|-----------------------------|
| 1. 30-day Alcohol Use | Source Survey Item: NSDUH Questionnaire. "Think specifically about the past 30 days, that is, from [DATEFILL] through today. During the past 30 days, on how many days did you drink one or more drinks of an alcoholic beverage?" [Response option: Write in a number between 0 and 30.] Outcome Reported: Percent who reported having used alcohol during the past 30 days. | Ages 12-17 - FFY 2005 (Baseline) <input type="text" value="15.60"/> | <input type="text"/> |
| | | Ages 18+ - FFY 2005 (Baseline) <input type="text" value="56.70"/> | <input type="text"/> |
| 2. 30-day Cigarette Use | Source Survey Item: NSDUH Questionnaire: "During the past 30 days, that is, since [DATEFILL], on how many days did you smoke part or all of a cigarette?" [Response option: Write in a number between 0 and 30.] | Ages 12-17 - FFY 2005 (Baseline) <input type="text" value="11"/> | <input type="text"/> |
| | | Ages 18+ - FFY 2005 (Baseline) <input type="text" value="24.90"/> | <input type="text"/> |
| 3. 30-day Use of Other Tobacco Product | Source Survey Item: NSDUH Questionnaire: "During the past 30 days, that is, since [DATEFILL], on how many days did you use [other tobacco products] † ?" [Response option: Write in a number between 0 and 30.] Outcome Reported: Percent who reported having used a tobacco product other than cigarettes during the past 30 days, | Ages 12-17 - FFY 2005 (Baseline) <input type="text" value="3.30"/> | <input type="text"/> |
| | | Ages 18+ - FFY 2005 (Baseline) <input type="text" value="6.10"/> | <input type="text"/> |
| 4. 30-day Use of Marijuana | Source Survey Item: NSDUH Questionnaire: "Think specifically about the past 30 days, from [DATEFILL] up to and including today. During the past 30 days, on how many days did you use marijuana or hashish?" [Response option: Write in a number between 0 and 30.] Outcome Reported: Percent who reported having used marijuana or hashish during the past 30 days. | Ages 12-17 - FFY 2005 (Baseline) <input type="text" value="7.50"/> | <input type="text"/> |
| | | Ages 18+ - FFY 2005 (Baseline) <input type="text" value="4.60"/> | <input type="text"/> |
| 5. 30-day Use of Illegal Drugs Other Than Marijuana | Source Survey Item: NSDUH Questionnaire: "Think specifically about the past 30 days, from [DATEFILL] up to and including today. During the past 30 days, on how many days did you use [any other illegal drug] ‡ ?" Outcome Reported: Percent who reported having used illegal drugs other than marijuana or hashish during the past 30 days, calculated by combining responses to questions about individual drugs (heroin, cocaine, stimulants, hallucinogens, inhalants, prescription drugs used without doctors' orders). | Ages 12-17 - FFY 2005 (Baseline) <input type="text" value="3.80"/> | <input type="text"/> |
| | | Ages 18+ - FFY 2005 (Baseline) <input type="text" value="3"/> | <input type="text"/> |

((s)) indicates that the respondents to the question may not constitute a representative sample. All NSDUH data are based on pooled 2004-2005 samples.

- † NSDUH asks separate questions for each tobacco product. The number provided combines responses to all questions about tobacco products other than cigarettes.
- ‡ NSDUH asks separate questions for each illegal drug. The number provided combines responses to all questions about illegal drugs other than marijuana or hashish.

Form P2

NOMs Domain: Reduced Morbidity—Abstinence from Drug Use/Alcohol Use

Measure: Perception of Risk/Harm of Use

| A. Measure | B. Question/Response | C. Pre-Populated Data | D. Approved Substitute Data |
|---------------------------------------|---|---|-----------------------------|
| 1. Perception of Risk From Alcohol | Source Survey Item: NSDUH Questionnaire: "How much do people risk harming themselves physically and in other ways when they have five or more drinks of an alcoholic beverage once or twice a week?" [Response options: No risk, slight risk, moderate risk, great risk] Outcome Reported: Percent reporting moderate or great risk. | Ages 12–17 - FFY 2005 (Baseline) <input type="text" value="77.10"/> | <input type="text"/> |
| | | Ages 18+ - FFY 2005 (Baseline) <input type="text" value="79.70"/> | <input type="text"/> |
| 2. Perception of Risk From Cigarettes | Source Survey Item: NSDUH Questionnaire: "How much do people risk harming themselves physically and in other ways when they smoke one or more packs of cigarettes per day?" [Response options: No risk, slight risk, moderate risk, great risk] Outcome Reported: Percent reporting moderate or great risk. | Ages 12–17 - FFY 2005 (Baseline) <input type="text" value="93.10"/> | <input type="text"/> |
| | | Ages 18+ - FFY 2005 (Baseline) <input type="text" value="93.50"/> | <input type="text"/> |
| 3. Perception of Risk From Marijuana | Source Survey Item: NSDUH Questionnaire: "How much do people risk harming themselves physically and in other ways when they smoke marijuana once or twice a week?" [Response options: No risk, slight risk, moderate risk, great risk] Outcome Reported: Percent reporting moderate or great risk. | Ages 12–17 - FFY 2005 (Baseline) <input type="text" value="82"/> | <input type="text"/> |
| | | Ages 18+ - FFY 2005 (Baseline) <input type="text" value="77.80"/> | <input type="text"/> |

((s)) indicates that the respondents to the question may not constitute a representative sample. All NSDUH data are based on pooled 2004-2005 samples.

Form P3

NOMs Domain: Reduced Morbidity—Abstinence from Drug Use/Alcohol Use Measure: Age of First Use

| A. Measure | B. Question/Response | C. Pre-Populated Data | D. Approved Substitute Data |
|--|--|---|-----------------------------|
| 1. Age at First Use of Alcohol | Source Survey Item: NSDUH Questionnaire: "Think about the first time you had a drink of an alcoholic beverage. How old were you the first time you had a drink of an alcoholic beverage? Please do not include any time when you only had a sip or two from a drink." [Response option: Write in age at first use.] | Ages 12-17 - FFY 2005 (Baseline) 12.90 | |
| | Outcome Reported: Average age at first use of alcohol. | Ages 18+ - FFY 2005 (Baseline) 17.50 | |
| 2. Age at First Use of Cigarettes | Source Survey Item: NSDUH Questionnaire: "How old were you the first time you smoked part or all of a cigarette?" [Response option: Write in age at first use.] | Ages 12-17 - FFY 2005 (Baseline) 12.60 | |
| | Outcome Reported: Average age at first use of cigarettes. | Ages 18+ - FFY 2005 (Baseline) 15.50 | |
| 3. Age at First Use of Tobacco Products Other Than Cigarettes | Source Survey Item: NSDUH Questionnaire: "How old were you the first time you used [any other tobacco product] † ?" [Response option: Write in age at first use.] | Ages 12-17 - FFY 2005 (Baseline) 13.60 | |
| | Outcome Reported: Average age at first use of tobacco products other than cigarettes. | Ages 18+ - FFY 2005 (Baseline) 20.50 | |
| 4. Age at First Use of Marijuana or Hashish | Source Survey Item: NSDUH Questionnaire: "How old were you the first time you used marijuana or hashish?" [Response option: Write in age at first use.] | Ages 12-17 - FFY 2005 (Baseline) 13.70 | |
| | Outcome Reported: Average age at first use of marijuana or hashish. | Ages 18+ - FFY 2005 (Baseline) 17.90 | |
| 5. Age at First Use of Illegal Drugs Other Than Marijuana or Hashish | Source Survey Item: NSDUH Questionnaire: "How old were you the first time you used [other illegal drugs] ‡ ?" [Response option: Write in age at first use.] | Ages 12-17 - FFY 2005 (Baseline) 12.50 | |
| | Outcome Reported: Average age at first use of other illegal drugs. | Ages 18+ - FFY 2005 (Baseline) 19.40 | |

((s)) indicates that the respondents to the question may not constitute a representative sample. All NSDUH data are based on pooled 2004-2005 samples.

† The question was asked about each tobacco product separately, and the youngest age at first use was taken as the measure.

‡ The question was asked about each drug in this category separately, and the youngest age at first use was taken as the measure.

Form P4

NOMs Domain: Reduced Morbidity—Abstinence from Drug Use/Alcohol Use Measure: Perception of Disapproval/Attitudes

| A. Measure | B. Question/Response | C. Pre-Populated Data | D. Approved Substitute Data |
|--|---|----------------------------------|-----------------------------|
| 1. Disapproval of Cigarettes | <p>Source Survey Item: NSDUH Questionnaire: "How do you feel about someone your age smoking one or more packs of cigarettes a day?" [Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove]</p> <p>Outcome Reported: Percent somewhat or strongly disapproving.</p> | Ages 12–17 - FFY 2005 (Baseline) | 87.20 |
| 2. Perception of Disapproval of Cigarettes | <p>Source Survey Item: NSDUH Questionnaire: "How do you think your close friends would feel about you smoking one or more packs of cigarettes a day?" [Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove]</p> <p>Outcome Reported: Percent reporting that their friends would somewhat or strongly disapprove.</p> | Ages 12–17 - FFY 2005 (Baseline) | 85.30 |
| 3. Disapproval of Using Marijuana Experimentally | <p>Source Survey Item: NSDUH Questionnaire: "How do you feel about someone your age trying marijuana or hashish once or twice?" [Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove]</p> <p>Outcome Reported: Percent somewhat or strongly disapproving.</p> | Ages 12–17 - FFY 2005 (Baseline) | 79.60 |
| 4. Disapproval of Using Marijuana Regularly | <p>Source Survey Item: NSDUH Questionnaire: "How do you feel about someone your age using marijuana once a month or more?" [Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove]</p> <p>Outcome Reported: Percent somewhat or strongly disapproving.</p> | Ages 12–17 - FFY 2005 (Baseline) | 80.40 |
| 5. Disapproval of Alcohol | <p>Source Survey Item: NSDUH Questionnaire: "How do you feel about someone your age having one or two drinks of an alcoholic beverage nearly every day?" [Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove]</p> <p>Outcome Reported: Percent somewhat or strongly disapproving.</p> | Ages 12–17 - FFY 2005 (Baseline) | 84.90 |

((s)) indicates that the respondents to the question may not constitute a representative sample. All NSDUH data are based on pooled 2004-2005 samples.

Form P5

NOMs Domain: Employment/Education Measure: Perception of Workplace Policy

| A. Measure | B. Question/Response | C. Pre-Populated Data | D. Approved Substitute Data |
|--------------------------------|---|-----------------------|-----------------------------|
| Perception of Workplace Policy | <p>Source Survey Item: NSDUH Questionnaire: "Would you be more or less likely to want to work for an employer that tests its employees for drug or alcohol use on a random basis? Would you say more likely, less likely, or would it make no difference to you?" [Response options: More likely, less likely, would make no difference]</p> | ((s)) | |
| | <p>Outcome Reported: Percent reporting that they would be more likely to work for an employer conducting random drug and alcohol tests.</p> | 32.60 | |

((s)) indicates that the respondents to the question may not constitute a representative sample. All NSDUH data are based on pooled 2004-2005 samples.

Form P7

NOMs Domain: Employment/Education

Measure: Average Daily School Attendance Rate

| A. Measure | B. Question/Response | | C. Pre-Populated Data | D. Approved Substitute Data |
|--------------------------------------|---|---------------------|-----------------------|-----------------------------|
| Average Daily School Attendance Rate | <p>Source: National Center for Education Statistics, Common Core of Data: The National Public Education Finance Survey available for download at http://nces.ed.gov/ccd/stfis.asp</p> <p>Measure calculation: Average daily attendance (NCES defined) divided by total enrollment and multiplied by 100.</p> | FFY 2005 (Baseline) | 93 | |

((s)) indicates that the respondents to the question may not constitute a representative sample. All NSDUH data are based on pooled 2004-2005 samples.

Form P8

NOMs Domain: Crime and Criminal Justice

Measure: Alcohol-Related Traffic Fatalities

| A. Measure | B. Question/Response | | C. Pre-Populated Data | D. Approved Substitute Data |
|------------------------------------|--|---------------------|-----------------------|-----------------------------|
| Alcohol-Related Traffic Fatalities | <p>Source: National Highway Traffic Safety Administration Fatality Analysis Reporting System</p> <p>Measure calculation: The number of alcohol-related traffic fatalities divided by the total number of traffic fatalities and multiplied by 100.</p> | FFY 2005 (Baseline) | 38 | |

((s)) indicates that the respondents to the question may not constitute a representative sample. All NSDUH data are based on pooled 2004-2005 samples.

Form P9

NOMs Domain: Crime and Criminal Justice Measure: Alcohol- and Drug-Related Arrests

| A. Measure | B. Question/Response | C. Pre-Populated Data | D. Approved Substitute Data |
|-----------------------------------|--|---|-----------------------------|
| Alcohol- and Drug-Related Arrests | <p>Source: Federal Bureau of Investigation Uniform Crime Reports</p> <p>Measure calculation: The number of alcohol- and drug-related arrests divided by the total number of arrests and multiplied by 100.</p> | FFY 2005 (Baseline) <input type="text" value="125"/> | <input type="text"/> |

((s)) indicates that the respondents to the question may not constitute a representative sample. All NSDUH data are based on pooled 2004-2005 samples.

Form P10

NOMs Domain: Social Connectedness

Measure: Family Communications Around Drug and Alcohol Use

| A. Measure | B. Question/Response | C. Pre-Populated Data | D. Approved Substitute Data |
|---|---|--|-----------------------------|
| 1. Family Communications Around Drug and Alcohol Use (Parents of children aged 12-17) | <p>Source Survey Item: NSDUH Questionnaire: "Now think about the past 12 months, that is, from [DATEFILL] through today. During the past 12 months, have you talked with at least one of your parents about the dangers of tobacco, alcohol, or drug use? By parents, we mean either your biological parents, adoptive parents, stepparents, or adult guardians, whether or not they live with you." [Response options: Yes, No] Outcome Reported: Percent reporting having talked with a parent.</p> | Ages 12-17 - FFY 2005 (Baseline) <input type="text" value="59.90"/> | <input type="text"/> |
| 2. Family Communications Around Drug and Alcohol Use (Parents of children aged 12-17) | <p>Source Survey Item: NSDUH Questionnaire: "During the past 12 months, how many times have you talked with your child about the dangers or problems associated with the use of tobacco, alcohol, or other drugs?" † [Response options: 0 times, 1 to 2 times, a few times, many times] Outcome Reported: Percent of parents reporting that they have talked to their child.</p> | Ages 18+ - FFY 2005 (Baseline) <input type="text" value="((s))"/> | <input type="text"/> |

((s)) indicates that the respondents to the question may not constitute a representative sample. All NSDUH data are based on pooled 2004-2005 samples.

† NSDUH does not ask this question of all sampled parents. It is a validation question posed to parents of 12- to 17-year-old survey respondents. Therefore, the responses are not representative of the population of parents in a State. The sample sizes are often too small for valid reporting.

Form P11

NOMs Domain: Retention

Measure: Percentage of Youth Seeing, Reading, Watching, or Listening to a Prevention Message

| A. Measure | B. Question/Response | | C. Pre-Populated Data | D. Approved Substitute Data |
|---------------------------------|--|----------------------------------|-----------------------|-----------------------------|
| Exposure to Prevention Messages | <p>Source Survey Item: NSDUH Questionnaire: "During the past 12 months, do you recall [hearing, reading, or watching an advertisement about the prevention of substance use] † ?" Outcome Reported: Percent reporting having been exposed to prevention message.</p> | Ages 12-17 - FFY 2005 (Baseline) | 92.90 | |

((s)) indicates that the respondents to the question may not constitute a representative sample. All NSDUH data are based on pooled 2004-2005 samples.

† This is a summary of four separate NSDUH questions each asking about a specific type of prevention message delivered within a specific context.

Form P12A

Programs and Strategies—Number of Persons Served by Age, Gender, Race, and Ethnicity

Question 1: Describe the data collection system you used to collect the NOMs data (e.g., MDS, DbB, KIT Solutions, manual process).

The State of Maryland uses the Minimum Data Set (MDS) to collect the NOMs data.

Question 2: Describe how your State’s data collection and reporting processes record a participant’s race, specifically for participants who are more than one race. Indicate whether the State added those participants to the number for each applicable racial category or whether the State added all those participants to the More Than One Race subcategory.

For those individuals receiving prevention services who indicated they are multi-racial, the state identifies each participant in one of the racial categories and then identifies the individual in the "More Than One Race" Category.

| Category | Description | Total Served |
|-----------|-------------------|--------------|
| A. Age | 1. 0-4 | 2895 |
| | 2. 5-11 | 11072 |
| | 3. 12-14 | 4015 |
| | 4. 15-17 | 1875 |
| | 5. 18-20 | 845 |
| | 6. 21-24 | 970 |
| | 7.25-44 | 4450 |
| | 8. 45-64 | 1658 |
| | 9. 65 And Over | 208 |
| | 10. Age Not Known | 0 |
| B. Gender | Male | 12908 |
| | Female | 15080 |
| | Gender Unknown | 0 |
| | White | 8662 |

| | | |
|--------------|--|-------|
| C. Race | Black or African American | 19216 |
| | Native Hawaiian/Other Pacific Islander | 20 |
| | Asian | 135 |
| | American indian/Alaska Native | 30 |
| | Race Unknown or Other (not OMB required) | 0 |
| D. Ethnicity | Hispanic or Latino | 1542 |
| | Not Hispanic or Latino | 26508 |

Form P12B

Population-Based Programs and Strategies—Number of Persons Served by Age, Gender, Race, and Ethnicity

| Category | Description | Total Served |
|-----------|--|--------------|
| A. Age | 1. 0-4 | 3115 |
| | 2. 5-11 | 23065 |
| | 3. 12-14 | 31316 |
| | 4. 15-17 | 30440 |
| | 5. 18-20 | 56521 |
| | 6. 21-24 | 16810 |
| | 7. 25-44 | 39397 |
| | 8. 45-64 | 30055 |
| | 9. 65 And Over | 1847 |
| | 10. Age Not Known | 0 |
| B. Gender | Male | 106656 |
| | Female | 125910 |
| | Gender Unknown | 0 |
| C. Race | White | 133925 |
| | Black or African American | 92263 |
| | Native Hawaiian/Other Pacific Islander | 959 |
| | Asian | 5562 |
| | American indian/Alaska Native | 398 |
| | Race Unknown or Other (not OMB required) | 0 |

| | | |
|--|------------------------|--------|
| | Hispanic or Latino | 9193 |
| | Not Hispanic or Latino | 223144 |

Form P13

Number of Persons Served by Type of Intervention

| Intervention Type | Number of Persons Served by Individual- or Population-Based Program or Strategy | |
|-----------------------|---|---|
| | A. Individual-Based Programs and Strategies | B. Population-Based Programs and Strategies |
| 1. Universal Direct | 24840 | N/A |
| 2. Universal Indirect | N/A | 218535 |
| 3. Selective | 14534 | N/A |
| 4. Indicated | 2645 | N/A |
| 5. Total | 42019 | 218535 |

Form P14

Evidence-Based Programs and Strategies by Type of Intervention

NOMs Domain: Retention

NOMs Domain: Evidence-Based Programs and Strategies

Measure: Number of Evidence-Based Programs and Strategies

Definition of Evidence-Based Programs and Strategies: The guidance document for the Strategic Prevention Framework State Incentive Grant, Identifying and Selecting Evidence-based Interventions, provides the following definition for evidence-based programs:

- Inclusion in a Federal List or Registry of evidence-based interventions
- Being reported (with positive effects) in a peer-reviewed journal
- Documentation of effectiveness based on the following guidelines:
 - Guideline 1: The intervention is based on a solid theory or theoretical perspective that has validated research, and
 - Guideline 2: The intervention is supported by a documented body of knowledge—a converging of empirical evidence of effectiveness—generated from similar or related interventions that indicate effectiveness, and
 - Guideline 3: The intervention is judged by informed experts to be effective (i.e., reflects and documents consensus among informed experts based on their knowledge that combines theory, research, and practice experience). “Informed experts” may include key community prevention leaders, and elders or other respected leaders within indigenous cultures.

1. Describe the process the State will use to implement the guidelines included in the above definition.

As a condition of grant award, all SAPT Block Grant recipients must implement at least one evidence based program according to the guidelines stated above.

2. Describe how the State collected data on the number of programs and strategies. What is the source of the data?

The state of Maryland collects data on prevention programs and strategies using CSAP's Minimum Data Set (MDS) data collection system.

Number of Evidence-Based Programs and Strategies by Type of Intervention

| | A. Universal Direct | B. Universal Indirect | C. Universal Total | D. Selected | E. Indicated | F. Total |
|--|------------------------------------|--------------------------------------|-----------------------------------|------------------------|-------------------------|---------------------|
| 1. Number of Evidence-Based Programs and Strategies Funded | 62 | 93 | 151 | 49 | 13 | 213 |
| 2. Total number of Programs and Strategies Funded | 81 | 118 | 199 | 64 | 16 | 279 |
| 3. Percent of Evidence-Based Programs and Strategies | 76.54% | 78.81% | 75.88% | 76.56% | 81.25% | 76.34% |

Form P15

Services Provided Within Cost Bands

| Type of Intervention | A. Number of Programs and Strategies | B. Number of Programs and Strategies Falling Within Cost Bands | C. Percent of Programs and Strategies Falling Within Cost Bands |
|---|---|--|---|
| 1. Universal Direct Programs and Strategies | 5 | 5 | 100 % |
| 2. Universal Indirect Programs and Strategies | 1 | 1 | 100 % |
| 3. Subtotal Universal Programs | 6 | 6 | 100.00% |
| 4. Selective Programs and Strategies | 8 | 7 | 88 % |
| 5. Indicated Programs and Strategies | 2 | 2 | 100 % |
| 6. Total All Programs | 16 | 15 | 93.75% |

Approved Substitute Data Submission Form

Substitute data has not been submitted for prevention forms.

**Prevention Attachment D:
2005 Block Grant Subrecipient Cost Band Worksheet**

Subrecipient Name: _____

Date Form Completed: _____

Name of Contact Person: _____

Phone: _____ **E-mail Address:** _____

Table 1: Program Detail

| 1 | 2 | 3 | 4 | 5 | 6 |
|------------------------------------|------------------------|----------------------------------|---------------------------|--|--|
| Program Name | Number of Participants | Number of Program Hours Received | Total Cost of the Program | Average Cost Per Participant (Col 4/Col 2) | Average Cost Per Participant Falls Within 2005 Cost Bands (Yes=1 No=0) |
| Universal Direct Programs | | | | | Universal Direct: \$58.01–\$693.98 |
| 1. | | | | | |
| 2. | | | | | |
| 3. | | | | | |
| 4. | | | | | |
| Universal Indirect Programs | | | | | Universal Indirect \$1.05–\$82.26 |
| 1. | | | | | |
| 2. | | | | | |
| 3. | | | | | |
| 4. | | | | | |
| Selective Programs | | | | | Selective \$151.88–\$6,409.29 |
| 1. | | | | | |
| 2. | | | | | |
| 3. | | | | | |
| 4. | | | | | |
| Indicated Programs | | | | | Indicated \$510.47–\$4,888.44 |
| 1. | | | | | |
| 2. | | | | | |
| 3. | | | | | |
| 4. | | | | | |

Table 2: Subrecipient Cost Band Summary

| | 1 | 2 |
|---------------------------|---------------------------|---|
| Program Type | Number of Programs | Number of Programs Falling Within Cost Bands |
| Universal Direct | | |
| Universal Indirect | | |
| Selective | | |
| Indicated | | |
| Total | | |

Instructions for Completing the 2005 Block Grant Subrecipient Cost Band Worksheet

The 2005 Block Grant Subrecipient Cost Band Worksheet is an optional tool that States may use for their providers to record the number of program participants, the number of hours received, the cost of each program, the average cost per program participant, and the number of programs whose average participant costs fall within the 2005 cost bands. Data should be based on total cost of program not only the funding from CSAP. States may use an alternative approach to obtain data used to report the aggregate cost band data in Form P15 of the SAPT Block Grant Application. These worksheets are not required as part of that submission.

1. Subrecipient Information

Grant Information. At the top of the page, enter the name of the subrecipient, the contact information for the person completing this form, and the date on which the form was completed.

2. Table 1: Program Detail

Column 1: Program Name. In column 1, list the names of all programs that were funded in whole or in part with Block Grant funds during Federal fiscal year (FY) 2005. Add additional rows if necessary.

A program is defined as an activity, a strategy, or an approach intended to prevent an outcome or to alter the course of an existing condition. In substance abuse prevention, interventions may be used to prevent or lower the rate of substance use or substance abuse-related risk factors.

Separate table sections are provided for programs that are defined as Universal Direct, Universal Indirect, Selective, and indicated. Universal indirect services are defined as services that support prevention activities, such as population-based activities, and the provision of information and technical assistance. Universal direct, selective, and indicated services are defined as prevention program interventions that directly serve participants.

- **Universal.** Activities targeted to the general public or a whole population group that has not been identified on the basis of individual risk.
 - **Universal Direct.** Interventions directly serve an identifiable group of participants but who have not been identified on the basis of individual risk (e.g., school curriculum, afterschool program, parenting class). This also could include interventions involving interpersonal and ongoing/repeated contact (e.g., coalitions).
 - **Universal Indirect.** Interventions support population-based programs and environmental strategies (e.g., establishing ATOD policies, modifying ATOD advertising practices). This also could include interventions involving programs and policies implemented by coalitions.
- **Selective.** Activities targeted to individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than average.
- **Indicated.** Activities targeted to individuals identified as having minimal but detectable signs or symptoms foreshadowing disorder or having biological markers indicating predisposition for disorder but not yet meeting diagnostic levels.

Column 2: Number of Participants. In this column, specify the number of participants who took part in the preventive program during FY 2005. If this intervention was delivered to multiple groups, combine all groups and report the total. If it is an indirect program, use the estimated number of people reached during the reporting year.

Column 3: Number of Program Hours Received. In this column, report the number of hours that program participants received over the course of the program.

Column 4: Total Cost of This Program. In this column, report the total of all costs expended on the program during the reporting year. This should include all costs associated with the program, such as staff training, staff time, and materials, during the year.

Column 5: Average Cost Per Participant. Report the average cost per participant. Calculate the average cost by dividing the Block Grant dollars expended on each program (column 4) by the number of participants served (column 2).

Column 6: Average Cost Per Participant Falls Within Cost Bands. Compare the average cost per participant (column 5) with the 2005 cost bands for each program type. If the average cost per participant falls within the specified interval, record a “1” in column 5. If the average cost is either higher or lower than the cost band interval, enter a zero in column 5.

3. Table 2: Subrecipient Cost Band Summary

Table 2 summarizes information recorded in Table 1.

Column 1: Number of Programs. In column 1, enter the total number of programs on which you reported in Table 1, by program types (Universal Direct, Universal Indirect, Selective, and Indicated). Total the number of programs in the last row.

Column 2: Number of Programs Falling Within Cost Bands. For each program type, enter the total number of programs that fell within the cost bands for that program type (i.e., programs that were coded “1” in Table 1, column 5).

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Appendix A - Additional Supporting Documents (Optional)

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No additional documentation is required to complete your application, besides those referenced in other sections. This area is strictly optional. However, if you wish to add extra documents to support your application, please attach it (them) here. If you have multiple documents, please 'zip' them together and attach here.