I: State Information

State Information

I. State Agency for the Block Grant

Agency Name	Division of Mental Health and Addiction Services
Organizational Unit	Office of Planning, Research, Evaluation, Information Systems and Technology
Mailing Address	222 South Warren Street, 4th Floor, Capital Place One, PO Box 700
City	Trenton
Zip Code	08625

II. Contact Person for the Block Grant

First Name	Suzanne
Last Name	Borys
Agency Name	Division of Mental Health and Addiction Services
Mailing Address	222 South Warren Street, 4th Floor, Capital Place One, PO Box 700
City	Trenton
Zip Code	08625
Telephone	609-984-4050
Fax	609-341-2317
Email Address	Suzanne.Borys@dhs.state.nj.us

III. Expenditure Period

State Expenditure Period

From	7/1/2013
To	6/30/2014

Block Grant Expenditure Period

From	10/1/2011
To	9/30/2013

IV. Date Submitted

Submission Date	11/26/2014 2:07:16 PM
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V. Contact Person Responsible for Report Submission

First Name	Helen
Last Name	Staton
Telephone	609-633-8781
Fax	609-341-2317
Email Address	Helen.Staton@dhs.state.nj.us

VI. Contact Person Responsible for Substance Abuse Data

First Name	Suzanne
Last Name	Borys
Telephone	609-984-4050
Email Address	Suzanne.Borys@dhs.state.nj.us

footnote:

For prevention data – Donald Hallcom, Phone 609-984-4049, Fax 609-341-2315, Email Donald.Hallcom@dhs.state.nj.us

II: Annual Report

Table 1 Priority Area and Annual Performance Indicators - Progress Report

Priority #: 1

Priority Area: Pregnant Women/Women with Children

Priority Type: SAT

Population(s): PWWDC

Goal of the priority area:

To expand the capacity of existing programs to make available treatment services designed for pregnant women and women with dependent children.

Strategies to attain the goal:

• Quarterly Women's Steering Committee meetings with women's treatment providers to discuss issues related to best practices including retention, engagement, access and referrals, systems collaboration, and training needs.
• Continuing contract with the community-based provider in Mercer County for the outstation of substance abuse counselors in four Health Care Centers that provide substance abuse screenings using the 4 P's Plus, assessment, case management and referrals to treatment for pregnant women.
• Implemented service elements from the National Association of State Alcohol/Drug Abuse Directors (NASADAD) "Guidance to States: Treatment Standards for Women with Substance Use Disorders" that emphasize best practice and modified women's treatment provider contracts to include language from the document that addresses the full continuum of treatment services.
• Require programs to provide: Family-Centered Treatment, Evidence-Based Parenting programs, Trauma-Informed and Trauma-Responsive treatment using "Seeking Safety, Strengthening Families and complete National Center on Substance Abuse and Child Welfare (NCSACW) online tutorials "Understanding Child Welfare and the Dependency Court: A Guide for Substance Abuse Treatment Professionals."
• During 2014, DMHAS will be integrating the CHOICES program, an evidence based intervention designed for women about choosing healthy behaviors to avoid alcohol –exposed pregnancies for use in by licensed substance abuse treatment providers serving pregnant and parenting women.
• Awarded In-Depth Technical Assistance (IDTA) from 2008 through 2012 from NCSACW. New Jersey received a customized program of IDTA designed to identify and implement key policy and practice changes based on New Jersey's readiness to change and progression through the phases of IDTA. New Jersey is in discussion with the IDTA team on continuing to build on the foundation established in the prior NCSACW IDTA project by working collaboratively with a NCSACW consultant(s) in a targeted effort to strengthen identification and system response to substance exposed infants (SEI), including those presenting with Neonatal Abstinence Syndrome (NAS) from maternal opioid use.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase number of pregnant women or women with children receiving substance abuse treatment

Baseline Measurement: 9816 estimated for FY 2013

First-year target/outcome measurement: Increase number of pregnant women or women with children receiving substance abuse treatment in 2014 by 2%.

Second-year target/outcome measurement: Increase number of pregnant women or women with children receiving substance abuse treatment by 5% by the end of 2015. The change in FY 2015 will be measured by calculating the percent difference from 2013 to 2015.

New Second-year target/outcome measurement*(if needed)*:

Data Source:

The number pregnant women and women with children in SFY 2014– 2015 (and beyond) will be tracked by the SSA's New Jersey Substance Abuse Monitoring System (NJSAMS).

New Data Source*(if needed)*:

Description of Data:

All agencies licensed to provide substance abuse treatment in New Jersey must report on NJSAMS, the SSA's real-time web-based client administrative data system. The system collects basic client demographic, financial, level of care and clinical information for every client. All national outcome measures (NOMS) are incorporated into the system. Outcome measures are linked to the client at admission and

discharge.

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

Outcome measures are collected at a client's admission and discharge per the approach used with TEDS and not at different periods of time during the course of treatment.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: ○ Achieved ○ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved *(optional)*:

Baseline measurement actual not estimated: 11,590 Actual for FY 2013
The number of pregnant women or women with children receiving substance abuse treatment in 2014 (12,212) increased by 5%.

Priority #: 2

Priority Area: Intravenous Drug Users

Priority Type: SAT

Population(s): IVDUs

Goal of the priority area:

To expand access to comprehensive treatment, including Medication Assisted Treatment (MAT), in combination with other treatment modalities, for opiate dependent individuals, including IVDUs, through mobile treatment units and other innovative approaches.

Strategies to attain the goal:

• Referral to specialty treatment from sterile syringe programs operating in New Jersey.
• Providing services in convenient locations, particularly the mobile medication vans, in order to reduce barriers and engage individuals in care as easily as possible.
• Promoting the use of medication assisted treatment (e.g., methadone, buprenorphine, Vivitrol) for opiate dependent individuals.
• Educating providers and clients about the benefits of MAT.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase the number of IVDUs who obtain MAT in combination with other treatment modalities

Baseline Measurement: 10,081 estimate for FY 2013

First-year target/outcome measurement: Increase the number of IVDUs who obtain MAT in combination with other treatment modalities by 2%.

Second-year target/outcome measurement: Increase the number of IVDUs who obtain MAT in combination with other treatment modalities by 5% by the end of 2015. The change in FY 2015 will be measured by calculating the percent difference from 2013 to 2015.

New Second-year target/outcome measurement*(if needed)*:
Wish to change second-year target to 2%. Stigma issues and decrease in opiate admissions are making it difficult to attain higher targets.

Data Source:

The number of IVDUs in SFY 2014 and 2015 will be tracked by the SSA's NJSAMS.

New Data Source*(if needed)*:

Description of Data:

All agencies licensed to provide substance abuse treatment in New Jersey must report on NJSAMS, the SSA's real-time web-based client administrative data system. The system collects basic client demographic, financial, level of care and clinical information for every client. All NOMS are incorporated into the system. Outcome measures are linked to the client at admission and discharge.

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

Outcome measures are collected at a client's admission and discharge per the approach used with TEDS and not at different periods of time during the course of treatment.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: ¢ Achieved ¢ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

Baseline measurement actual not estimated: 13,469 actual for FY 2013
The number of IVDUs who obtained MAT in combination with other treatment modalities in FY 2014 (13,610) increased by 1%.
Despite continued efforts by DMHAS to promote the use of MAT, there is a stigma issue that continues to hinder efforts to utilize MAT. Also, across the entire system there is a decrease in admissions for opiates. The NJ Behavioral Health Planning Council (BHPC) is planning to bring up this issue at its next consumer forum for a discussion among consumers. Also, DMHAS has brought this issue to its partners at the Administrative Office of the Courts (AOC) and we are beginning to plan how to improve the acceptance of MAT with NJ Drug Court opiate addicted clients. DMHAS will also increase efforts to try to reduce the bias of some treatment providers who are reluctant to use MAT.

How first year target was achieved *(optional)*:

Indicator #:	2
Indicator:	Increase the number of opiate dependent individuals who obtain MAT in combination with other treatment modalities
Baseline Measurement:	17,798 estimate for FY 2013
First-year target/outcome measurement:	Increase the number of opiate dependent individuals who obtain MAT in combination with other treatment modalities by 2%.
Second-year target/outcome measurement:	Increase number of opiate dependent individuals who obtain MAT in combination with other treatment modalities by 5% by the end of 2015. The change in FY 2015 will be measured by calculating the percent difference from 2013 to 2015.

New Second-year target/outcome measurement*(if needed)*:
Wish to change second-year target to 2%. Stigma issues and decrease in opiate admissions are making it difficult to attain higher targets.

Data Source:

The number opiate dependent individuals in SFY 2014 and 2015 will be tracked by the SSA's NJSAMS.

New Data Source*(if needed)*:

Description of Data:

All agencies licensed to provide substance abuse treatment in New Jersey must report on NJSAMS, the SSA's real-time web-based client administrative data system. The system collects basic client demographic, financial, level of care and clinical information for every client. All NOMS are incorporated into the system. Outcome measures are linked to the client at admission and discharge.

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

Outcome measures are collected at a client's admission and discharge per the approach used with TEDS and not at different periods of time during the course of treatment.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: ○ Achieved ○ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

Baseline measurement actual not estimated: 23,331 actual for FY 2013
The number of opiate dependent individuals who obtained MAT in combination with other treatment modalities in FY 2014 (22,931) decreased by 2%.
Despite continued efforts by DMHAS to promote the use of MAT, there is a stigma issue that continues to hinder efforts to utilize MAT. Also, across the entire system there is a decrease in admissions for opiates. The NJ Behavioral Health Planning Council (BHPC) is planning to bring up this issue at its next consumer forum for a discussion among consumers. Also, DMHAS has brought this issue to its partners at the Administrative Office of the Courts (AOC) and we are beginning to plan how to improve the acceptance of MAT with NJ Drug Court opiate addicted clients. DMHAS will also increase efforts to try to reduce the bias of some treatment providers who are reluctant to use MAT.

How first year target was achieved *(optional)*:

Priority #: 3

Priority Area: Individuals with or at risk of HIV/AIDS who are in treatment for substance abuse

Priority Type: SAT

Population(s): HIV EIS

Goal of the priority area:

To provide funding and increase capacity for the provision of HIV Early Intervention Services (EIS) at designated substance abuse treatment facilities.

Strategies to attain the goal:

• Expend 5% of the SAPTBG award for HIV Early Intervention Services.
• Continue MOA with the University of Medicine and Dentistry of New Jersey (UMDNJ) for Rapid HIV Testing.
• Provide funding to the DOH Public Health and Environmental laboratory (PHEL) for laboratory services.
• Conduct web-based survey of agencies to assess where HIV testing services are most needed and their interest in providing such services.
• Coordinate and provide trainings/conferences in regards to the provision of best practices in HIV testing and counseling services for DMHAS licensed agencies (e.g., motivational interviewing).
• Develop data sharing agreement with the Department of Health (DOH).
• Provide de-identified data to DOH to match against their HIV/AIDS database to determine the number of infected or at risk clients in substance abuse treatment.

Annual Performance Indicators to measure goal success

Indicator #: 3

Indicator: Increase the number of agencies engaged in the Rapid HIV Testing Initiative in 2015

Baseline Measurement: 24 sites

First-year target/outcome measurement: 30 sites

Second-year target/outcome measurement: 34 sites

New Second-year target/outcome measurement*(if needed)*:

Data Source:

DOH HIV database, NJSAMS and UMDNJ agency listing

New Data Source*(if needed)*:

Rutgers Robert Wood Johnson Medical School

Description of Data:

Data on the number of SSA licensed agencies engaged in the Rapid HIV Testing initiative is provided by UMDNJ. The change in FY 2015 will be measured by calculating the percent difference from FY 2013 to FY 2015.

New Description of Data:*(if needed)*

Data on the number of SSA licensed agencies engaged in the Rapid HIV Testing initiative is provided by Rutgers Robert Wood Johnson Medical School.

Data issues/caveats that affect outcome measures:

None

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: ○ Achieved ○ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

As of June 30, 2014, 26 sites were engaged in the Rapid HIV Testing Initiative. The increase was lower than what was projected; however, DMHAS is on track to meet its second-year target. Since July 1, 2014, DMHAS has engaged five new sites for a total of 31 sites, and a mobile testing pilot was launched at three new sites in October.

How first year target was achieved *(optional)*:

Priority #: 4

Priority Area: Underage Drinking

Priority Type: SAP

Population(s): Other (Persons aged 12 - 20)

Goal of the priority area:

Reduce the percentage of persons aged 12 – 20 who report drinking in the past month.

Strategies to attain the goal:

Beginning in January, 2012, DMHAS funded 17 Regional Prevention Coalitions, all of whom utilize the SPF model to guide their work. These coalitions are all required to address underage drinking. The coalitions use, primarily, environmental strategies along with occasional individual approaches as appropriate. Below is a listing of approaches used by the coalitions to address underage drinking in their regions.

Environmental Strategies
• Enhance Access/Reduce Barriers – Coordinate a countywide high school PSA contest on the dangers of underage drinking to enhance access to effective prevention strategies and information.
• Enhance Access/Reduce Barriers – Enhance access to effective prevention strategies and information through the use of a social media campaign and the development of human capital and networks of support.
• Enhance Barriers/Reduce Access – Partner with local law enforcement agencies to coordinate a DWI checkpoint aimed at reducing drunk drivers and to provide information to motorists.
• Enhance Barriers/Reduce Access - Increase compliance checks and enforcement and reporting.
• Enhance Barriers/Reduce Access - Work towards implementing Responsible Beverage Server training in cooperation with local liquor establishments to better train employees on proper identification techniques and reducing sales to underage persons.
• Change Consequences/Enhance Access/Reduce Barriers – Coordinate the efforts of countywide juvenile diversion programs related to underage drinking such as stationhouse adjustments with local police departments.
• Change Consequences/Enhance Skills – Enhance and build capacity within JCC and Stationhouse Adjustment Programs with law enforcement.
• Change Physical Design – Through the compliance check report and GIS mapping, provide municipalities and state alcoholic beverage control with report of how outlet density and location impact alcohol availability to youth.
• Change Physical Design/Enhance Barriers/Reduce Access – Reduce the number of alcohol outlets serving to underage youth through the use of the Compliance Check Summary Report, which will be available for NJ-ABC and all law enforcement agencies.
• Modify/Change Policies – Enhance or create policies related to underage drinking on a countywide level. This will be done through the increase of

private property ordinances, enhancement of school policies, policies related to scholarship eligibility or extracurricular activities, and policies related to adult alcohol use at youth-oriented events.

Individual Strategies
• Provide information – Educate parents and youth on the dangers of underage drinking through awareness efforts, workshops, and countywide events. These programs will be provided through county alcohol and drug funding, municipal alliances, New Jersey National Guard Counterdrug Task Force, and other community organizations.
• Provide Information – Educate youth on the dangers of underage drinking through the use of evidence-based middle and elementary school prevention programs, New Jersey National Guard Counterdrug Task Force Fly-In and Drunk Driving Awareness Prevention Programs, Union County Red Ribbon Drug Awareness Event, and other community programs.

Additionally, DMHAS funds community-based services targeting high-risk individuals or groups in each of New Jersey's 21 counties. Many of these providers are also focused on the prevention of underage drinking.

With assistance from SAMHSA, New Jersey produced an informational video for parents, entitled, "Empowering Parents to Prevent Underage Drinking in New Jersey." The video focuses on the issues and risks related to underage drinking.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Past month use of alcohol among persons aged 12 to 20.

Baseline Measurement: 29.94% of the target population reported drinking any alcohol during the month prior to participating in the survey (NSDUH, 2010-2011)

First-year target/outcome measurement: A reduction of 1% below the baseline measure.

Second-year target/outcome measurement: An additional reduction of 1% below the first year measure.

New Second-year target/outcome measurement*(if needed)*:

Data Source:

National Survey on Drug Use and Health (NSDUH), 2010-2011 State Estimates of Substance Use and Mental Disorders, Alcohol Use in Past Month and Binge Alcohol Use in Past Month among Persons Aged 12 to 20 in New Jersey

New Data Source*(if needed)*:

Description of Data:

Data from the NSDUH provide national and state-level estimates on the use of tobacco products, alcohol, illicit drugs (including non-medical use of prescription drugs) and mental health in the United States.

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

None.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: ○ Achieved ○ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved *(optional)*:

Priority #: 5

Priority Area: Supportive Housing

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

Increase opportunities for community living among mental health consumers who currently reside in inpatient settings and for those consumers who are at-risk of being hospitalized and/or homeless.

Strategies to attain the goal:

The SMHA will announce additional RFPs for Supportive Housing Programs which are designed to develop and support community-based programs that promote: housing stability in community settings, engagement with mental health services, regular access to primary health services; community inclusion, and wellness & recovery.

Contracted providers of Supportive Housing will continue to supply the SMHA with data to ensure that desired service levels are achieved. SMHA staff will monitor the continued development of new Supportive Housing opportunities. Workforce development activities will expand the reach and efficacy of community-based services for consumers receiving Supportive Housing. Improvements in the SMHA's data infrastructure—particularly around supportive housing and residential services, will foster more timely and accurate tracking of residential resources, as well as facilitate their more efficient utilization (e.g., to reduce vacancy rates and increase community placements).

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Increased number of individuals served by Supportive Housing
Baseline Measurement:	The number of consumers served by Supportive Housing in SFY 2013 is estimated to be approximately 4,792 (see footnote 1).
First-year target/outcome measurement:	The number of consumers served by Supportive Housing in SFY 2014 is estimated to be 4,900.
Second-year target/outcome measurement:	In SFY 2015 this number will be increased 2% to a total of 5,000 individuals served by Supportive Housing.

New Second-year target/outcome measurement*(if needed)*:

Data Source:

The number of consumers served by Supportive Housing in SFY 2014 – 2015 (and beyond) will be tracked by the SMHA's QCMR database.

New Data Source*(if needed)*:

Description of Data:

The QCMR Database collects quarterly, cumulative, program-specific data from each of the service providers contracted by DMHS. The current QCMR for Supportive Housing contains 50 data elements. The key data field relevant for this performance indicator is Item 4, "Ending Active Caseload (Last Day of Quarter)". Currently 46 agencies contracted by the SMHA provide QCMR data for Supportive Housing.

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

The QCMR emphasizes aggregate program processes and units of service/persons served, rather than individual consumer outcomes. Proposals awarded under current and forthcoming RFPs for Supportive Housing will be monitored through contract negotiations and data will be maintained through the QCMR database.

Failure to reach the performance indicator may result in review of agency admission and discharge policies to ensure that the target population receives this service and to ensure that consumers are not discharged prematurely nor unreasonably. Failure to reach performance indicators may also result in contract contingencies or termination

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: € Achieved € Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved *(optional)*:

Indicator #:	2
Indicator:	Creation of additional community-based supportive housing beds
Baseline Measurement:	At the time of writing, 292 supportive housing beds were created in SFY 2013.
First-year target/outcome measurement:	In SFY 2014, the SMHA will develop no fewer than 250 community-based supportive housing beds.
Second-year target/outcome measurement:	Due to the exigencies of the court-mandated Olmstead Settlement that expires at the end of SFY 2014, the SMHA is not currently able to indicate the number of community-based supportive housing beds that will be created in SFY 2015.

New Second-year target/outcome measurement*(if needed)*:

Data Source:

The SMHA, in collaboration with the DHS Office of Licensing will continue to provide updates on the development of community-based supportive housing beds. Specifically, internal SMHA contracting data will be used for the baseline measurement and for the first-year target outcomes. In the second year, this data will be buttressed by the SMHA's forthcoming Bed Enrollment Data System (BEDS) which is expected to be operational by early SFY 2014.

New Data Source*(if needed)*:

Description of Data:

Current internal SMHA contracting data indicates the state contracting awards to agencies whom create Supportive Housing Beds. Key data indicates the date and amount of the grant award, as well as the date that the housing unit was available to consumers (e.g., "came online").

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

These new housing opportunities will be specifically earmarked for: 1. those at risk for homelessness and/or inpatient psychiatric hospitalization, and 2. individuals on CEPP status (e.g. individuals who are medically and clinically permitted to be discharged from state/county inpatient psychiatric hospitals but whom are unable to be discharged due to a lack of permanent housing options). The total number of beds to be developed from SFY 2010 through SFY 2014 is targeted to be 1065 in accordance with the Olmstead Settlement Agreement.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: € Achieved € Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved *(optional)*:

Indicator #:	3
Indicator:	Increased technical assistance activities to be delivered to providers of Supportive Housing (SH). Overview- the SMHA is currently in negotiation with the University Behavioral Health Care (UBHC) School of Health-Related Professions (SHRP) to provide technical assistance for SH providers to facilitate better community integration of consumers of SH services. In SFY 2014, the SMHA will contract with SHRP to provide two separate tracks of Technical Assistance for SH providers. Track 1 is for SH supervisors, where they will receive TA on how to supervise their staff in their efforts to have SH consumers better integrated into their communities. Track 2 will be geared toward direct care providers and is to provide training

	in core competencies. Both tracks of TA will be conducted in a series of trainings to be conducted over the course of a year. In addition, the TA will attempt to facilitate training communities (peer networks of SH supervisors and direct care staff) in order to refine, deepen and expand the understanding of the concepts taught in the TA sessions themselves.
Baseline Measurement:	Not relevant. The Technical Assistance to Supportive Housing Programs will be a new initiative with no antecedents.
First-year target/outcome measurement:	To be determined. The SMHA plans to contract SHRP to provide TA to a specific number of either agencies, or personnel. (The exact number has yet to be determined through vendor contract negotiations).
Second-year target/outcome measurement:	To be determined (See above).

New Second-year target/outcome measurement*(if needed)*:

Data Source:

The exact number of agencies (or personnel) trained by this TA effort will be reported to the SMHA by the training provider (UBHC-SHRP).

New Data Source*(if needed)*:

Description of Data:

The SMHA anticipates that the TA provider will submit quarterly training reports to the SMHA on a range of outcome indictors such as: number (and dates) of training, the number of agencies that have received the TA, number of personnel participating in training, and number of activities conducted by the TA training communities.

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

The manner at which the outcome measures are to be established, quantified and reported on have yet to be determined (contingent on direct negotiations between the SMHA and UBHC-SHRP to occur in mid-May 2013).

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: € Achieved € Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved *(optional)*:

Priority #: 6

Priority Area: Suicide Prevention Hotline

Priority Type: MHP

Population(s): SMI

Goal of the priority area:

To reduce suicides among New Jersey's residents through the expansion and increased availability of a suicide prevention hotline designed to support New Jersey's residents experiencing mental health crises.

Strategies to attain the goal:

DMHAS issued an RFP for a Suicide Prevention Hotline on 12/13/12. In early 2013, this RFP was awarded to the University Behavioral Healthcare (UBHC) for the development of a NJ-based suicide hotline to be answered by a trained staff member or volunteer and to accept calls that are routed by the National Suicide Prevention Lifeline Network (NSPLN). The phone number was launched on o May 1, 2013 and is 855—NJHOPELINE (855-654-6735).

This "Hopeline" serves as suicide prevention hotline, similar to the NSPLN, but located in New Jersey, with 27/7 coverage, and it will have clinical

supervisors whom are familiar with the constellation of New Jersey behavioral health resources. In addition, the Hope Line will be a backup to the current active Lifeline Crisis Centers hotline and it will receive and answer calls that are transferred by Lifeline that cannot be answered by these entities during times of excess call volume or after the Lifeline Crisis Centers' operating hours. To better describe this in sequential terms, the NSPLN is the 'first line of defense'--the default for handling suicide-related phone calls from the community. The NJ Hopeline will receive additional calls which 'overflow" from NSPLN. In the event that additional call volume necessitates 'overflow' that cannot be expedited by the NJ Hopeline, then out-of-state Lifeline backup crisis centers will handle any remaining calls.

One of the reasons that the NJ Hopeline was created was to avoid the need for a third entity, (and one located outside of New Jersey) to handle excess suicide prevention calls.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Reduce the number of suicide prevention hotline calls originating within New Jersey that are answered by parties outside of New Jersey
Baseline Measurement:	Due to the start of the newly-operational NJ Hopeline, no baseline/SFY 2013 data will be available.
First-year target/outcome measurement:	The target/outcome measurement for SFY 2014 is for the newly-created, DMHAS-funded, "NJ Hopeline" suicide prevention hotline to answer 85% of the calls originating in New Jersey transferred by the National Suicide Prevention Lifeline Network (NSPLN) which can't be answered by the current active New Jersey Lifeline Crisis Centers (either due to excess call volume or after the Lifeline Crisis Centers' operating hours (see footnote 2)). NJ Hopeline is contracted to provide 25,194 calls for the year.
Second-year target/outcome measurement:	In year two of the grant award (SFY 2015) this benchmark will be increased to 90%.

New Second-year target/outcome measurement*(if needed)*:

Data Source:

In October 2013, the SMHA will receive the first call record dataset from NSPLN for the first quarter of SFY 2014. Every quarter subsequent to that, the SMHA will review the additional datasets provided by NSPLN. In addition, the SMHA will attempt to collect analogous call data from the NJ Hopeline.

New Data Source*(if needed)*:

Description of Data:

The National Suicide Prevention Lifeline Network maintains data that tracks all calls from their point of origin to the point of where they are ultimately answered. DMHAS will receive this data on a regular basis, and that dataset will form the basis for measuring this performance indicator. The SMHA is looking forward to receiving both raw and summary call data from both NSPLN and NJ Hopeline on a quarterly basis. It is anticipated that both datasets will include: dates of calls, lengths of calls, call source data, dispositions, and frequencies of all diversion.

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

In the summer of 2013, DMHAS will begin reviewing NSPLN call record data to learn about the format and quality of the data. The New Jersey Hopeline began operations on May 1, 2013 so the SMHA anticipates the standard operational and data reporting challenges endemic to new institutions. The SMHA is prepared to make best use of whatever data is submitted by both sources.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: € Achieved € Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved *(optional)*:

Priority #: 7

Priority Area: Consumer Operated Services

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

To promote wellness and recovery among individuals attending DMHAS sponsored peer-operated self-help centers (SHCs) throughout New Jersey.

Strategies to attain the goal:

Provide a wide range of peer delivered wellness and recovery activities at DMHAS sponsored self-help centers statewide. Encourage participation by publicizing planned activities in monthly activity calendars, discussing at center community meetings, networking with DMHAS self-help centers, and marketing self-help services with other community service providers.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase consumer participation in wellness and recovery activities.

Baseline Measurement: Not available. The SMHA has not recently performed comparable studies of these performance indicators.

First-year target/outcome measurement: In SFY 2014, 80% of individuals participating in Consumer Operated Services will participate in wellness/recovery activities (i.e. developing Wellness and Recovery Action Plans, which may include enrollment in groups such as Exercise Groups, Anxiety Support Groups, etc.).

Second-year target/outcome measurement: In SFY 2015, 83% of individuals participating in Consumer Operated Services will participate in wellness/recovery activities

New Second-year target/outcome measurement*(if needed)*:

Data Source:

This performance indicator will be measured through use of the Self-Help Outcome Utilization Tracking (SHOUT) data application. SHOUT is used by 30 DMHAS-funded and community-based, self-help centers to track member participation at SHCs through a unified, individual record system specifically designed for self-help centers.

New Data Source*(if needed)*:

Description of Data:

Reports are generated on a monthly and quarterly basis to assess performance against contract indicators. To meet the performance measurement objectives, self-help center staff will input and monitor self-help center member participation in wellness and recovery activities statewide through the use of SHOUT™. Electronic surveys will be administered annually with self-help center members and in combination with SHOUT utilization data which will be used to assess performance against the stated indicator.

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

Differential submission of SHOUT data by the SHCs may impact the timing of quarterly reports. Due to the independent nature of the Self-Help Centers themselves, the completeness and comprehensiveness of SHOUT data is expected to vary considerably from center to center.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: € Achieved € Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved *(optional)*:

Priority #: 8

Priority Area: Access to community-based services for children, youth and young adults with a dual diagnosis of DD/ID and behavioral health

Priority Type: MHS

Population(s): SED

Goal of the priority area:

Increase access to community-based services for children, youth and young adults with a dual diagnosis of DD/ID and behavioral health challenges.

Strategies to attain the goal:

DCSOC will continue to expand its community-based services throughout the State of New Jersey in SFY 2014 and 2015 in order to increase the total number of children, youth and young adults and the number of children, youth, and young adults with SED provided services through DCSOC. Community based services include both in-home and out of home services.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: In SFY 2014, DCSOC will develop a baseline of the number of children, youth and young adults with DD/ID and behavioral health challenges served.

Baseline Measurement: The total number of children, youth and young adults enrolled by DCSOC during SFY 2012 was 35,859. The number of children, youth and young adults with SED receiving DCSOC services during SFY 2012 was 27,028. The transition of services for children, youth and young adults with developmental disabilities and/or intellectual disabilities and behavioral health challenges to the DCF began on January 1, 2013.

First-year target/outcome measurement: 5% increase in 2013 baseline of children, youth and young adults with DD/ID and behavioral challenges.

Second-year target/outcome measurement: 5% increase in 2014 number of children, youth and young adults served by DCSOC.

New Second-year target/outcome measurement*(if needed)*:

Data Source:

DCSOC will utilize the CYBER database to collect enrollment data.

New Data Source*(if needed)*:

Description of Data:

The total number of children, youth and young adults enrolled by DCSOC as well as the number of children, youth and young adults with SED served during SFY 2013 will be reported in the SFY 2013 Implementation Report. Additionally DCSOC will provide a 6-month baseline measurement of children, youth and young adults with DD/ID and behavioral health challenges.

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

Access to community-based services for children, youth and young adults with a dual diagnosis of substance abuse and behavioral health will be transitioned to DCSOC beginning July 1, 2013. At the close of SFY 2014 DCSOC will provide a baseline of the number of children, youth and young adults with substance abuse and behavioral health challenges served. The addition of this population to DCSOC services will impact the total number of children, youth and young adults served.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: € Achieved € Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved *(optional)*:

Priority #: 9

Priority Area: Provision of in-state, community-based specialty treatment services to children, youth and young adults with specialized treatment needs.

Priority Type: MHS

Population(s): SED

Goal of the priority area:

Provide in-state services to children, youth and young adults with specialized treatment needs.

Strategies to attain the goal:

Continue to identify gaps in service for children, youth and young adults with specialized treatment needs. Develop in-state services and supports to address the needs of children, youth and young adults with specialized treatment needs including, but not limited to: deaf/hard of hearing, mental illness/developmental disabilities and/or medical challenges.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: In SFY 2014, DCSOC will continue to decrease the number of children, youth, and young adults receiving treatment for specialized needs out of state.

Baseline Measurement: At the close of SFY 2012, four youth requiring services for deaf/heard of hearing continued to receive services in an out of state treatment setting.

First-year target/outcome measurement: SFY 2014 will use the same database to measure a specified percentage of change.

Second-year target/outcome measurement: SFY 2015 will use the same database to measure a specified percentage of change.

New Second-year target/outcome measurement*(if needed)*:

Data Source:

DCSOC will utilize reports generated by the CYBER database and the DCSOC Special Residential Treatment Unit (SRTU), which facilitates all referrals to out of state treatment settings.

New Data Source*(if needed)*:

Description of Data:

CYBER and SRTU reports will identify gaps in services and the array of services needed to develop in-state capacity.

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

DCSOC anticipates the transition of new populations (DD/ID and youth with substance abuse challenges) to increase the number of children, youth and young adults requiring specialized treatment services.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: € Achieved € Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved *(optional)*:

Priority #: 10

Priority Area: Youth Suicide

Priority Type: MHP

Population(s): SED

Goal of the priority area:

Decrease youth suicide attempts and completions.

Strategies to attain the goal:

The Traumatic Loss Coalition (TLC) for Youth Program at UBHC provides Suicide Awareness Training for Educators to fulfill the professional development requirement, in accordance with N.J.S.A. 18A:6-11. A team of clinicians experienced in the evaluation and treatment of children and adolescents with mental health disorders and suicidal behaviors provide this training. The content can be customized to meet the needs of a single school or an entire school district, as well as mental health and social agency staff. On-site school counselors or administrators are included in the presentation to talk about the specific protocols outlined in their school's crisis plan for referring at-risk youth for further evaluation and treatment.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: DCSOC/TLC will continue to increase the number of school personnel trained in Suicide Awareness Training for Educators.

Baseline Measurement: The number of school personnel trained during SFY 2013 will serve as baseline.

First-year target/outcome measurement: SFY 2014 will use the same database to measure a specified percentage of change.

Second-year target/outcome measurement: SFY 2015 will use the same database to measure a specified percentage of change.

New Second-year target/outcome measurement*(if needed)*:

Data Source:

DCSOC will utilize reports generated by the Traumatic Loss Coalition (UMDNJ).

New Data Source*(if needed)*:

Description of Data:

The number of school personnel trained during given SFY.

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

None.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: € Achieved € Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved *(optional)*:

footnote:

Priority #1 Pregnant Women/Women with Children

Indicator #1 Increase number of pregnant women or women with children receiving substance abuse treatment - Baseline measurement actual not estimated: 11,590 Actual for FY 2013

Priority #2 Intravenous Drug Users
Indicator #1 Increase the number of IVDUs who obtain MAT in combination with other treatment modalities - Baseline measurement actual not estimated: 13,469 actual for FY 2013
Indicator #2 Increase the number of opiate dependent individuals who obtain Mat in combination with other treatment modalities - Baseline measurement actual not estimated: 23,331 actual for FY 2013

Priority areas (#5 to #10) of the State Mental Health Authority and the Division of Children's System of Care are not applicable to this report.

III: Expenditure Reports

Table 2 - State Agency Expenditure Report

Expenditure Period Start Date: 7/1/2013 Expenditure Period End Date: 6/30/2014

Activity	A. SA Block Grant	B. MH Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other
1. Substance Abuse Prevention and Treatment	$ 23,678,032	$	$	$ 5,409,058	$ 92,324,437	$	$
2. Primary Prevention	$ 10,864,801	$	$	$	$ 2,318,460	$	$
3. Tuberculosis Services	$ 0	$	$	$	$	$	$
4. HIV Early Intervention Services	$ 2,092,782	$	$	$	$	$	$
5. State Hospital	$	$	$	$	$	$	$
6. Other 24 Hour Care	$ 0	$	$	$	$	$	$
7. Ambulatory/Community Non-24 Hour Care	$ 0	$	$	$	$	$	$
8. Administration (Excluding Program and Provider Level)	$ 2,556,457	$	$	$	$ 4,238,082	$	$
9. Subtotal (Rows 1, 2, 3, 4, and 8)	$39,192,072	$	$	$5,409,058	$98,880,979	$	$
10. Subtotal (Rows 5, 6, 7, and 8)	$2,556,457	$	$	$	$4,238,082	$	$
11. Total	$39,192,072	$	$	$5,409,058	$98,880,979	$	$

Please indicate the expenditures are actual or estimated.

(•) Actual ( ) Estimated

Footnotes:

III: Expenditure Reports

Table 3 - SAPT Block Grant Expenditure By Service

Expenditure Period Start Date: 7/1/2013 Expenditure Period End Date: 6/30/2014

Service	Unduplicated Individuals	Units	Expenditures
Healthcare Home/Physical Health			$0
Specialized Outpatient Medical Services			$0
Acute Primary Care			$0
General Health Screens, Tests and Immunizations			$0
Comprehensive Care Management			$0
Care coordination and Health Promotion			$0
Comprehensive Transitional Care			$0
Individual and Family Support			$0
Referral to Community Services Dissemination			$0
Prevention (Including Promotion)			$0
Screening, Brief Intervention and Referral to Treatment			$0
Brief Motivational Interviews			$0
Screening and Brief Intervention for Tobacco Cessation			$0
Parent Training			$0
Facilitated Referrals			$0
Relapse Prevention/Wellness Recovery Support			$0
Warm Line			$0
Substance Abuse (Primary Prevention)			$0
Classroom and/or small group sessions (Education)			$0
Media campaigns (Information Dissemination)			$0
Systematic Planning/Coalition and Community Team Building(Community Based Process)			$0
Parenting and family management (Education)			$0

Education programs for youth groups (Education)			$0
Community Service Activities (Alternatives)			$0
Student Assistance Programs (Problem Identification and Referral)			$0
Employee Assistance programs (Problem Identification and Referral)			$0
Community Team Building (Community Based Process)			$0
Promoting the establishment or review of alcohol, tobacco, and drug use policies (Environmental)			$0
Engagement Services			$0
Assessment			$0
Specialized Evaluations (Psychological and Neurological)			$0
Service Planning (including crisis planning)			$0
Consumer/Family Education			$0
Outreach			$0
Outpatient Services			$0
Evidenced-based Therapies			$0
Group Therapy			$0
Family Therapy			$0
Multi-family Therapy			$0
Consultation to Caregivers			$0
Medication Services			$0
Medication Management			$0
Pharmacotherapy (including MAT)			$0
Laboratory services			$0
Community Support (Rehabilitative)			$0
Parent/Caregiver Support			$0
Skill Building (social, daily living, cognitive)			$0
Case Management			$0

Behavior Management			$0
Supported Employment			$0
Permanent Supported Housing			$0
Recovery Housing			$0
Therapeutic Mentoring			$0
Traditional Healing Services			$0
Recovery Supports			$0
Peer Support			$0
Recovery Support Coaching			$0
Recovery Support Center Services			$0
Supports for Self-directed Care			$0
Other Supports (Habilitative)			$0
Personal Care			$0
Homemaker			$0
Respite			$0
Supported Education			$0
Transportation			$0
Assisted Living Services			$0
Recreational Services			$0
Trained Behavioral Health Interpreters			$0
Interactive Communication Technology Devices			$0
Intensive Support Services			$0
Substance Abuse Intensive Outpatient (IOP)			$0
Partial Hospital			$0
Assertive Community Treatment			$0
Intensive Home-based Services			$0
Multi-systemic Therapy			$0

Intensive Case Management			$0
Out-of-Home Residential Services			$0
Children's Mental Health Residential Services			$0
Crisis Residential/Stabilization			$0
Clinically Managed 24 Hour Care (SA)			$0
Clinically Managed Medium Intensity Care (SA)			$0
Adult Mental Health Residential			$0
Youth Substance Abuse Residential Services			$0
Therapeutic Foster Care			$0
Acute Intensive Services			$0
Mobile Crisis			$0
Peer-based Crisis Services			$0
Urgent Care			$0
23-hour Observation Bed			$0
Medically Monitored Intensive Inpatient (SA)			$0
24/7 Crisis Hotline Services			$0
Other (please list)			$0

footnote:
This table is requested, not required and is not being submitted at this time.

III: Expenditure Reports

Table 4 - State Agency SABG Expenditure Compliance Report

Expenditure Period Start Date: 10/1/2011 Expenditure Period End Date: 9/30/2013

Category	FY 2012 SAPT Block Grant Award
1. Substance Abuse Prevention* and Treatment	$29,950,696
2. Primary Prevention	$13,487,397
3. Tuberculosis Services	$0
4. HIV Early Invervention Services**	$2,329,270
5. Administration (excluding program/provider level)	$818,045
6. Total	$46,585,408

*Prevention other than Primary Prevention

**HIV Designated States

footnote:

III: Expenditure Reports

Table 5a - Primary Prevention Expenditures Checklist

Expenditure Period Start Date: 10/1/2011 Expenditure Period End Date: 9/30/2013

Strategy	IOM Target	SAPT Block Grant	Other Federal	State	Local	Other
Information Dissemination	Selective	$	$	$	$	$
Information Dissemination	Indicated	$	$	$	$	$
Information Dissemination	Universal	$	$	$	$	$
Information Dissemination	Unspecified	$	$	$	$	$
Information Dissemination	Total	$	$	$	$	$
Education	Selective	$	$	$	$	$
Education	Indicated	$	$	$	$	$
Education	Universal	$	$	$	$	$
Education	Unspecified	$	$	$	$	$
Education	Total	$	$	$	$	$
Alternatives	Selective	$	$	$	$	$
Alternatives	Indicated	$	$	$	$	$
Alternatives	Universal	$	$	$	$	$
Alternatives	Unspecified	$	$	$	$	$
Alternatives	Total	$	$	$	$	$
Problem Identification and Referral	Selective	$	$	$	$	$
Problem Identification and Referral	Indicated	$	$	$	$	$
Problem Identification and Referral	Universal	$	$	$	$	$
Problem Identification and Referral	Unspecified	$	$	$	$	$
Problem Identification and Referral	Total	$	$	$	$	$
Community-Based Process	Selective	$	$	$	$	$

Community-Based Process	Indicated	$	$	$	$	$
Community-Based Process	Universal	$	$	$	$	$
Community-Based Process	Unspecified	$	$	$	$	$
Community-Based Process	Total	$	$	$	$	$
Environmental	Selective	$	$	$	$	$
Environmental	Indicated	$	$	$	$	$
Environmental	Universal	$	$	$	$	$
Environmental	Unspecified	$	$	$	$	$
Environmental	Total	$	$	$	$	$
Section 1926 Tobacco	Selective	$	$	$	$	$
Section 1926 Tobacco	Indicated	$	$	$	$	$
Section 1926 Tobacco	Universal	$	$	$	$	$
Section 1926 Tobacco	Unspecified	$	$	$	$	$
Section 1926 Tobacco	Total	$	$	$	$	$
Other	Selective	$0	$0	$0	$0	$0
Other	Indicated	$0	$0	$0	$0	$0
Other	Universal	$0	$0	$0	$0	$0
Other	Unspecified	$0	$0	$0	$0	$0
Other	Total	$0	$0	$0	$0	$0
	Grand Total	$0	$0	$0	$0	$0

Footnotes:

DMHAS has selected the option to complete Table 5b, rather than Table 5a; however, as required, we are reporting the amount spent on Section 1926 Tobacco, herein, on Table 5a, which as indicated above is $0 for each column.

III: Expenditure Reports

Table 5b - Primary Prevention Expenditures by IOM Category

Expenditure Period Start Date: 10/1/2011 Expenditure Period End Date: 9/30/2013

Activity	SAPT Block Grant	Other Federal Funds	State Funds	Local Funds	Other
Universal Direct	$2,209,870				
Universal Indirect	$3,318,608	$150,074	$3,291,318		
Selective	$2,425,537		$733,332		
Indicated	$3,741,518				
Column Total	$11,695,533.00	$150,074.00	$4,024,650.00	$0.00	$0.00

footnote:

III: Expenditure Reports

Table 5c - SABG Primary Prevention Priorities and Special Population Categories

Expenditure Period Start Date: 10/1/2011 Expenditure Period End Date: 9/30/2013

Targeted Substances	
Alcohol	þ
Tobacco	¢
Marijuana	þ
Prescription Drugs	þ
Cocaine	¢
Heroin	¢
Inhalants	¢
Methamphetamine	¢
Synthetic Drugs (i.e. Bath salts, Spice, K2)	¢
Targeted Populations	
Students in College	þ
Military Families	þ
LGBTQ	þ
American Indians/Alaska Natives	¢
African American	¢
Hispanic	¢
Homeless	¢
Native Hawaiian/Other Pacific Islanders	¢
Asian	¢
Rural	þ
Underserved Racial and Ethnic Minorities	þ

footnote:

III: Expenditure Reports

Table 6 - Resource Development Expenditure Checklist

Expenditure Period Start Date: 10/1/2011 Expenditure Period End Date: 9/30/2013

Resource Development Expenditures Checklist						
Activity	A. Prevention-MH	B. Prevention-SA	C. Treatment-MH	D. Treatment-SA	E. Combined	F. Total
1. Planning, Coordination and Needs Assessment				$172,230.00		$172,230.00
2. Quality Assurance				$548,524.00		$548,524.00
3. Training (Post-Employment)						$0.00
4. Program Development		$797,815.00		$1,695,099.00		$2,492,914.00
5. Research and Evaluation		$994,050.00		$2,164,912.00		$3,158,962.00
6. Information Systems						$0.00
7. Education (Pre-Employment)						$0.00
8. Total	$0.00	$1,791,865.00	$0.00	$4,580,765.00	$0.00	$6,372,630.00

footnote:
The amount in both the Treatment-SA Column D Row 4, and in the Column D Row 8-Total, above, includes $101,445 in Resource Development costs for HIV EIS staff support; these costs are not otherwise allocable within the matrix design above.

III: Expenditure Reports

Table 7 - Statewide Entity Inventory

Expenditure Period Start Date: 10/1/2011 Expenditure Period End Date: 9/30/2013

	Entity Number	I-BHS ID		Area Served (Statewide or SubState Planning Area)	Provider / Program Name	Mailing Address	City	State	Zip	SAPT Block Grant - A. Block Grant Funds (B + D + E)	SAPT Block Grant - B. Prevention (other than primary prevention) and Treatment Services	SAPT Block Grant - C. Pregnant Women and Women with Dependent Children	SAPT Block Grant - D. Primary Prevention	SAPT Block Grant - E. Early Intervention Services for HIV
*	*900247*	*NJ900247*		*Mercer County*	*Catholic Charities*	*383 West State Street*	*Trenton*	*NJ*	*08618*	*$127,532*	*($3,772)*	*$0*	*$131,304*	*$0*
*	*750810*	*NJ750810*		*Gloucester County*	*Maryville*	*1903 Grant Avenue*	*Williamstown*	*NJ*	*08094*	*($160,954)*	*($160,954)*	*$0*	*$0*	*$0*
	991151	NJ991151		Mercer County	Advancing Opportunities	1005 Whitehead Road Extension	Ewing	NJ	08638	$63,735	$0	$0	$63,735	$0
	100776	NJ100776		Atlantic County	Atlantic Prevention Resources	1416 N. Main Street	Pleasantville	NJ	08232	$269,726	$0	$0	$269,726	$0
	100883	NJ100883		Atlantic County	Atlanticare Behavioral Health	2511 Fire Road	Egg Harbor Township	NJ	08234	$50,635	$50,635	$50,635	$0	$0
	101796	NJ101796		Gloucester County	Big Brothers Big Sisters	100 Dobbs Land	Cherry Hill	NJ	08034	$89,080	$0	$0	$89,080	$0
	100685	NJ100685		Burlington County	Burlington Coomprehensive	75 Washington Street	Mt. Holly	NJ	08060	$78,990	$78,990	$8,995	$0	$0
	306175	NJ306175		Camden County	Camden County Council on	1 Alpha Ave.	Voorhees	NJ	08043	$270,985	$0	$0	$270,985	$0
	750133	NJ750133		Cape May County	Cape May County Council Alcoholism and Drug Abuse	3819 New Jersey Avenue	Wildwood	NJ	08260	$355,570	$0	$0	$355,570	$0
	102020	NJ102020		Essex County	Catholic Charities of the Arch	590 North 7th Street	Newark	NJ	07107	$105,820	$0	$0	$105,820	$0
	999191	NJ999191		Sussex County	Center for Prevention & Counseling	61 Spring Street	Newton	NJ	07860	$324,365	$0	$0	$324,365	$0
	105072	NJ105072		Essex County	Central Jersey Behavioral Health	1695 US Highway 9	Toms River	NJ	08754	$1,011,833	$0	$0	$1,011,833	$0
	101830	NJ101830		Bergen County	Children's Aid and Family Services	200 Robin Road	Paramus	NJ	07652	$406,168	$0	$0	$406,168	$0
	100164	NJ100164		Ocean County	Counseling and Referral Services	35 Beaverson Blvd	Brick	NJ	08723	$258,589	$258,589	$258,589	$0	$0
	305300	NJ305300		Essex County	Cura Incorporated	PO Box 180	Newark	NJ	07101 -0180	$1,787,886	$1,787,886	$289,332	$0	$0
	306167	NJ306167		Middlesex County	Damon House	105 Joyce Kilmer Avenue	New Brunswick	NJ	08901	$897,002	$897,002	$0	$0	$0
	101806	NJ101806		Middlesex County	Dare New Jersey	292 Prospect Plains Road	Cranbury	NJ	08512	$81,342	$0	$0	$81,342	$0
	300236	NJ300236		Monmouth County	Discovery Inc.	80 Conover Road	Marlboro	NJ	07746	$1,026,117	$1,026,117	$0	$0	$0
	300806	NJ300806		Essex County	East Orange City	160 Halsted Street	East Orange	NJ	07018	$202,012	$202,012	$23,389	$0	$0
	105353	NJ105353		Burlington County	Elm Lifelines Womens Issues	23 South Main Street	Medford	NJ	08055	$74,005	$74,005	$74,005	$0	$0
	750612	NJ750612		Somerset County	Empower Somerset	34 West Main St.	Somerville	NJ	08876	$207,346	$0	$0	$207,346	$0
	101329	NJ101329		Passaic County	Eva's Kitchen	393 Main Street	Paterson	NJ	07501	$131,912	$131,912	$131,912	$0	$0

	300855	NJ300855	X	Essex County	Family Connections	395 South Center Street	Orange	NJ	07050	$420,093	$0	$0	$420,093	$0
	902635	NJ902635	X	Warren County	Family Guidance Center	492 Route 57 West	Washington	NJ	07882	$281,796	$146,510	$146,510	$135,286	$0
	101162	NJ101162	X	Hunterdon County	Freedom House	3 Pavillion Road	Glen Gardner	NJ	08826 -0367	$52,953	$52,953	$52,953	$0	$0
	101477	NJ101477	X	Hunterdon County	Good News Home for	33 Bartles Corner Road	Flemington	NJ	08822	$436,832	$436,832	$436,832	$0	$0
	306357	NJ306357	X	Camden County	Hispanic Family Center	35-47 South 29th Street	Camden	NJ	08105	$113,817	$0	$0	$113,817	$0
	104232	NJ104232	X	Hunterdon County	Hunterdon Prevention Resources	4 Walter Foran Boulevard	Flemington	NJ	08822	$309,509	$0	$0	$309,509	$0
	100420	NJ100420	X	Essex County	Integrity, Inc.	103 Lincoln Park	Newark	NJ	07102	$2,785,119	$2,773,715	$135,473	$0	$11,404
	306209	NJ306209	X	09	Inter County Council On	416 Kearny Avenue	Kearny	NJ	07032	$215,740	$150,940	$23,389	$0	$64,800
	300103	NJ300103	X	Atlantic County	John Brooks Recovery Center	19 South Tennessee Avenue	Atlantic City	NJ	08401	$2,076,237	$1,888,030	$46,778	$0	$188,207
	100156	NJ100156	X	Monmouth County	JSAS Healthcare Inc.	685 Neptune Boulevard	Neptune	NJ	07753	$639,692	$507,545	$79,523	$0	$132,147
	100404	NJ100404	X	Essex County	Lennard Clinic Inc.	461 Frelinghuysen Avenue	Newark	NJ	07114	$3,641,349	$3,139,193	$199,168	$0	$502,156
	902924	NJ902924	X	Mercer County	Mercer Council on Alcoholism	447 Bellevue Ave.	Trenton	NJ	08618	$253,903	$0	$0	$253,903	$0
	101818	NJ101818	X	Morris County	Morris Co Prevention is Key	25 West Main Street	Rockaway	NJ	07866	$323,808	$0	$0	$323,808	$0
	750299	NJ750299	X	Mercer County	NACADD of New Jersey	360 Corporate Boulevard	Robbinsville	NJ	08691	$323,690	$0	$0	$323,690	$0
	103309	NJ103309	X	09	National Council on Alcoholism	152 Tices Lane	East Brunswick	NJ	08816	$925,596	$0	$0	$925,596	$0
	302026	NJ302026	X	Middlesex County	New Brunswick Counseling	320 Suydam Street	New Brunswick	NJ	08901	$738,353	$645,554	$54,793	$0	$92,799
	102467	NJ102467	X	Monmouth County	New Hope Foundation	546 Route 520	Marlboro	NJ	07746 -0066	$769,930	$769,930	$769,930	$0	$0
	100461	NJ100461	X	Morris County	New Horizon Treatment Services	132 Perry Street	Trenton	NJ	08602	$416,581	$368,085	$32,744	$0	$48,496
	759802	NJ759802	X	Ocean County	New Jersey Prevention Network	150 Airport Road	Lakewood	NJ	08701	$2,110,786	$1,107,584	$0	$1,003,202	$0
	306092	NJ306092	X	07	Newark Renaissance	50-56 Norfolk Street	Newark	NJ	07107	$397,778	$397,778	$397,778	$0	$0
	101640	NJ101640	X	Essex County	North Jersey Aids Alliance, Inc.	393 Central Avenue	Newark	NJ	07103	$243,750	$0	$0	$243,750	$0
	100487	NJ100487	X	Passaic County	Northeast Life Skills Grant	121 Howe Avenue	Passaic	NJ	07055	$291,335	$226,535	$32,745	$0	$64,800
	100503	NJ100503	X	Union County	Organization for Recovery	519 North Avenue	Plainfield	NJ	07061	$306,516	$241,716	$23,389	$0	$64,800
	999211	NJ999211	X	99	Oxford House Inc.	1010 Wayne Avenue	Silver Spring	NJ	20910	$171,125	$171,125	$0	$0	$0
	100495	NJ100495	X	Passaic County	Paterson Counseling	319-321 Main Street	Paterson	NJ	07505	$888,455	$734,457	$107,590	$0	$153,998
	101295	NJ101295	X	Ocean County	Preferred Behavioral Health	700 Airport Road	Lakewood	NJ	08701	$245,857	$245,857	$245,857	$0	$0
	750554	NJ750554	X	Monmouth County	Prevention First Inc.	1405 Highway 35	Ocean	NJ	07712	$585,108	$0	$0	$585,108	$0
	750802	NJ750802	X	Union County	Prevention Links	121-125 Chestnut Ave	Roselle	NJ	07203	$443,570	$0	$0	$443,570	$0
	999031	NJ999031	X	03	Prevention Plus of Burlington	1824 Route 38 East	Lumberton	NJ	08048	$461,160	$0	$0	$461,160	$0

	902072	NJ902072	✗	Mercer County	Proceed, Inc.	1126 Dickinson Street	Elizabeth	NJ	07201	$216,667	$0	$0	$216,667	$0
	100768	NJ100768	✗	Middlesex County	Raritan Bay Medical Ctr	530 New Brunswick Avenue	Perth Amboy	NJ	08861	$169,658	$139,244	$23,749	$0	$30,414
	100651	NJ100651	✗	01	Resource Center for the Chemically Dependent	1574 Sussex Turnpike	Randolph	NJ	07869	$264,536	$264,536	$21,878	$0	$0
	1214	NJ1214	✗	Middlesex County	Rutgers The State University of NJ	3 Rutgers Plaza	New Brunswick	NJ	08901	$338,577	$0	$0	$338,577	$0
	105197	NJ105197	✗	04	Sikora Center Inc.	613-615 Clinton Street	Camden	NJ	08101	$130,455	$130,455	$130,455	$0	$0
	301309	NJ301309	✗	08	SODAT NJ INC	919 Broadway Street	Westville	NJ	08093	$486,009	$0	$0	$486,009	$0
	100693	NJ100693	✗	Somerset County	Somerset Treatment Svcs	118 West End Avenue	Somerville	NJ	08876	$194,353	$129,553	$23,389	$0	$64,800
	100677	NJ100677	✗	04	South Jersey Drug	162 Sunny Slope Drive	Bridgeton	NJ	08302	$134,694	$109,532	$0	$0	$25,162
	101309	NJ101309	✗	06	Southwest Council Inc	1405 North Delsea Drive	Vineland	NJ	08360	$540,679	$0	$0	$540,679	$0
	306316	NJ306316	✗	09	Spectrum Health Care Inc. St Gt	74-80 Pacific Avenue	Jersey City	NJ	07304	$892,338	$725,691	$130,841	$0	$166,647
	999074	NJ999074	✗	Passaic County	Straight & Narrow INC	508 Straight Street	Paterson	NJ	07652	$4,736,900	$4,590,643	$1,574,937	$99,839	$46,418
	306258	NJ306258	✗	Sussex County	Sunrise House	37 Sunset Inn Road	Lafayette	NJ	07848	$753,040	$753,040	$753,040	$0	$0
	750729	NJ750729	✗	07	Turning Point INC	680 Broadway	Paterson	NJ	07514	$1,808,509	$1,808,509	$106,481	$0	$0
	101212	NJ101212	✗	07	UMDNJ	671 Hoes Lane	Piscataway	NJ	08855 -1392	$135,062	$112,252	$112,252	$22,810	$0
	750406	NJ750406	✗	07	University Hospital	150 Bergen Street	Newark	NJ	07103 -2714	$500,518	$156,500	$156,500	$344,018	$0
	100939	NJ100939	✗	04	Urban Treatment Assoc.	424-32 Market Street	Camden	NJ	08102	$402,386	$300,619	$20,627	$0	$101,767
	903021	NJ903021	✓	02	Vantage Health System	2 Park Avenue	Dumont	NJ	07628	$1,266,503	$1,266,503	$0	$0	$0
	371203	NJ371203	✗	Passaic County	Wayne Counseling CTR INC	1022 Hamburg Turnpike	Wayne	NJ	07470	$233,002	$0	$0	$233,002	$0
	101936	NJ101936	✗	Passaic County	William Paterson University	300 Pompton Road	Wayne	NJ	07444	$340,097	$0	$0	$340,097	$0
	999142	NJ999142	✗	Morris County	Willow Tree Inc.	415 Speedwell Avenue	Morris Plains	NJ	07950	$107,319	$0	$0	$107,319	$0
Total										$42,181,436	$28,833,838	$6,676,458	$11,588,783	$1,758,815

* Indicates the imported record has an error.

footnote:
There is a total adjustment credit of ($2,786,702.87) which is not displayed in in the SAPT Block Grant Funds -Column A, above, which is allocable across Columns B, C, D, and E. In sum, after the adjustments, the total in Column A equals $39,394,733.63.

III: Expenditure Reports

Table 8a - Maintenance of Effort for State Expenditures for SAPT

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

Yes _____ No X

If yes, specify the amount and the State fiscal year: _____

Did the State or Jurisdiction include these funds in previous year MOE calculations?

Yes _____ No _____

When did the State submit an official request to the SAMHSA Administrator to exclude these funds from the MOE calculations? _____

Total Single State Agency (SSA) Expenditures for Substance Abuse Prevention and Treatment		
Period (A)	Expenditures (B)	B1(2012) + B2(2013) 2 (C)
SFY 2012 (1)	$103,692,940	
SFY 2013 (2)	$103,532,945	$103,612,943
SFY 2014 (3)	$103,811,975	

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

SFY 2012 Yes _____ No X

SFY 2013 Yes _____ No X

SFY 2014 Yes _____ No X

If estimated expenditures are provided, please indicate when actual expenditure data will be submitted to SAMHSA: 12/1/2015

footnote:
The methodology for calculation of this MOE is included as an attachment to this report.

III: Expenditure Reports

Table 8b - Base and Maintenance of Effort for State Expenditures for TB

State Expenditures for Tuberculosis Services to Individuals in Substance Use Disorder Treatment BASE				
Period	Total of All State Funds Spent on TB Services (A)	% of TB Expenditures Spent on Individuals in Substance Use Disorder Treatment (B)	Total State Funds Spent on Individuals in Substance Use Disorders Treatment (A x B) (C)	Average of Column C1 and C2 $\frac{C1+C2}{2}$ (MOE BASE) (D)
SFY 1991 (1)	$1,579,967	13.20%	$208,556	
SFY 1992 (2)	$1,752,586	13.20%	$231,341	$219,948

State Expenditures for Tuberculosis Services to Individuals in Substance Use Disorder Treatment MAINTENANCE			
Period	Total of All State Funds Spent on TB Services (A)	% of TB Expenditures Spent on Individuals in Substance Use Disorder Treatment (B)	Total State Funds Spent on Individuals in Substance Use Disorders Treatment (A x B) (C)
SFY 2014 (3)	$3,250,250	7.40%	$240,519

footnote:

This MOE is provided by New Jersey's Department of Health.

The methodology for calculation of this MOE is included as an attachment to this report.

III: Expenditure Reports

Table 8c - Base and Maintenance of Effort for Expenditures for HIV Early Intervention Services

Enter the year in which your State last became a designated State, Federal Fiscal Year _. Enter the 2 prior years' expenditure data in A1 and A2. Compute the average of the amounts in boxes A1 and A2. Enter the resulting average (MOE Base) in box B2.

State Expenditures for HIV Early Intervention Services to Individuals in Substance Use Disorder Treatment BASE		
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)
(1) SFY 1991	$143,954	
(2) SFY 1992	$187,211	$165,583

Statewide Non-Federal Expenditures for HIV Early Intervention Services to Individuals in Substance Use Disorder Treatment MAINTENANCE	
Period	Total of All State Funds Spent on Early Intervention Services for HIV (A)
(3) SFY 2014	$533,000

footnote:
This MOE is provided by New Jersey's Department of Health.

The methodology for calculation of this MOE is included as an attachment to this report.

III: Expenditure Reports

Table 8d - Expenditures for Services to Pregnant Women and Women with Dependent Children

Expenditures for Services to Pregnant Women and Women with Dependent Children		
Period	Total Women's Base (A)	Total Expenditures (B)
SFY 1994	$6,497,485	
SFY 2012		$16,338,471
SFY 2013		$17,109,388
SFY 2014		$16,552,432
Enter the amount the State plans to expend in 2015 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)): $ 165522432.00		

footnote:
The methodology for calculation of this MOE is included as an attachment to this report.

Table 9 - Prevention Strategy Report

Column A (Risks)	Column B (Strategies)	Column C (Providers)
Children of substance abusers	2. Education	
	1. Parenting and family management	12
	2. Ongoing classroom and/or small group sessions	14
	4. Education programs for youth groups	18
	5. Mentors	5
	3. Alternatives	
	1. Drug free dances and parties	6
Violent and delinquent behavior	2. Education	
	1. Parenting and family management	3
	2. Ongoing classroom and/or small group sessions	3
	5. Mentors	3
Mental health problems	1. Information Dissemination	
	7. Health fairs and other health promotion, e.g., conferences, meetings, seminars	6
	2. Education	
	2. Ongoing classroom and/or small group sessions	4
Economically disadvantaged	2. Education	
	1. Parenting and family management	2
	2. Ongoing classroom and/or small group sessions	2
Already using substances	2. Education	
	2. Ongoing classroom and/or small group sessions	3
	4. Problem Identification and Referral	
	1. Employee Assistance Programs	1
	5. Community-Based Process	
	3. Multi-agency coordination and collaboration/coalition	3
Homeless and/or runaway youth	2. Education	
	2. Ongoing classroom and/or small group sessions	1
	3. Alternatives	
	1. Drug free dances and parties	1
	2. Youth/adult leadership activities	1
	3. Community drop-in centers	1

	6. Recreation activities	1
18 to 25 year olds statewide	6. Environmental	
	5. Enactment of municipal ordinances, merchant education, beverage server trainings	17

footnote:

IV: Populations and Services Reports

Table 10 - Treatment Utilization Matrix

Expenditure Period Start Date: 7/1/2013 Expenditure Period End Date: 6/30/2014

Level of Care	Number of Admissions ≥ Number of Persons Served		Costs per Person		
	Number of Admissions (A)	Number of Persons Served (B)	Mean Cost of Services (C)	Median Cost of Services (D)	Standard Deviation of Cost (E)
DETOXIFICATION (24-HOUR CARE)					
1. Hospital Inpatient	372	369	$0	$0	$0
2. Free-Standing Residential	5206	4667	$0	$0	$0
REHABILITATION/RESIDENTIAL					
3. Hospital Inpatient	398	369	$0	$0	$0
4. Short-term (up to 30 days)	6184	5692	$0	$0	$0
5. Long-term (over 30 days)	4609	3862	$0	$0	$0
AMBULATORY (OUTPATIENT)					
6. Outpatient	10426	9904	$0	$0	$0
7. Intensive Outpatient	8216	7547	$0	$0	$0
8. Detoxification	253	241	$0	$0	$0
OPIOID REPLACEMENT THERAPY					
9. Opioid Replacement Therapy	221	218	$0	$0	$0
10. ORT Outpatient	2906	2742	$0	$0	$0

footnote:
Admission counts based on treatment providers that had FY 2014 public funding.

Table 11 - Unduplicated Count of Persons

Expenditure Period Start Date: 7/1/2013 Expenditure Period End Date: 6/30/2014

Age	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	
		Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
1. 17 and Under	677	336	159	108	41	3	1	3	0	3	0	6	2	10	5	345	155	122	51
2. 18 - 24	5102	2591	1254	667	315	18	7	41	7	11	2	42	19	85	43	2904	1423	524	216
3. 25 - 44	14903	7153	3786	2014	1187	76	28	64	25	34	16	62	36	249	173	7785	4557	1814	654
4. 45 - 64	6369	2712	1153	1485	653	33	8	19	4	15	6	14	14	156	97	3727	1784	686	137
5. 65 and Over	185	98	33	36	5	0	1	1	0	0	0	0	0	10	1	130	37	14	3
6. Total	27236	12890	6385	4310	2201	130	45	128	36	63	24	124	71	510	319	14891	7956	3160	1061
7. Pregnant Women	348		231		92		0		1		1		4		19		287		60

Number of persons served who were admitted in a period prior to the 12 month reporting period	21488
Number of persons served outside of the levels of care described on Table 10	1061

footnote:
The number of persons served who were admitted in a period prior to the 12-month reporting period is compiled differently from the above total, because it is comprised of males, females, transgenders, and other genders.

Also, the row "6." total may not match the total for columns "I." and "J.", possibly due to 261 unique Client IDs that had null/blank ethnicity codes and 385 unique Client IDs had multiple ethnicities of which 125 had a null/blank ethnicity code.

Counts based on treatment providers that had FY 2014 public funding.

IV: Populations and Services Reports

Table 12 - HIV Designated States Early Intervention Services

Expenditure Period Start Date: 7/1/2013 Expenditure Period End Date: 6/30/2014

Early Intervention Services for Human Immunodeficiency Virus (HIV)		
1. Number of SAPT HIV EIS programs funded in the State	Statewide: 23	Rural: 1
2. Total number of individuals tested through SAPT HIV EIS funded programs	3968	
3. Total number of HIV tests conducted with SAPT HIV EIS funds	4116	
4. Total number of tests that were positive for HIV	31	
5. Total number of individuals who prior to the 12-month reporting period were unaware of their HIV infection	13	
6. Total number of HIV-infected individuals who were diagnosed and referred into treatment and care during the 12-month reporting period	22	

Identify barriers, including State laws and regulations, that exist in carrying out HIV testing services:
• Lack of Motivational Interviewing techniques/skills of HIV Counselors at licensed substance abuse treatment programs. Training did not occur until July 2014 (after reporting period). Training was for NJ State substance abuse treatment counselors who conduct on-site HIV testing. It is hypothesized the training held in July 2014 may assist in developing interviewing and motivating skills for HIV counselors; whereas, more individuals may agree to be tested.• Since the Division of HIV/AIDS, STDs and Tuberculosis Services (DHSTS) and the Division of Mental Health and Addiction Services (DMHAS) are in separate Departments within the State of New Jersey, policies and procedures differ which has prohibited a more rapid increase in testing at substance abuse treatment programs.• In order to conduct Rapid HIV Testing in New Jersey, all State licensed substance abuse treatment programs are required to provide a bioanalytical laboratory director and training competency assessment of testing personnel, testing policies and procedures consistent with what has been put in place for the NJ Department of Health's DHSTS. This has proven to be a barrier for some of the State's licensed substance abuse treatment programs since they do not have this ability.

footnote:
Footnote for Question 5- Total number of individuals who prior to the 12-month reporting period were unaware of their HIV infection: Providers indicated that 13 of the 31 individuals testing positive for HIV were unaware of their HIV infection in the prior 12-month reporting period. The other 18 individuals testing positive had previously had an HIV diagnosis but fell out of HIV treatment and required an HIV test to verify HIV status.
Footnote for Question 6- Total number of HIV-infected individuals who were diagnosed and referred into treatment and care during the 12-month reporting period: 22 of the 31 individuals testing positive were referred into treatment. The remaining individuals were already reported to be engaged in HIV treatment.

IV: Populations and Services Reports

Table 13 - Charitable Choice

Expenditure Period Start Date: 7/1/2013 Expenditure Period End Date: 6/30/2014

Notice to Program Beneficiaries - Check all that apply:

- þ Used model notice provided in final regulation.
- ¢ Used notice developed by State (please attach a copy to the Report).
- þ State has disseminated notice to religious organizations that are providers.
- þ 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.
- þ State maintains record of referrals made by religious organizations that are providers.
- þ 0 Enter total number of referrals necessitated by religious objection to other substance abuse providers ("alternative providers"), as defined 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.

The New Jersey Division of Mental Health and Addiction Services (DMHAS) have continued its efforts to train monitoring staff in Charitable Choice Provisions and Regulations. In March 2013, all DMHAS addictions providers received correspondence (see attachment) indicating the Division's intent to monitor the provisions of the Charitable Choice Act. The correspondence included the model notice and the Charitable Choice law. In addition to the questionnaire portion of the annual site visit monitoring form (the form is sent to the agency prior to the review period and requires the agency to identify if they are, or are not faith-based in their approach to substance abuse treatment), providers are required to submit quarterly referral logs to the Program Management Officers of the Contract Monitoring Unit. There were zero referrals during SFY 2014.

footnote:

State of New Jersey
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MENTAL HEALTH AND ADDICTION SERVICES
222 SOUTH WARREN STREET
PO BOX 700
TRENTON, NJ 08625-0700

CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

JENNIFER VELEZ
Commissioner

LYNN A. KOVICH
Assistant Commissioner

March 21, 2013

Dear Provider:

The Division of Mental Health and Addiction Services is writing to you with regard to the Federal Register Part VIII, Department of Health and Human Services 42 CFR - Parts 54 and 54a and 45 CFR - Parts 96, 260 and 1050, Charitable Choice Provision and Regulations (http://www.access.gpo.gov/nara/cfr/waisidx_09/42cfr54_09.html).

Under the Federal Charitable Choice Law, all treatment providers are required to inform consumers receiving substance abuse treatment that they can not be discriminated against on the basis of religion, a religious belief, a refusal to hold a religious belief, and/ or refusal to actively participate in a religious practice. If a consumer objects to the religious or non-religious character of the agency, they have a right to a referral to another provider.

Enclosed for your review and use is the Federal Register, a sample Model Notice of Individuals Receiving Substance Abuse Services that can be used to comply with these regulations and the Charitable Choice Referral Log that shall be submitted to your Program Management Officers (PMO) on a quarterly basis.

Should you have any questions and/or concerns, please feel to contact Mrs. Kathleen Goat-Delgado, Contract Monitoring Unit Supervisor at (609) 292-0563.

Sincerely,

Lynn A. Kovich
Assistant Commissioner

Enclosure
C: Kathy Goat-Delgado
Roger Borichewski
PMO's

New Jersey Is An Equal Opportunity Employer

Appendix-Part 54a-Model Notice of Individuals Receiving Substance Abuse Services

Model Notice to Individuals Receiving Substance Abuse Services

No provider of substance abuse services receiving Federal funds from the U.S. Substance Abuse and Mental Health Services Administration, including this organization, may discriminate against you on the basis of religion, a religious belief, a refusal to hold a religious belief, or a refusal to actively participate in a religious practice.

If you object to the religious or non-religious character of this organization, Federal law gives you the right to a referral to another provider of substance abuse services. The referral, and your receipt of alternative services, must occur within a reasonable period of time after you request them. The alternative provider must be accessible to you and have the capacity to provide substance abuse services. The services provided to you by the alternative provider must be of a value not less than the value of the services you would have received from this organization.

Code of Federal Regulations

42

Parts 1 to 399
Revised as of October 1, 2009

Public Health

Containing a codification of documents of general applicability and future effect

As of October 1, 2009

With Ancillaries

Published by
Office of the Federal Register
National Archives and Records
Administration

A Special Edition of the Federal Register

FEDERAL REGISTER to announce the proposed amount.

[51 FR 39376, Oct. 28, 1986]

PART 54—CHARITABLE CHOICE REGULATIONS APPLICABLE TO STATES RECEIVING SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANTS AND/OR PROJECTS FOR ASSISTANCE IN TRANSITION FROM HOMELESSNESS GRANTS

Sec.

AUTHORITY: 42 U.S.C. 300x–65, *et seq.*, 42 U.S.C. 290kk, *et seq.*, 42 U.S.C. 300x–21, *et seq.*, 42 U.S.C. 290cc–21, *et seq.*, and 42 U.S.C. 2000bb, *et seq.*

SOURCE: 68 FR 56444, Sept. 30, 2003, unless otherwise noted.

§ 54.1 Scope.

These provisions apply only to funds provided directly to pay for substance abuse prevention and treatment services under 42 U.S.C. 300x–21 *et seq.*, and 42 U.S.C. 290cc–21 to 290cc–35. This part does not apply to direct funding under any such authorities for activities that do not involve the provision of substance abuse services, such as for infrastructure activities authorized under Section 1971 of the PHS Act, 42 U.S.C. 300y, and for technical assistance activities. This part implements the SAMHSA Charitable Choice provisions, 42 U.S.C. 300x–65 and 42 U.S.C. 290kk, *et seq.*

§ 54.2 Definitions.

(a) *Applicable program* means the programs authorized under:

(1) The Substance Abuse Prevention and Treatment (SAPT) Block Grant, 42 U.S.C. 300x to 300x–66, and

(2) The Projects for Assistance in Transition from Homelessness (PATH) Formula Grants, 42 U.S.C. 290cc–21 to 290cc–35 insofar as they fund substance abuse prevention and/or treatment services.

(b) *Religious organization* means a nonprofit religious organization.

(c) *Program beneficiary* means an individual who receives substance abuse services under a program funded in whole or in part by applicable programs.

(d) *Program participant* means a public or private entity that has received financial assistance, under an applicable program.

(e) *SAMHSA* means the U.S. Substance Abuse and Mental Health Services Administration.

(f) *SAMHSA Charitable Choice provisions* means the provisions of 42 U.S.C. 300x–65 and 42 U.S.C. 290kk, *et seq.*

(g) *Direct funding or Funds provided directly* means funding that is provided to an organization directly by a governmental entity or intermediate organization that has the same duties under this part as a governmental entity, as opposed to funding that an organization receives as the result of the genuine and independent private choice of a beneficiary through a voucher, certificate, coupon, or other similar mechanism.

§ 54.3 Nondiscrimination against religious organizations.

(a) Religious organizations are eligible, on the same basis as any other organization, to participate in applicable programs, as long as their services are provided consistent with the Establishment Clause and the Free Exercise Clause of the First Amendment to the United States Constitution. Except as provided herein or in the SAMHSA Charitable Choice provisions, nothing in these regulations shall restrict the ability of the Federal government, or a State or local government, from applying to religious organizations the same

eligibility conditions in applicable programs as are applied to any other nonprofit private organization.

(b) Neither the Federal government nor a State or local government receiving funds under these programs shall discriminate against an organization that is, or applies to be, a program participant on the basis of religion or the organization's religious character or affiliation.

§54.4 Religious activities.

No funds provided directly from SAMHSA or the relevant State or local government to organizations participating in applicable programs may be expended for inherently religious activities, such as worship, religious instruction, or proselytization. If an organization conducts such activities, it must offer them separately, in time or location, from the programs or services for which it receives funds directly from SAMHSA or the relevant State or local government under any applicable program, and participation must be voluntary for the program beneficiaries.

§54.5 Religious character and independence.

A religious organization that participates in an applicable program will retain its independence from Federal, State, and local governments and may continue to carry out its mission, including the definition, practice and expression of its religious beliefs. The organization may not expend funds that it receives directly from SAMHSA or the relevant State or local government to support any inherently religious activities, such as worship, religious instruction, or proselytization. Among other things, faith-based organizations may use space in their facilities to provide services supported by applicable programs, without removing religious art, icons, scriptures, or other symbols. In addition, a SAMHSA-funded religious organization retains the authority over its internal governance, and it may retain religious terms in its organization's name, select its board members on a religious basis, and include religious references in its organization's mission statements and other governing documents.

§54.6 Employment practices.

(a) The participation of a religious organization in, or its receipt of funds from, an applicable program does not affect that organization's exemption provided under 42 U.S.C. 2000e–1 regarding employment practices.

(b) To the extent that 42 U.S.C. 300x–57(a)(2) or 42 U.S.C. 290cc–33(a)(2) precludes a program participant from employing individuals of a particular religion to perform work connected with the carrying on of its activities, those provisions do not apply if such program participant is a religious corporation, association, educational institution, or society and can demonstrate that its religious exercise would be substantially burdened by application of these religious nondiscrimination requirements to its employment practices in the program or activity at issue. In order to make this demonstration, the program participant must certify: that it sincerely believes that employing individuals of a particular religion is important to the definition and maintenance of its religious identity, autonomy, and/or communal religious exercise; that it makes employment decisions on a religious basis in analogous programs; that the grant would materially affect its ability to provide the type of services in question; and that providing the services in question is expressive of its values or mission. The organization must maintain documentation to support these determinations and must make such documentation available to SAMHSA upon request.

(c) Nothing in this section shall be construed to modify or affect any State law or regulation that relates to discrimination in employment.

(d) The phrases "with respect to the employment," "individuals of a particular religion," and "religious corporation, association, educational institution, or society" shall have the same meaning as those terms have under section 702 of the Civil Rights Act of 1964, 42 U.S.C. 2000e–1(a).

§54.7 Nondiscrimination requirement.

A religious organization that is a program participant shall not, in providing program services or engaging in outreach activities under applicable

programs, discriminate against a program beneficiary or prospective program beneficiary on the basis of religion, a religious belief, a refusal to hold a religious belief, or a refusal to actively participate in a religious practice.

§ 54.8 Right to services from an alternative provider.

(a) *General requirements.* If an otherwise eligible program beneficiary or prospective program beneficiary objects to the religious character of a program participant, within a reasonable period of time after the date of such objection, such program beneficiary shall have rights to notice, referral, and alternative services, as outlined in paragraphs (b) through (d) of this section.

(b) *Notice.* Program participants that refer an individual to alternative service providers, and the State government that administers the applicable programs, shall ensure that notice of the individual's right to services from an alternative provider is provided to all program beneficiaries or prospective beneficiaries. The notice must clearly articulate the program beneficiary's right to a referral and to services that reasonably meet the requirements of timeliness, capacity, accessibility, and equivalency as discussed in this section. A model notice is set out in appendix A to part 54a.

(c) *Referral to an alternative provider.* If a program beneficiary or prospective program beneficiary objects to the religious character of a program participant that is a religious organization, that participating religious organization shall, within a reasonable time after the date of such objection, refer such individual to an alternative provider. The State shall have a system in place to ensure that referrals are made to an alternative provider. That system shall ensure that the following occurs:

(1) The religious organization that is a program participant shall, within a reasonable time after the date of such objection, refer the beneficiary to an alternative provider;

(2) In making such referral, the program participant shall consider any list that the State or local government makes available to entities in the geographic area that provide program services, which may include utilizing any treatment locator system developed by SAMHSA;

(3) All referrals shall be made in a manner consistent with all applicable confidentiality laws, including, but not limited to, 42 CFR Part 2 ("Confidentiality of Alcohol and Drug Abuse Patient Records");

(4) Upon referring a program beneficiary to an alternative provider, the program participant shall notify the State or responsible unit of government of such referral; and

(5) The program participant shall ensure that the program beneficiary makes contact with the alternative provider to which he or she is referred.

(d) *Provision and funding of alternative services.* If an otherwise eligible applicant or recipient objects to the religious character of a SAMHSA-funded service provider, the recipient is entitled to receive services from an alternative provider. In such cases, the State or local agency must provide the individual with alternative services within a reasonable period of time, as defined by the State agency. That alternative provider must be reasonably accessible and have the capacity to provide comparable services to the individual. Such services shall have a value that is not less than the value of the services that the individual would have received from the program participant to which the individual had such objection, as defined by the State agency. The alternative provider need not be a secular organization. It must simply be a provider to which the recipient has no religious objection. States may define and apply the terms "reasonably accessible," "a reasonable period of time," "comparable," "capacity," and "value that is not less than." The appropriate State or local governments that administer SAMHSA-funded programs shall ensure that notice of their right to alternative services is provided to applicants or recipients. The notice must clearly articulate the recipient's right to a referral and to services that reasonably meet the timeliness, capacity, accessibility, and equivalency requirements discussed above.

(e) *PATH annual report.* As part of the annual report to SAMHSA, PATH grantees shall include a description of the activities the grantee has taken to comply with 42 CFR part 54.

§ 54.9 Assurances and State oversight of the Charitable Choice requirements.

In order to ensure that States receiving grant funding under the SAPT block grant and PATH formula grant programs comply with the SAMHSA Charitable Choice provisions and provide oversight of religious organizations that provide substance abuse services under such programs, States are required as part of their applications for funding to certify that they will comply with all of the requirements of such provisions and the implementing regulations under this part, and that they will provide such oversight of religious organizations.

§ 54.10 Fiscal accountability.

(a) Religious organizations that receive applicable program funds for substance abuse services are subject to the same regulations as other nongovernmental organizations to account, in accordance with generally accepted auditing and accounting principles, for the use of such funds.

(b) Religious organizations shall segregate Federal funds they receive under an applicable program into a separate account from non-Federal funds. Only the Federal funds shall be subject to audit by government under the SAMHSA program.

§ 54.11 Effects on State and local funds.

If a State or local government contributes its own funds to supplement activities carried out under the applicable programs, the State or local government has the option to separate out the Federal funds or commingle them. If the funds are commingled, the provisions of this part shall apply to all of the commingled funds in the same manner, and to the same extent, as the provisions apply to the Federal funds.

§ 54.12 Treatment of intermediate organizations.

If a nongovernmental organization (referred to here as an "intermediate organization"), acting under a contract or other agreement with the Federal Government or a State or local government, is given the authority under the contract or agreement to select nongovernmental organizations to provide services under any applicable program, the intermediate organization shall have the same duties under this part as the government. The intermediate organization retains all other rights of a nongovernmental organization under this part and the SAMHSA Charitable Choice provisions.

§ 54.13 Educational requirements for personnel in drug treatment programs.

In determining whether personnel of a program participant that has a record of successful drug treatment for the preceding three years have satisfied State or local requirements for education and training, a State or local government shall not discriminate against education and training provided to such personnel by a religious organization, so long as such education and training is comparable to that provided by nonreligious organizations, or is comparable to education and training that the State or local government would otherwise credit for purposes of determining whether the relevant requirements have been satisfied.

PART 54a—CHARITABLE CHOICE REGULATIONS APPLICABLE TO STATES, LOCAL GOVERNMENTS AND RELIGIOUS ORGANIZATIONS RECEIVING DISCRETIONARY FUNDING UNDER TITLE V OF THE PUBLIC HEALTH SERVICE ACT, 42 U.S.C. 290aa, ET SEQ., FOR SUBSTANCE ABUSE PREVENTION AND TREATMENT SERVICES

Sec.

AUTHORITY: 42 U.S.C. 300x–65, and 42 U.S.C. 290kk, *et seq.*, 42 U.S.C. 290aa, *et seq.*

SOURCE: 68 FR 56446, Sept. 30, 2003, unless otherwise noted.

§ 54a.1 Scope.

These provisions apply only to funds provided directly to pay for substance abuse prevention and treatment services under Title V of the Public Health Service Act, 42 U.S.C. 290aa, *et seq.*, which are administered by the Substance Abuse and Mental Health Services Administration. This part does not apply to direct funding under any such authorities for only mental health services or for certain infrastructure and technical assistance activities, such as cooperative agreements for technical assistance centers, that do not provide substance abuse services to clients. This part implements the provisions of 42 U.S.C. 300x–65 and 42 U.S.C. 290kk, *et seq.*

§ 54a.2 Definitions.

(a) *Applicable program* means the programs authorized under Title V of the PHS Act, 42 U.S.C. 290aa, *et seq.*, for the provision of substance abuse prevention and or treatment services.

(b) *Religious organization* means a nonprofit religious organization.

(c) *Program beneficiary* means an individual who receives substance abuse services under a program funded in whole or in part by applicable programs.

(d) *Program participant* means a public or private entity that has received financial assistance under an applicable program.

(e) *SAMHSA* means the Substance Abuse and Mental Health Services Administration.

(f) *SAMHSA Charitable Choice* provisions means the provisions of 42 U.S.C. 300x–65 and 42 U.S.C. 290kk, *et seq.*

(g) *Direct funding* or *Funds provided directly* means funding that is provided to an organization directly by a governmental entity or intermediate organization that has the same duties under this part as a governmental entity, as opposed to funding that an organization receives as the result of the genuine and independent private choice of a beneficiary through a voucher, certificate, coupon, or other similar mechanism.

§ 54a.3 Nondiscrimination against religious organizations.

(a) Religious organizations are eligible, on the same basis as any other organization, to participate in applicable programs as long as their services are provided consistent with the Establishment Clause and the Free Exercise Clause of the First Amendment to the United States Constitution. Except as provided herein or in the SAMHSA Charitable Choice provisions, nothing in these regulations shall restrict the ability of the Federal government, or a State or local government, from applying to religious organizations the same eligibility conditions in applicable programs as are applied to any other nonprofit private organization.

(b) Neither the Federal government nor a State or local government receiving funds under these programs shall discriminate against an organization that is, or applies to be, a program participant on the basis of the organization's religious character or affiliation.

§ 54a.4 Religious activities.

No funds provided directly from SAMHSA or the relevant State or local government to organizations participating in applicable programs may be expended for inherently religious activities, such as worship, religious instruction, or proselytization. If an organization conducts such activities, it must offer them separately, in time or location, from the programs or services for which it receives funds directly from SAMHSA or the relevant State or

local government under any applicable program, and participation must be voluntary for the program beneficiaries.

§ 54a.5 Religious character and independence.

A religious organization that participates in an applicable program will retain its independence from Federal, State, and local governments and may continue to carry out its mission, including the definition, practice and expression of its religious beliefs. The organization may not expend funds that it receives directly from SAMHSA or the relevant State or local government to support any inherently religious activities, such as worship, religious instruction, or proselytization. Among other things, faith-based organizations may use space in their facilities to provide services supported by applicable programs, without removing religious art, icons, scriptures, or other symbols. In addition, a SAMHSA-funded religious organization retains the authority over its internal governance, and it may retain religious terms in its organization's name, select its board members on a religious basis, and include religious references in its organization's mission statements and other governing documents.

§ 54a.6 Employment practices.

(a) The participation of a religious organization in or its receipt of funds from an applicable program does not affect that organization's exemption provided under 42 U.S.C. 2000e–1 regarding employment practices.

(b) Nothing in this section shall be construed to modify or affect any State law or regulation that relates to discrimination in employment.

§ 54a.7 Nondiscrimination requirement.

A religious organization that is a program participant shall not, in providing program services or engaging in outreach activities under applicable programs, discriminate against a program beneficiary or prospective program on the basis of religion, a religious belief, a refusal to hold a religious belief, or a refusal to actively participate in a religious practice.

§ 54a.8 Right to services from an alternative provider.

(a) *General requirements.* If an otherwise eligible program beneficiary or prospective program beneficiary objects to the religious character of a program participant, within a reasonable period of time after the date of such objection, such program beneficiary shall have rights to notice, referral, and alternative services, as outlined in paragraphs (b) through (d) of this section. With respect to SAMHSA discretionary programs, for purposes of determining what is the appropriate Federal, State, or local government, the following principle shall apply: When SAMHSA provides funding directly to another unit of government, such as a State or local government, that unit of government is responsible for providing the alternative services. When SAMHSA provides discretionary grant funding directly to a nongovernmental organization, SAMHSA is the responsible unit of government.

(b) *Notice.* Program participants that refer an individual to alternative providers, and the appropriate Federal, State, or local governments that administer the applicable programs, shall ensure that notice of the individual's rights to services from an alternative provider is provided to all program beneficiaries or prospective beneficiaries. The notice must clearly articulate the program beneficiary's right to a referral and to services that reasonably meet the requirements of timeliness, capacity, accessibility, and equivalency as discussed in this section. A model notice is set out in appendix A to this part.

(c) *Referral to services from an alternative provider.* If a program beneficiary or a prospective program beneficiary objects to the religious character of a program participant that is a religious organization, that participating religious organization shall, within a reasonable time after the date of such objection, refer such individual to an alternative provider.

(1) When the State or local government is the responsible unit of government, the State shall have a system in place to ensure that such referrals are made. That system shall ensure that the following occurs:

(i) The religious organization that is a program participant shall, within a reasonable time after the date of such objection, refer the beneficiary to an alternative provider;

(ii) In making such referral, the religious organization shall consider any list that the State or local government makes available to entities in the geographic area that provide program services, which may include utilizing any treatment locator system developed by SAMHSA;

(iii) All referrals are to be made in a manner consistent with all applicable confidentiality laws, including, but not limited to, 42 CFR part 2 ("Confidentiality of Alcohol and Drug Abuse Patient Records");

(iv) Upon referring a program beneficiary to an alternative provider, the religious organization shall notify the responsible unit of government of such referral; and

(v) The religious organization shall ensure that the program beneficiary makes contact with the alternative provider to which he or she is referred.

(2) When SAMHSA is the responsible unit of government, the referral process is as follows:

(i) When a program beneficiary requests alternative services, the religious organization will seek to make such a referral.

(ii) If the religious organization cannot locate an appropriate provider of alternative services, the religious organization will contact SAMHSA. They will work together to identify additional alternative providers, utilizing the SAMHSA Treatment Locator system, if appropriate.

(iii) The religious organization will contact these alternative providers and seek to make the referral, in a manner consistent with all applicable confidentiality laws, including, but not limited to, 42 CFR part 2 ("Confidentiality of Alcohol and Drug Abuse Patient Records").

(iv) In the event the religious organization is still unable to locate an alternative provider, it may again contact SAMHSA for assistance.

(d) *Referral reporting procedures.* The program participant shall notify the appropriate Federal, State or local government agency that administers the program of such referral. If a State or local government is the responsible unit of government, it may determine its own reporting procedures. When SAMHSA is the responsible unit of government, this notification will occur during the course of the regular reports that may be required under the terms of the funding award.

(e) *Provision and funding of alternative services.* The responsible unit of government, as defined in paragraph (a) of this section, shall provide to an otherwise eligible program beneficiary or prospective program beneficiary who objects to the religious character of a program participant, services and fund services from an alternative provider that is reasonably accessible to, and has the capacity to provide such services to the individual. Such services shall have a value that is not less than the value of the services that the individual would have received from the program participant to which the individual had such objection. The appropriate State or local governments that administer SAMHSA-funded programs shall ensure that notice of their right to alternative services is provided to applicants or recipients. The alternative provider need not be a secular organization. It must simply be a provider to which the program beneficiary has no religious objection.

(1) When the State receives a discretionary grant from SAMHSA, it shall utilize its own implementation procedures for these provisions and shall use funds from the SAMHSA discretionary grant to finance such alternative services, as needed;

(2) When the local government receives a discretionary grant from SAMHSA, it shall utilize State implementation procedures for these provisions and shall use funds from the SAMHSA discretionary grant to finance such alternative services, as needed;

(3) When a religious organization receives a discretionary grant from SAMHSA, if a publicly funded alternative provider is available that is reasonably accessible and can provide equivalent services, the religious organization shall refer the beneficiary to

that provider. However, if such a provider is not available, the religious organization shall contract with an alternative provider to provide such services and may finance such services with funds from the SAMHSA discretionary grant.

§ 54a.9 Oversight of the Charitable Choice requirements.

In order to ensure that program funds are used in compliance with the SAMHSA Charitable Choice provisions, applicants for funds under applicable programs are required, as part of their applications for funding, to certify that they will comply with all of the requirements of the SAMHSA Charitable Choice provisions and the implementing regulations under this part.

§ 54a.10 Fiscal accountability.

(a) Religious organizations that receive applicable program funds for substance abuse services are subject to the same regulations as other nongovernmental organizations to account, in accordance with generally accepted auditing and accounting principles, for the use of such funds.

(b) Religious organizations shall segregate Federal funds they receive under applicable programs into a separate account from non-Federal funds. Only the Federal funds shall be subject to audit by the government under the SAMHSA program.

§ 54a.11 Effect on State and local funds.

If a State or local government contributes its own funds to supplement activities carried out under the applicable programs, the State or local government has the option to separate out the Federal funds or commingle them. If the funds are commingled, the provisions of this part shall apply to all of the commingled funds, in the same manner, and to the same extent, as the provisions apply to the Federal funds.

§ 54a.12 Treatment of intermediate organizations.

If a nongovernmental organization (referred to here as an "intermediate organization"), acting under a contract or other agreement with the Federal Government or a State or local government, is given the authority under the contract or agreement to select nongovernmental organizations to provide services under any applicable program, the intermediate organization shall have the same duties under this part as the government. The intermediate organization retains all other rights of a nongovernmental organization under this part and the SAMHSA Charitable Choice provisions.

§ 54a.13 Educational requirements for personnel in drug treatment programs.

In determining whether personnel of a program participant that has a record of successful drug treatment for the preceding three years have satisfied State or local requirements for education and training, a State or local government shall not discriminate against education and training provided to such personnel by a religious organization, so long as such education and training is comparable to that provided by nonreligious organizations, or is comparable to education and training that the State or local government would otherwise credit for purposes of determining whether the relevant requirements have been satisfied.

§ 54a.14 Determination of nonprofit status.

The nonprofit status of any SAMHSA applicant can be determined by any of the following:

(a) Reference to the organization's listing in the Internal Revenue Service's (IRS) most recent list of tax-exempt organizations described in section 501(c)(3) of the IRS code.

(b) A copy of a currently valid IRS Tax exemption certificate.

(c) A statement from a State taxing body, State Attorney General, or other appropriate State official certifying that the applicant organization has a nonprofit status and that none of its net earnings accrue to any private shareholder or individuals.

(d) A certified copy of the organization's certificate of incorporation or similar document if it clearly establishes the nonprofit status of the organization.

(e) Any of the above proof for a State or national parent organization and a

statement signed by the parent organization that the applicant organization is a local nonprofit affiliate.

APPENDIX TO PART 54A—MODEL NOTICE OF INDIVIDUALS RECEIVING SUBSTANCE ABUSE SERVICES

MODEL NOTICE TO INDIVIDUALS RECEIVING SUBSTANCE ABUSE SERVICES

No provider of substance abuse services receiving Federal funds from the U.S. Substance Abuse and Mental Health Services Administration, including this organization, may discriminate against you on the basis of religion, a religious belief, a refusal to hold a religious belief, or a refusal to actively participate in a religious practice.

If you object to the religious character of this organization, Federal law gives you the right to a referral to another provider of substance abuse services. The referral, and your receipt of alternative services, must occur within a reasonable period of time after you request them. The alternative provider must be accessible to you and have the capacity to provide substance abuse services. The services provided to you by the alternative provider must be of a value not less than the value of the services you would have received from this organization.

PART 55a—PROGRAM GRANTS FOR BLACK LUNG CLINICS

Subpart A—General Provisions

Sec.

Subpart B—Grants to States

Subpart C—Grants to Entities Other Than States

AUTHORITY: Sec. 427(a), Federal Mine Safety and Health Act of 1977, 92 Stat. 100 (30 U.S.C. 937(a)).

SOURCE: 50 FR 7913, Feb. 27, 1985, unless otherwise noted.

Subpart A—General Provisions

§ 55a.101 Definitions.

Act, as used in this part, means the Federal Mine Safety and Health Act of 1977, as amended (30 U.S.C. 801 *et seq.*).

Secretary means the Secretary of Health and Human Services and any other officer or empolyee of the Department of Health and Human Services to whom the authority involved has been delegated.

Miner or *coal miner* means any individual who works or has worked in or around a coal mine or coal preparation facility in the extraction or preparation of coal. The term also includes an individual who works or has worked in coal mine construction or transportation in or around a coal mine, to the extent that the individual was exposed to coal dust as a result of employment.

§ 55a.102 Who is eligible to apply for a Black Lung clinics grant?

Any State or public or private entity may apply for a grant under this part.

§ 55a.103 What criteria has HHS established for deciding which grant application to fund?

(a) The Secretary will give preference to a State, which meets the requirements of this part and applies for a grant under this part, over other applicants in that State.

(b) Within the limits of funds available for these purposes the Secretary may award grants to assist in the carrying out of those programs which will in the Secretary's judgment best promote the purposes of section 427(a) of the Act, taking into account;

(1) The number of miners to be served and their needs; and

(2) The quality and breadth of services to be provided.

§ 55a.104 What confidentiality requirements must be met?

All information as to personal facts and circumstances obtained by the grantee's staff about recipients of services shall be held confidential and shall not be disclosed without the individual's consent except as may be required

V: Performance Indicators and Accomplishments

Table 14 - Treatment Performance Measure Employment/Education Status (From Admission to Discharge)

Short-term Residential(SR)

Employment/Education Status – Clients employed or student (full-time and part-time) (prior 30 days) at admission vs. discharge

	At Admission(T1)	At Discharge(T2)
Number of clients employed or student (full-time and part-time) [numerator]	731	708
Total number of clients with non-missing values on employment/student status [denominator]	5,386	5,386
Percent of clients employed or student (full-time and part-time)	13.6 %	13.1 %

Notes (for this level of care):	
Number of CY 2013 admissions submitted:	7,116
Number of CY 2013 discharges submitted:	6,958
Number of CY 2013 discharges linked to an admission:	5,744
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	5,662
Number of CY 2013 linked discharges eligible for this calculation (non-missing values):	5,386

Source: SAMHSA/CBHSQ TEDS CY 2013 admissions file and CY 2013 linked discharge file
[Records received through 5/2/2014]

Long-term Residential(LR)

Employment/Education Status – Clients employed or student (full-time and part-time) (prior 30 days) at admission vs. discharge

	At Admission(T1)	At Discharge(T2)
Number of clients employed or student (full-time and part-time) [numerator]	284	1,026
Total number of clients with non-missing values on employment/student status [denominator]	4,116	4,116
Percent of clients employed or student (full-time and part-time)	6.9 %	24.9 %

Notes (for this level of care):	
Number of CY 2013 admissions submitted:	5,515
Number of CY 2013 discharges submitted:	5,250
Number of CY 2013 discharges linked to an admission:	4,435

Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	4,269
Number of CY 2013 linked discharges eligible for this calculation (non-missing values):	4,116

Source: SAMHSA/CBHSQ TEDS CY 2013 admissions file and CY 2013 linked discharge file
[Records received through 5/2/2014]

Outpatient (OP)

Employment/Education Status – Clients employed or student (full-time and part-time) (prior 30 days) at admission vs. discharge

	At Admission(T1)	At Discharge(T2)
Number of clients employed or student (full-time and part-time) [numerator]	5,751	6,996
Total number of clients with non-missing values on employment/student status [denominator]	10,902	10,902
Percent of clients employed or student (full-time and part-time)	52.8 %	64.2 %

Notes (for this level of care):	
Number of CY 2013 admissions submitted:	28,887
Number of CY 2013 discharges submitted:	26,064
Number of CY 2013 discharges linked to an admission:	14,205
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	11,174
Number of CY 2013 linked discharges eligible for this calculation (non-missing values):	10,902

Source: SAMHSA/CBHSQ TEDS CY 2013 admissions file and CY 2013 linked discharge file
[Records received through 5/2/2014]

Intensive Outpatient (IO)

Employment/Education Status – Clients employed or student (full-time and part-time) (prior 30 days) at admission vs. discharge

	At Admission(T1)	At Discharge(T2)
Number of clients employed or student (full-time and part-time) [numerator]	2,549	3,561
Total number of clients with non-missing values on employment/student status [denominator]	8,542	8,542
Percent of clients employed or student (full-time and part-time)	29.8 %	41.7 %

Notes (for this level of care):	
Number of CY 2013 admissions submitted:	18,870
Number of CY 2013 discharges submitted:	17,040
Number of CY 2013 discharges linked to an admission:	9,776

Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	8,879
Number of CY 2013 linked discharges eligible for this calculation (non-missing values):	8,542

Source: SAMHSA/CBHSQ TEDS CY 2013 admissions file and CY 2013 linked discharge file
[Records received through 5/2/2014]

footnote:
DMHAS has opted to use the pre-populated data.

V: Performance Indicators and Accomplishments

Table 15 - Treatment Performance Measure Stability of Housing (From Admission to Discharge)

Short-term Residential(SR)

Stability of Housing – Clients reporting being in a stable living situation (prior 30 days) at admission vs. discharge

	At Admission(T1)	At Discharge(T2)
Number of clients in a stable living situation [numerator]	5,078	5,019
Total number of clients with non-missing values on living arrangements [denominator]	5,439	5,439
Percent of clients in stable living situation	93.4 %	92.3 %

Notes (for this level of care):	
Number of CY 2013 admissions submitted:	7,116
Number of CY 2013 discharges submitted:	6,958
Number of CY 2013 discharges linked to an admission:	5,744
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	5,662
Number of CY 2013 linked discharges eligible for this calculation (non-missing values):	5,439

Source: SAMHSA/CBHSQ TEDS CY 2013 admissions file and CY 2013 linked discharge file
[Records received through 5/2/2014]

Long-term Residential(LR)

Stability of Housing – Clients reporting being in a stable living situation (prior 30 days) at admission vs. discharge

	At Admission(T1)	At Discharge(T2)
Number of clients in a stable living situation [numerator]	3,625	3,654
Total number of clients with non-missing values on living arrangements [denominator]	4,206	4,206
Percent of clients in stable living situation	86.2 %	86.9 %

Notes (for this level of care):	
Number of CY 2013 admissions submitted:	5,515
Number of CY 2013 discharges submitted:	5,250
Number of CY 2013 discharges linked to an admission:	4,435

Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	4,269
Number of CY 2013 linked discharges eligible for this calculation (non-missing values):	4,206

Source: SAMHSA/CBHSQ TEDS CY 2013 admissions file and CY 2013 linked discharge file
[Records received through 5/2/2014]

Outpatient (OP)

Stability of Housing – Clients reporting being in a stable living situation (prior 30 days) at admission vs. discharge

	At Admission(T1)	At Discharge(T2)
Number of clients in a stable living situation [numerator]	10,740	10,734
Total number of clients with non-missing values on living arrangements [denominator]	11,024	11,024
Percent of clients in stable living situation	97.4 %	97.4 %

Notes (for this level of care):	
Number of CY 2013 admissions submitted:	28,887
Number of CY 2013 discharges submitted:	26,064
Number of CY 2013 discharges linked to an admission:	14,205
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	11,174
Number of CY 2013 linked discharges eligible for this calculation (non-missing values):	11,024

Source: SAMHSA/CBHSQ TEDS CY 2013 admissions file and CY 2013 linked discharge file
[Records received through 5/2/2014]

Intensive Outpatient (IO)

Stability of Housing – Clients reporting being in a stable living situation (prior 30 days) at admission vs. discharge

	At Admission(T1)	At Discharge(T2)
Number of clients in a stable living situation [numerator]	8,414	8,384
Total number of clients with non-missing values on living arrangements [denominator]	8,771	8,771
Percent of clients in stable living situation	95.9 %	95.6 %

Notes (for this level of care):	
Number of CY 2013 admissions submitted:	18,870
Number of CY 2013 discharges submitted:	17,040
Number of CY 2013 discharges linked to an admission:	9,776

Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	8,879
Number of CY 2013 linked discharges eligible for this calculation (non-missing values):	8,771

Source: SAMHSA/CBHSQ TEDS CY 2013 admissions file and CY 2013 linked discharge file
[Records received through 5/2/2014]

footnote:

V: Performance Indicators and Accomplishments

Table 16 - Treatment Performance Measure Criminal Justice Involvement (From Admission to Discharge)

Short-term Residential(SR)

Clients without arrests (any charge) (prior 30 days) at admission vs. discharge

	At Admission(T1)	At Discharge(T2)
Number of Clients without arrests [numerator]	5,136	5,595
Total number of Admission and Discharge clients with non-missing values on arrests [denominator]	5,694	5,694
Percent of clients without arrests	90.2 %	98.3 %

Notes (for this level of care):	
Number of CY 2013 admissions submitted:	7,116
Number of CY 2013 discharges submitted:	6,958
Number of CY 2013 discharges linked to an admission:	5,744
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	5,694
Number of CY 2013 linked discharges eligible for this calculation (non-missing values):	5,694

Source: SAMHSA/CBHSQ TEDS CY 2013 admissions file and CY 2013 linked discharge file
[Records received through 5/2/2014]

Long-term Residential(LR)

Clients without arrests (any charge) (prior 30 days) at admission vs. discharge

	At Admission(T1)	At Discharge(T2)
Number of Clients without arrests [numerator]	4,140	4,256
Total number of Admission and Discharge clients with non-missing values on arrests [denominator]	4,342	4,342
Percent of clients without arrests	95.3 %	98.0 %

Notes (for this level of care):	
Number of CY 2013 admissions submitted:	5,515
Number of CY 2013 discharges submitted:	5,250
Number of CY 2013 discharges linked to an admission:	4,435

Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	4,344
Number of CY 2013 linked discharges eligible for this calculation (non-missing values):	4,342

Source: SAMHSA/CBHSQ TEDS CY 2013 admissions file and CY 2013 linked discharge file
[Records received through 5/2/2014]

Outpatient (OP)

Clients without arrests (any charge) (prior 30 days) at admission vs. discharge

	At Admission(T1)	At Discharge(T2)
Number of Clients without arrests [numerator]	11,115	11,174
Total number of Admission and Discharge clients with non-missing values on arrests [denominator]	11,506	11,506
Percent of clients without arrests	96.6 %	97.1 %

Notes (for this level of care):	
Number of CY 2013 admissions submitted:	28,887
Number of CY 2013 discharges submitted:	26,064
Number of CY 2013 discharges linked to an admission:	14,205
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	11,512
Number of CY 2013 linked discharges eligible for this calculation (non-missing values):	11,506

Source: SAMHSA/CBHSQ TEDS CY 2013 admissions file and CY 2013 linked discharge file
[Records received through 5/2/2014]

Intensive Outpatient (IO)

Clients without arrests (any charge) (prior 30 days) at admission vs. discharge

	At Admission(T1)	At Discharge(T2)
Number of Clients without arrests [numerator]	8,744	8,929
Total number of Admission and Discharge clients with non-missing values on arrests [denominator]	9,255	9,255
Percent of clients without arrests	94.5 %	96.5 %

Notes (for this level of care):	
Number of CY 2013 admissions submitted:	18,870
Number of CY 2013 discharges submitted:	17,040
Number of CY 2013 discharges linked to an admission:	9,776

Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	9,258
Number of CY 2013 linked discharges eligible for this calculation (non-missing values):	9,255

Source: SAMHSA/CBHSQ TEDS CY 2013 admissions file and CY 2013 linked discharge file
[Records received through 5/2/2014]

footnote:

V: Performance Indicators and Accomplishments

Table 17 - Treatment Performance Measure Change in Abstinence - Alcohol Use (From Admission to Discharge)

Short-term Residential(SR)

A. ALCOHOL ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)
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]	4,097	5,605
All clients with non-missing values on at least one substance/frequency of use [denominator]	5,625	5,625
Percent of clients abstinent from alcohol	72.8 %	99.6 %

B. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL USERS 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]		1,512
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	1,528	
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T2 / #T1 x 100]		99.0 %

C. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL 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]		4,093
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	4,097	
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T2 / #T1 x 100]		99.9 %

Notes (for this level of care):	
Number of CY 2013 admissions submitted:	7,116
Number of CY 2013 discharges submitted:	6,958
Number of CY 2013 discharges linked to an admission:	5,744
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	5,694
Number of CY 2013 linked discharges eligible for this calculation (non-missing values):	5,625

Source: SAMHSA/CBHSQ TEDS CY 2013 admissions file and CY 2013 linked discharge file
[Records received through 5/2/2014]

Long-term Residential(LR)

A. ALCOHOL ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)
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]	3,676	4,225
All clients with non-missing values on at least one substance/frequency of use [denominator]	4,291	4,291
Percent of clients abstinent from alcohol	85.7 %	98.5 %

B. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL USERS 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]		598
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	615	
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T2 / #T1 x 100]		97.2 %

C. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL 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]		3,627
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	3,676	
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T2 / #T1 x 100]		98.7 %

Notes (for this level of care):	
Number of CY 2013 admissions submitted:	5,515
Number of CY 2013 discharges submitted:	5,250
Number of CY 2013 discharges linked to an admission:	4,435
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	4,344
Number of CY 2013 linked discharges eligible for this calculation (non-missing values):	4,291

Source: SAMHSA/CBHSQ TEDS CY 2013 admissions file and CY 2013 linked discharge file
[Records received through 5/2/2014]

Outpatient (OP)

A. ALCOHOL ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)
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]	7,860	10,833
All clients with non-missing values on at least one substance/frequency of use [denominator]	11,416	11,416
Percent of clients abstinent from alcohol	68.9 %	94.9 %

B. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL USERS 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]		3,178
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	3,556	
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T2 / #T1 x 100]		89.4 %

C. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL 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]		7,655
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	7,860	
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T2 / #T1 x 100]		97.4 %

Notes (for this level of care):	
Number of CY 2013 admissions submitted:	28,887
Number of CY 2013 discharges submitted:	26,064
Number of CY 2013 discharges linked to an admission:	14,205
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	11,512
Number of CY 2013 linked discharges eligible for this calculation (non-missing values):	11,416

Source: SAMHSA/CBHSQ TEDS CY 2013 admissions file and CY 2013 linked discharge file
[Records received through 5/2/2014]

Intensive Outpatient (IO)

A. ALCOHOL ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)
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]	6,716	8,671

All clients with non-missing values on at least one substance/frequency of use [denominator]	9,155	9,155
Percent of clients abstinent from alcohol	73.4 %	94.7 %

B. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL USERS 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]		2,126
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	2,439	
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T2 / #T1 x 100]		87.2 %

C. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL 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]		6,545
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	6,716	
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T2 / #T1 x 100]		97.5 %

Notes (for this level of care):	
Number of CY 2013 admissions submitted:	18,870
Number of CY 2013 discharges submitted:	17,040
Number of CY 2013 discharges linked to an admission:	9,776
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	9,258
Number of CY 2013 linked discharges eligible for this calculation (non-missing values):	9,155

Source: SAMHSA/CBHSQ TEDS CY 2013 admissions file and CY 2013 linked discharge file
[Records received through 5/2/2014]

footnote:

V: Performance Indicators and Accomplishments

Table 18 - Treatment Performance Measure Change in Abstinence - Other Drug Use (From Admission to Discharge)

Short-term Residential(SR)

A. DRUG ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)
Drug Abstinence – Clients with no Drug 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 drugs [numerator]	1,465	5,542
All clients with non-missing values on at least one substance/frequency of use [denominator]	5,625	5,625
Percent of clients abstinent from drugs	26.0 %	98.5 %

B. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG USERS AT ADMISSION
Clients abstinent from Drug at discharge among clients using Drug 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]		4,086
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	4,160	
Percent of clients abstinent from drugs at discharge among clients using Drug at admission [#T2 / #T1 x 100]		98.2 %

C. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG ABSTINENT AT ADMISSION
Clients abstinent from Drug at discharge among clients abstinent from Drug 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]		1,456
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	1,465	
Percent of clients abstinent from drugs at discharge among clients abstinent from Drug at admission [#T2 / #T1 x 100]		99.4 %

Notes (for this level of care):	
Number of CY 2013 admissions submitted:	7,116
Number of CY 2013 discharges submitted:	6,958
Number of CY 2013 discharges linked to an admission:	5,744
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	5,694
Number of CY 2013 linked discharges eligible for this calculation (non-missing values):	5,625

Source: SAMHSA/CBHSQ TEDS CY 2013 admissions file and CY 2013 linked discharge file
[Records received through 5/2/2014]

Long-term Residential(LR)

A. DRUG ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)
Drug Abstinence – Clients with no Drug 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 drugs [numerator]	2,352	4,092
All clients with non-missing values on at least one substance/frequency of use [denominator]	4,291	4,291
Percent of clients abstinent from drugs	54.8 %	95.4 %

B. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG USERS AT ADMISSION
Clients abstinent from Drug at discharge among clients using Drug 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]		1,846
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	1,939	
Percent of clients abstinent from drugs at discharge among clients using Drug at admission [#T2 / #T1 x 100]		95.2 %

C. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG ABSTINENT AT ADMISSION
Clients abstinent from Drug at discharge among clients abstinent from Drug 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]		2,246
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	2,352	
Percent of clients abstinent from drugs at discharge among clients abstinent from Drug at admission [#T2 / #T1 x 100]		95.5 %

Notes (for this level of care):	
Number of CY 2013 admissions submitted:	5,515
Number of CY 2013 discharges submitted:	5,250
Number of CY 2013 discharges linked to an admission:	4,435
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	4,344
Number of CY 2013 linked discharges eligible for this calculation (non-missing values):	4,291

Source: SAMHSA/CBHSQ TEDS CY 2013 admissions file and CY 2013 linked discharge file
[Records received through 5/2/2014]

Outpatient (OP)

A. DRUG ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)
Drug Abstinence – Clients with no Drug 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 drugs [numerator]	8,050	10,272
All clients with non-missing values on at least one substance/frequency of use [denominator]	11,416	11,416
Percent of clients abstinent from drugs	70.5 %	90.0 %

B. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG USERS AT ADMISSION
Clients abstinent from Drug at discharge among clients using Drug 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]		2,693
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	3,366	
Percent of clients abstinent from drugs at discharge among clients using Drug at admission [#T2 / #T1 x 100]		80.0 %

C. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG ABSTINENT AT ADMISSION
Clients abstinent from Drug at discharge among clients abstinent from Drug 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]		7,579
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	8,050	
Percent of clients abstinent from drugs at discharge among clients abstinent from Drug at admission [#T2 / #T1 x 100]		94.1 %

Notes (for this level of care):	
Number of CY 2013 admissions submitted:	28,887
Number of CY 2013 discharges submitted:	26,064
Number of CY 2013 discharges linked to an admission:	14,205
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	11,512
Number of CY 2013 linked discharges eligible for this calculation (non-missing values):	11,416

Source: SAMHSA/CBHSQ TEDS CY 2013 admissions file and CY 2013 linked discharge file
[Records received through 5/2/2014]

Intensive Outpatient (IO)

A. DRUG ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)
Drug Abstinence – Clients with no Drug 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 drugs [numerator]	4,502	7,769

All clients with non-missing values on at least one substance/frequency of use [denominator]	9,155	9,155
Percent of clients abstinent from drugs	49.2 %	84.9 %

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

Clients abstinent from Drug at discharge among clients using Drug 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]		3,594
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	4,653	
Percent of clients abstinent from drugs at discharge among clients using Drug at admission [#T2 / #T1 x 100]		77.2 %

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

Clients abstinent from Drug at discharge among clients abstinent from Drug 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]		4,175
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	4,502	
Percent of clients abstinent from drugs at discharge among clients abstinent from Drug at admission [#T2 / #T1 x 100]		92.7 %

Notes (for this level of care):	
Number of CY 2013 admissions submitted:	18,870
Number of CY 2013 discharges submitted:	17,040
Number of CY 2013 discharges linked to an admission:	9,776
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	9,258
Number of CY 2013 linked discharges eligible for this calculation (non-missing values):	9,155

Source: SAMHSA/CBHSQ TEDS CY 2013 admissions file and CY 2013 linked discharge file
[Records received through 5/2/2014]

footnote:

V: Performance Indicators and Accomplishments

Table 19 - Treatment Performance Measure Change in Social Support Of Recovery (From Admission to Discharge)

Short-term Residential(SR)

Social Support of Recovery – Clients attending Self-help Programs (e.g., AA, NA, etc.) (prior 30 days) at admission vs. discharge

	At Admission(T1)	At Discharge(T2)
Number of clients attending self-help programs [numerator]	185	350
Total number of clients with non-missing values on self-help attendance [denominator]	360	360
Percent of clients attending self-help programs	51.4 %	97.2 %
Percent of clients with self-help attendance at discharge minus percent of clients with self-help attendance at admission Absolute Change [%T2-%T1]	45.8 %	
Notes (for this level of care):		
Number of CY 2013 admissions submitted:		7,116
Number of CY 2013 discharges submitted:		6,958
Number of CY 2013 discharges linked to an admission:		5,744
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):		5,694
Number of CY 2013 linked discharges eligible for this calculation (non-missing values):		360

Source: SAMHSA/CBHSQ TEDS CY 2013 admissions file and CY 2013 linked discharge file
[Records received through 5/2/2014]

Long-term Residential(LR)

Social Support of Recovery – Clients attending Self-help Programs (e.g., AA, NA, etc.) (prior 30 days) at admission vs. discharge

	At Admission(T1)	At Discharge(T2)
Number of clients attending self-help programs [numerator]	535	919
Total number of clients with non-missing values on self-help attendance [denominator]	933	933
Percent of clients attending self-help programs	57.3 %	98.5 %
Percent of clients with self-help attendance at discharge minus percent of clients with self-help attendance at admission Absolute Change [%T2-%T1]	41.2 %	
Notes (for this level of care):		
Number of CY 2013 admissions submitted:		5,515
Number of CY 2013 discharges submitted:		5,250

Number of CY 2013 discharges linked to an admission:	4,435
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	4,344
Number of CY 2013 linked discharges eligible for this calculation (non-missing values):	933

Source: SAMHSA/CBHSQ TEDS CY 2013 admissions file and CY 2013 linked discharge file
[Records received through 5/2/2014]

Outpatient (OP)

Social Support of Recovery – Clients attending Self-help Programs (e.g., AA, NA, etc.) (prior 30 days) at admission vs. discharge

	At Admission(T1)	At Discharge(T2)
Number of clients attending self-help programs [numerator]	235	403
Total number of clients with non-missing values on self-help attendance [denominator]	758	758
Percent of clients attending self-help programs	31.0 %	53.2 %
Percent of clients with self-help attendance at discharge minus percent of clients with self-help attendance at admission Absolute Change [%T2-%T1]	22.2 %	

Notes (for this level of care):	
Number of CY 2013 admissions submitted:	28,887
Number of CY 2013 discharges submitted:	26,064
Number of CY 2013 discharges linked to an admission:	14,205
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	11,512
Number of CY 2013 linked discharges eligible for this calculation (non-missing values):	758

Source: SAMHSA/CBHSQ TEDS CY 2013 admissions file and CY 2013 linked discharge file
[Records received through 5/2/2014]

Intensive Outpatient (IO)

Social Support of Recovery – Clients attending Self-help Programs (e.g., AA, NA, etc.) (prior 30 days) at admission vs. discharge

	At Admission(T1)	At Discharge(T2)
Number of clients attending self-help programs [numerator]	284	352
Total number of clients with non-missing values on self-help attendance [denominator]	580	580
Percent of clients attending self-help programs	49.0 %	60.7 %
Percent of clients with self-help attendance at discharge minus percent of clients with self-help attendance at admission Absolute Change [%T2-%T1]	11.7 %	

Notes (for this level of care):

Number of CY 2013 admissions submitted:	18,870
Number of CY 2013 discharges submitted:	17,040
Number of CY 2013 discharges linked to an admission:	9,776
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	9,258
Number of CY 2013 linked discharges eligible for this calculation (non-missing values):	580

Source: SAMHSA/CBHSQ TEDS CY 2013 admissions file and CY 2013 linked discharge file
[Records received through 5/2/2014]

footnote:

V: Performance Indicators and Accomplishments

Table 20 - Retention - Length of Stay (in Days) of Clients Completing Treatment

Manually Enter Data

Level of Care	Average (Mean)	25th Percentile	50th Percentile (Median)	75th Percentile
DETOXIFICATION (24-HOUR CARE)				
1. Hospital Inpatient	29	3	3	4
2. Free-Standing Residential	6	4	5	7
REHABILITATION/RESIDENTIAL				
3. Hospital Inpatient	16	8	14	27
4. Short-term (up to 30 days)	24	12	22	28
5. Long-term (over 30 days)	112	46	103	162
AMBULATORY (OUTPATIENT)				
6. Outpatient	111	36	88	139
7. Intensive Outpatient	89	27	63	109
8. Detoxification	7	5	5	7
OPIOID REPLACEMENT THERAPY				
9. Opioid Replacement Therapy	19	3	5	6
10. ORT Outpatient	449	61	176	543

Level of Care	2013 TEDS discharge record count	
	Discharges submitted	Discharges linked to an admission
DETOXIFICATION (24-HOUR CARE)		
1. Hospital Inpatient	1284	251
2. Free-Standing Residential	8500	3396
REHABILITATION/RESIDENTIAL		

3. Hospital Inpatient	7	3
4. Short-term (up to 30 days)	6958	5744
5. Long-term (over 30 days)	5250	4435
AMBULATORY (OUTPATIENT)		
6. Outpatient	26064	11533
7. Intensive Outpatient	17040	9776
8. Detoxification	381	32
OPIOID REPLACEMENT THERAPY		
9. Opioid Replacement Therapy	0	2735
10. ORT Outpatient	0	2672

Source: SAMHSA/CBHSQ TEDS CY 2013 admissions file and CY 2013 linked discharge file
[Records received through 5/2/2014]

footnote:

V: Performance Indicators and Accomplishments

Table 21 - Prevention Performance Measures - 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.		
	Age 12 - 17 - CY 2011 - 2012	19.8	
	Age 18+ - CY 2011 - 2012	59.9	
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.] Outcome Reported: Percent who reported having smoked a cigarette during the past 30 days.		
	Age 12 - 17 - CY 2011 - 2012	7.1	
	Age 18+ - CY 2011 - 2012	22.2	
3. 30-day Use of Other Tobacco Products	Survey Item: NSDUH Questionnaire: "During the past 30 days, that is, since [DATEFILL], on how many days did you use [other tobacco products][1]?[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, calculated by combining responses to questions about individual tobacco products (snuff, chewing tobacco, pipe tobacco).		
	Age 12 - 17 - CY 2011 - 2012	3.6	
	Age 18+ - CY 2011 - 2012	4.9	
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.		
	Age 12 - 17 - CY 2011 - 2012	6.4	
	Age 18+ - CY 2011 - 2012	5.5	
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]?[2] 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).		
	Age 12 - 17 - CY 2011 - 2012	3.3	
	Age 18+ - CY 2011 - 2012	3.3	

[1]NSDUH asks separate questions for each tobacco product. The number provided combines responses to all questions about tobacco products other than cigarettes.
[2]NSDUH asks separate questions for each illegal drug. The number provided combines responses to all questions about illegal drugs other than marijuana or hashish.

footnote:

V: Performance Indicators and Accomplishments

Table 22 - Prevention Performance Measures - 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.		
	Age 12 - 17 - CY 2011 - 2012	78.4	
	Age 18+ - CY 2011 - 2012	82.3	
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.		
	Age 12 - 17 - CY 2011 - 2012	93.7	
	Age 18+ - CY 2011 - 2012	94.8	
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.		
	Age 12 - 17 - CY 2011 - 2012	77.9	
	Age 18+ - CY 2011 - 2012	73.2	

footnote:

V: Performance Indicators and Accomplishments

Table 23 - Prevention Performance Measures - 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.] Outcome Reported: Average age at first use of alcohol.risk.		
	Age 12 - 17 - CY 2011 - 2012	13.9	
	Age 18+ - CY 2011 - 2012	17.7	
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.] Outcome Reported: Average age at first use of cigarettes.		
	Age 12 - 17 - CY 2011 - 2012	14.2	
	Age 18+ - CY 2011 - 2012	16.1	
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][1]?[Response option: Write in age at first use.] Outcome Reported: Average age at first use of tobacco products other than cigarettes.		
	Age 12 - 17 - CY 2011 - 2012	14.2	
	Age 18+ - CY 2011 - 2012	21.1	
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.] Outcome Reported: Average age at first use of marijuana or hashish.		
	Age 12 - 17 - CY 2011 - 2012	14.5	
	Age 18+ - CY 2011 - 2012	18.1	
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][2]?[Response option: Write in age at first use.] Outcome Reported: Average age at first use of other illegal drugs.		
	Age 12 - 17 - CY 2011 - 2012	13.1	
	Age 18+ - CY 2011 - 2012	21.1	

[1]The question was asked about each tobacco product separately, and the youngest age at first use was taken as the measure.
[2]The question was asked about each drug in this category separately, and the youngest age at first use was taken as the measure.

footnote:

V: Performance Indicators and Accomplishments

Table 24 - Prevention Performance Measures - 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	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] Outcome Reported: Percent somewhat or strongly disapproving.		
	Age 12 - 17 - CY 2011 - 2012	92.1	
2. Perception of Peer Disapproval of Cigarettes	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] Outcome Reported: Percent reporting that their friends would somewhat or strongly disapprove.		
	Age 12 - 17 - CY 2011 - 2012	91.7	
3. Disapproval of Using Marijuana Experimentally	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] Outcome Reported: Percent somewhat or strongly disapproving.		
	Age 12 - 17 - CY 2011 - 2012	78.3	
4. Disapproval of Using Marijuana Regularly	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] Outcome Reported: Percent somewhat or strongly disapproving.		
	Age 12 - 17 - CY 2011 - 2012	76.9	
5. Disapproval of Alcohol	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] Outcome Reported: Percent somewhat or strongly disapproving.		
	Age 12 - 17 - CY 2011 - 2012	89.0	

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V: Performance Indicators and Accomplishments

Table 25 - Prevention Performance Measures - Employment/Education; Measure: Perception of Workplace Policy

A. Measure	B. Question/Response	C. Pre-populated Data	D. Approved Substitute Data
Perception of Workplace Policy	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] Outcome Reported: Percent reporting that they would be more likely to work for an employer conducting random drug and alcohol tests.		
	Age 18+ - CY 2011 - 2012	25.1	
	Age 12 - 17 - CY 2011 - 2012		

footnote:

V: Performance Indicators and Accomplishments

Table 26 - Prevention Performance Measures - 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	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. Measure calculation: Average daily attendance (NCES defined) divided by total enrollment and multiplied by 100.		
	School Year 2012	95.5	

footnote:

V: Performance Indicators and Accomplishments

Table 27 - Prevention Performance Measures - 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	Source: National Highway Traffic Safety Administration Fatality Analysis Reporting System Measure calculation: The number of alcohol-related traffic fatalities divided by the total number of traffic fatalities and multiplied by 100.		
	CY 2011 - 2012	35.8	

footnote:

V: Performance Indicators and Accomplishments

Table 28 - Prevention Performance Measures - 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	Source: Federal Bureau of Investigation Uniform Crime Reports Measure calculation: The number of alcohol- and drug-related arrests divided by the total number of arrests and multiplied by 100.		
	CY 2011	24.9	

footnote:

V: Performance Indicators and Accomplishments

Table 29 - Prevention Performance Measures - 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 (Youth)	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.		
	Age 12 - 17 - CY 2011 - 2012	59.6	
2. Family Communications Around Drug and Alcohol Use (Parents of children aged 12-17)	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?[1][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.		
	Age 18+ - CY 2011 - 2012		

[1]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.

footnote:

V: Performance Indicators and Accomplishments

Table 30 - Prevention Performance Measures - 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	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][1]? Outcome Reported: Percent reporting having been exposed to prevention message.		
	Age 12 - 17 - CY 2011 - 2012	93.8	

[1]This is a summary of four separate NSDUH questions each asking about a specific type of prevention message delivered within a specific context having been exposed to prevention message.

footnote:

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Table 31-35 - Reporting Period - Start and End Dates for Information Reported on Tables 31, 32, 33, 34, and 35

Reporting Period Start and End Dates for Information Reported on Tables 33, 34, 35, 36 and 37
Please indicate the reporting period (start date and end date totaling 12 months by the State) for each of the following forms:

Tables	A. Reporting Period Start Date	B. Reporting Period End Date
1. Table 31 - Prevention Performance Measures - Individual-Based Programs and Strategies; Measure: Number of Persons Served By Age, Gender, Race, And Ethnicity	1/1/2012	12/31/2012
2. Table 32 - Prevention Performance Measures - Population-Based Programs And Strategies; Measure: Number of Persons Served By Age, Gender, Race, And Ethnicity	1/1/2012	12/31/2012
3. Table 33 - Prevention Performance Measures - Number of Persons Served by Type of Intervention	1/1/2012	12/31/2012
4. Table 34 - Prevention Performance Measures - Number of Evidence-Based Programs by Types of Intervention	1/1/2012	12/31/2012
5. Table 35 - Prevention Performance Measures - Total Number of Evidence-Based Programs and Total SAPTBG Dollars Spent on Evidence-Based Programs/Strategies	10/1/2011	9/30/2012

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

New Jersey's web-based prevention outcomes management system (POMS) and manual process

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 thes State added those participants to the number for each applicable racial category or whether the State added all those partipants to the More Than One Race subcategory.

Those participants are only included in the more than one race category.

footnote:

V: Performance Indicators and Accomplishments

Table 31 - Prevention Performance Measures - Individual-Based Programs and Strategies; Measure: Number of Persons Served By Age, Gender, Race, And Ethnicity

Category	Total
Age	
0-4	1293
5-11	30624
12-14	13293
15-17	3597
18-20	770
21-24	616
25-44	6765
45-64	3548
65 and over	2887
Age Not Known	0
Gender	
Male	29612
Female	33781
Gender Unknown	0
Race	
White	23991
Black or African American	17540
Native Hawaiian/Other Pacific Islander	50
Asian	2277
American Indian/Alaska Native	82
More Than One Race (not OMB required)	3504

Race Not Known or Other (not OMB required)	15949
Ethnicity	
Hispanic or Latino	13404
Not Hispanic or Latino	49989

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

New Jersey's web-based prevention outcomes management system (POMS) and manual process

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 thes State added those participants to the number for each applicable racial category or whether the State added all those partipants to the More Than One Race subcategory.

Those participants are only included in the more than one race category.

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V: Performance Indicators and Accomplishments

Table 32 - Prevention Performance Measures - Population-Based Programs And Strategies; Measure: Number of Persons Served By Age, Gender, Race, And Ethnicity

Category	Total
Age	
0-4	1850
5-11	20700
12-14	19600
15-17	17525
18-20	31000
21-24	34700
25-44	16200
45-64	14000
65 and over	8500
Age Not Known	0
Gender	
Male	80397
Female	83678
Gender Unknown	0
Race	
White	83600
Black or African American	53200
Native Hawaiian/Other Pacific Islander	175
Asian	10000
American Indian/Alaska Native	715
More Than One Race (not OMB required)	1975

Race Not Known or Other (not OMB required)	14410
Ethnicity	
Hispanic or Latino	24611
Not Hispanic or Latino	139464

footnote:

V: Performance Indicators and Accomplishments

Table 33 - Prevention Performance Measures - Number of Persons Served by Type of Intervention

Number of Persons Served by Individual- or Population-Based Program or Strategy

Intervention Type	A. Individual-Based Programs and Strategies	B. Population-Based Programs and Strategies
1. Universal Direct	48806	N/A
2. Universal Indirect	N/A	164075
3. Selective	8869	N/A
4. Indicated	5718	N/A
5. Total	63393	164075

footnote:

V: Performance Indicators and Accomplishments

Table 34 - Prevention Performance Measures - Number of Evidence-Based Programs by Types of Intervention

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

All prevention programs and strategies funded by DMHAS must meet at least one of the above criteria.

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

Contracts with funded agencies or coalitions describe the program or strategy being used.

Table 34 - SUBSTANCE ABUSE PREVENTION Number of Evidence-Based Programs and Strategies by Type of Intervention

	A. Universal Direct	B. Universal Indirect	C. Universal Total	D. Selective	E. Indicated	F. Total
1. Number of Evidence-Based Programs and Strategies Funded	6	7	13	7	8	28
2. Total number of Programs and Strategies Funded	6	7	13	7	8	28
3. Percent of Evidence-Based Programs and Strategies	100.00 %	100.00 %	100.00 %	100.00 %	100.00 %	100.00 %

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Table 35 - Prevention Performance Measures - Total Number of Evidence-Based Programs and Total SAPTBG Dollars Spent on Evidence-Based Programs/Strategies

	Total Number of Evidence-Based Programs/Strategies for IOM Category Below	Total SAPT Block Grant Dollars Spent on evidence-based Programs/Strategies
Universal Direct	Total # 6	$ 2209870.00
Universal Indirect	Total # 7	$ 3318608.00
Selective	Total # 7	$ 2425537.00
Indicated	Total # 8	$ 3741518.00
	Total EBPs: 28	Total Dollars Spent: $11695533.00

footnote:

V: Performance Indicators and Accomplishments

Prevention Attachments

Submission Uploads

FFY 2013 Prevention Attachment Category A:		Browse...	Upload
FFY 2013 Prevention Attachment Category B:		Browse...	Upload
FFY 2013 Prevention Attachment Category C:		Browse...	Upload
FFY 2013 Prevention Attachment Category D:		Browse...	Upload

footnote:

MAINTENANCE OF EFFORT (MOE) CALCULATIONS FOR SFY 2014: SUBSTANCE ABUSE PREVENTION AND TREATMENT (SAPT) BLOCK GRANT

This Attachment, presented as a single document with four (4) sub-sections, explains the methodology for calculation for each of the four (4) Maintenance of Effort (MOE) tables, i.e., Tables 8a, 8b, 8c and 8d.

Specifically, the SAPT has four (4) distinct MOE requirements that must be observed: a) a statewide calculation; b) a separate calculation for services to individuals with tuberculosis; c) a separate calculation for services to individuals with HIV; and, finally, d) a separate calculation for pregnant women and women with dependent children (PW/WDC). The ensuing narratives target these respective federal requirements, and then describe the procedures for calculating the amounts to be reported for State Fiscal Year (SFY) 2014. With respect to the last three (3) subsets of MOE, displayed in Table 8b, Table 8c, and Table 8d, the original procedures used to calculate the base period amounts are summarized. They are the historical benchmarks against which current expenditures are measured.

REQUIREMENTS for STATEWIDE MOE: 45 CFR Part § 96.134

The Secretary may make a Block Grant for a fiscal year only if the State involved submits to the Secretary information sufficient for the Secretary to make the determination required in paragraph (a) of this section, which includes the dollar amount reflecting the aggregate State expenditures by the principal agency for authorized activities for the two State fiscal years preceding the fiscal year for which the State is applying for the grant. The base shall be calculated using Generally Accepted Accounting Principles and the composition of the base shall be applied consistently from year to year.

Methodology: Calculation of SAPT Block Grant (BG) Statewide Maintenance of Effort (MOE)

New Jersey's SAPT MOE is defined as general revenue and State dollars administered by the Division of Mental Health and Addiction Services (DMHAS), the SSA, within the New Jersey Department of Human Services; these funds include the following Appropriation Units and transfer accounts including:

100-054-7700-158 Funds transferred from NJ Administrative Office of Courts posted in this account
100-054-7700-159 Funds transferred from Department of Children and Families posted in this account
100-054-7700-161 Substance Abuse Treatment for DCP&P/Work First Mothers
100-054-7700-162 Community Based Substance Abuse Treatment and Prevention – State Share
100-054-7700-163 Medication Assisted Treatment Initiative
100-054-7700-165 Mutual Agreement Parolee Rehabilitation Project for Substance Abusers
100-054-7700-172 Licensing Costs
100-054-7700-176 Alcohol Education Rehabilitation and Enforcement Fund (AEREF)
100-054-7700-177 Drug Enforcement and Demand Reduction Fund; Program for the Deaf and Disabled
100-054-7700-178 Drug Enforcement and Demand Reduction Fund; Partnership for a Drug-Free NJ
760-054-7700-001 AEREF; funding for the Local Alcohol Authorities Expansion Program

The following two (2) accounts continue to be excluded from the calculation: the Intoxicated Driver Resources Center Fund (100-054-7700-175) and the Compulsive Gambling fund (100-054-7700-164).

Specifically, New Jersey's SAPT MOE calculation includes State expenditures through execution of interagency Memoranda of Agreements (MOA) with other State agencies. Specifically, funds transferred from New Jersey Administrative Office of Court are posted in account 100-054-7700-158; funds transferred from the NJ Department of Children and Families are posted in account 100-054-7700-159; and funds transferred from Department of Corrections and State Parole Board are posted in account 100-054-7700-165.

New Jersey's SAPT BG Statewide MOE calculation does not include costs derived from the Department of Treasury for rent, fringe benefits, and indirect costs.

New Jersey's MOE calculation does not include construction cost that is awarded through RFP. It is in alignment with SAPT Block Grant federal procedures per 42 USC 300x-3 (a); 45 CFR section 96.135 (a) (3), and (d) that Grant funds shall not be used to purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or any other facilities, or purchase major medical equipment.

Process to calculate New Jersey SAPT Statewide MOE

At the beginning of the State Fiscal Year (SFY), which extends from July 1st through June 30th, available resources from the identified accounts above are calculated to project the total amount available for the State SAPT MOE. Any changes in direct appropriations, MOA/MOU with other State agencies, and financial recording methodologies will impact SAPT MOE calculation. The projections are updated and reported on the DMHAS quarterly spending plan reports to the Department of Human Services (DHS).

A MOE analysis is conducted based on Year-To-Date encumbrance and expenditures, and future projections; it is monitored periodically to project any possible MOE deficiency.

At the end of State Fiscal Year, expenditures and unliquidated encumbrances are downloaded from the New Jersey Comprehensive Financial System (NJCFS). The report is generated by fund source and cost center to include costs that are defined in the above. Funding sources include all direct State Service, State Aid, dedicated fund, and Trust fund. Cost centers are the 4XXX lower level organization in NJCFS.

DESCRIPTION OF THE METHODS USED TO CALCULATE THE BASE AND MAINTENANCE OF EFFORT (MOE) AMOUNT FOR TUBERCULOSIS (TB) SERVICES

This narrative will repeat the methodology used to calculate and document the Tuberculosis (TB) Maintenance of Effort (MOE) base amount for substance abuse, by describing the following four (4) sequential steps:

(l) establishing nonfederal expenditures by the New Jersey Department of Health (DOH) for TB control activities during SFY 1991 and SFY 1992 to establish the base expenditure amount, and for each State Fiscal Year (SFY) thereafter to establish compliance with the TB MOE State expenditure requirement;

(2) determining the portion of these nonfederal expenditures by DOH for TB control activities provided to substance abusers with either diagnosed or suspected TB, and/or to substance abusers at risk of developing active TB because of their contact or reactor status, during SFY 1991, SFY 1992 and each SFY thereafter;

(3) a description of the methods used to calculate each of the nonfederal expenditure amounts cited in #2 above; and

(4) averaging the non-federal amounts spent in SFY 1991 and SFY 1992, respectively (i.e., the base amounts), both for all TB control activities, statewide, and for the portion expended for substance abuse related TB services, respectively.

Each of these nonfederal expenditure amounts, by State Fiscal Year (SFY), and the average expenditure amounts are detailed on the *TB MOE Expenditure Summary Chart*, below. Of note, this original calculation is again prepopulated and locked in Web BGAS as the TB Base chart on Table 8b.

The expenditures listed on row l (columns A and B) of the Expenditure Summary Chart include all those nonfederal funds spent by the DOH Tuberculosis Control Program [now the Tuberculosis Program within the Division of HIV, Sexually Transmitted Diseases, and Tuberculosis **(DHSTS)** statewide, for medical evaluation, diagnosis, treatment and prevention services provided to persons with either diagnosed or suspected TB, and/or to persons who were at risk of developing TB because of their contact or reactor status. These amounts are $1,579,967 for SFY 1991 and $1,752,586 for SFY 1992. The amount of $1,666,277 on row 1, column C represents the average of the sum of the expenditures itemized in row 1, column A for SFY 1991, and in row 1, column B for SFY 1992.

The expenditures listed on row 2 (columns A and B) of the TB MOE Expenditure Summary Chart represent nonfederal funds spent for TB control activities described above by the Tuberculosis Program for the portion of these services provided to substance abusers. These amounts are $208,556 for SFY 1991 and $231,341 for SFY 1992. The amount of $219,949 listed on row 2, column C represents the average of the sum of the expenditures itemized in; row 2, column A for SFY 1991, and in row 2, column B for SFY 1992. This amount constitutes the TB MOE base amount for substance abuse for SFY 1993, and all subsequent fiscal years. New Jersey established this TB MOE base amount, retroactively during FFY 1993; it required the development of a calculation formula described in detail after the summary chart.

TB MOE Expenditure Summary Chart	**TB MOE Expenditure Summary Chart**		
State Expenditures for:	SFY 1991	SFY 1992	Average of SFY 1991 & SFY 1992
TB Control Activities (Statewide)	$1,579,967	$1,752,586	$1,666,277
TB Control Activities (Substance Abuse Portion Only)	$ 208,556	$ 231,341	$ 219,949

Description of Methods to Calculate the TB MOE Base

1. The first step, (now updated annually), in calculating the TB nonfederal expenditures attributable to substance abuse was to determine an appropriate percentage of such expenditures which were allocable to substance abuse services. The best available data regarding substance abuse was from Center for Disease Control (CDC) databases used by the Department of Health (DOH) TB Program within the Division of Epidemiology, Environmental and Occupational Health Services of the New Jersey DOH. This data includes basic epidemiologic, demographic and surveillance information about each active TB case counted, beginning on January 1, 1993 through June 30, 1994, including information about clients' alcoholism and substance abuse status. Because of startup problems associated with gathering the data during the first six months of 1993, DHSS decided to use the 12¬month reporting period between July 1, 1993 and June 30, 1994, in order to determine the percentage of TB expenditures attributable to substance abusers. Specifically, a total of 539 active TB cases responded to the three (3) questions on the federal CDC client reporting format concerning substance abuse. The questions included use of injected and/or non-injected drugs and/or excess alcohol use during the past year. Of these 539 cases, 71 cases, or 13.2%, indicated in their responses that they were alcohol or substance abusers.

2. The second step consisted of establishing the nonfederal expenditures for the TB Control Program for SFY 1991, SFY 1992 and then multiplying each amount by 13.2%, in order to obtain totals for the portion of nonfederal TB expenditures attributable to services for alcoholism/substance abuse (as listed on row 2, columns A and B of the Expenditure Summary Chart for FFY 1991 and FFY 1992, respectively). The calculation of these TB expenditures is illustrated below:

SFY 1991 Expenditures of $1,579,967 X 13.2% = $ 208,556
SFY 1992 " " $1,752,586 X 13.2% = $ 231,341

3. The third step in the calculation was to establish the average of nonfederal expenditures for all TB expenditures statewide for SFY 1991 and SFY 1992, by: (a) adding the TB expenditures for SFY 1991 and SFY 1992; and (b) dividing their sum by two, as illustrated below. This average expenditure amount totaled $1,666,277, as follow:

(a) $1,579,967 (SFY 1991) + $1,752,586 (SFY 1992) = $3,322,553
(b) $3,322,553 divided by 2 = $1,666,277

4. The final step in the calculation was to establish the average of nonfederal expenditures for TB services provided to alcohol/substance abusers for SFY 1991 and SFY 1992 by:
(a) Adding the TB alcohol/substance abuse expenditure amounts for SFY 1991 and SFY 1992; and,

(b) Dividing their sum by two, as illustrated below.

(a) $208,556 (SFY 1991) + $231,341 (SFY 1992) = $439,897
(b) $439,897 divided by 2 = $219,948.50

This average expenditure amount of $219,949 constitutes the TB MOE base amount for SFY 1993 and all subsequent years, and it is contained on row 2, column C of the TB MOE Expenditure Summary Chart, and on row 2, column D of Table II Base of the TB MOE Expenditure tables entered on Table 8b in Web BGAS. In sum, as documented in the calculations contained in step #2 above, New Jersey did expend in excess of the TB MOE base of $219,949 in SFY 2014, as displayed on Table 8b (Base), Box D2.

DESCRIPTION OF METHODS TO CALCULATE THE SFY 2014 MAINTENANCE OF EFFORT FOR TB SERVICES

During SFY 2014, **DHSTS**, our partner agency in the DOH, applied and documented the traditional steps cited above to document DMHAS compliance with the SFY 2014 TB MOE. These steps are summarized below:

1. The TB Program diagnosed and served 322 active TB cases through an operating budget of State funds totaling $3,250,250 during SFY 2014. Expenditures included grants in aid to local providers statewide, the provision of medical/testing services.
2. During SFY 2014 322 patients were diagnosed with active TB.
3. Of these cases, 24 (or 7.4%) were documented as active substance abusers (i.e. alcohol abusers, and/or abusers of non-injectable or injectable drugs of abuse drugs, or combined users).
4. Next by multiplying the applicable State TB budget for services and support in #1 (N=24) above, by the applicable percentage of abusers (7.4%) in #2, above, results in the SFY 2014 SFY TB MOE amount of $240,518.50.

DESCRIPTION OF AMOUNTS AND EFFORTS USED TO CALCULATE THE BASE AND MAINTENANCE OF EFFORT FOR HIV EARLY INTERVENTION SERVICES

The narrative and Table I in this section update the information concerning the statewide non-federal expenditures relating to HIV early intervention services (EIS)of the FFY 2014 SAPT Block Grant Application, i.e., HIV Maintenance of Effort (MOE). Specifically, this narrative will summarize again information concerning the method used to establish the State expenditure base for HIV early intervention services from SFY 1991 and SFY 1992 and provide updated information for SFY 2014. Specifically, Table I illustrating the HIV MOE base years' calculation. The calculation was derived from the average of expenditures derived by a formula applied to expenditures from the two State Fiscal Years preceding SFY 1993.

In 1994, the Division of Addiction Services (DAS), now the Division of Mental Health and Addiction Services (DMHAS) coordinated with the fiscal and program representatives of the Division of AIDS Prevention and Control (DOAPC), now the Division of HIV, STD and TB Services (DHSTS) within the New Jersey Department of Health in order to establish a reasonable HIV MOE base for SFY 1993 for HIV early intervention services (EIS). This effort was based on a review of State expenditures during SFY 1991 and SFY 1992, respectively, for early intervention services relating to HIV, consistent with the definition provided at 45 CFR Part 96.121, and which services were provided at substance abuse treatment facilities. After establishing the HIV MOE base, DAS then reviewed the State expenditures by DOAPC during SFY 1993 for comparable services to ensure compliance with the HIV MOE requirement. A summary of these reviews follows.

During SFY 1991, SFY 1992 and SFY 1993, respectively, DOAPC provided Health Service Grants to 20 drug treatment agencies, which were also funded by DAS to provide drug treatment services. A portion of the funds provided by DOAPC to these agencies were State funds expended for HIV early intervention services. The majority of these State funds were used to fund AIDS coordinators within the 20 drug treatment programs. These coordinators provided AIDS education, made community presentations, and provided case coordination and management. The case coordination and management function was determined to be consistent with the Federal early intervention services definition. The DOAPC provided documentation of the percentage of time which each AIDS coordinator spent on the case management function. These percentages ranged between 15 percent and 85 percent. It was also determined that on average 50 percent of the HIV positive clients served by these employees were asymptomatic, and 50 percent were symptomatic. Only the case management (CM) services provided to asymptomatic persons are consistent with the regulatory definition. Therefore, for SFY 1992 and SFY 1993 the calculated percentage of time that each AIDS coordinator spent providing case management services (e.g., 15% to 85%) to HIV positive clients who were asymptomatic (i.e., 50%) was multiplied by the State supported salary and fringe benefits paid to each AIDS coordinator. A clarifying assumption concerning the calculation of the asymptomatic percentage for SFY 1991 follows.

Until the early 1990's, the AIDS coordinators at publicly funded drug treatment clinics only provided case management services to HIV positive clients who were symptomatic.

Subsequently, the percentage of their time which they provided to asymptomatic clients began to increase. Therefore, in calculating the SFY 1991 State expenditure, it was assumed that the percentage of asymptomatic clients receiving case management services was half of the percentage of asymptomatic clients receiving those services in SFY 1992 and thereafter; i.e., 50% x 50% = 25% for SFY 1991.

In addition, DOAPC provided limited funds for counseling and testing (CT) activities to three (3) drug treatment facilities statewide during SFY 1991 and SFY 1992, respectively. This funding was not, however, provided in SFY 1993, or thereafter.

Table I, below, illustrates the State expenditures by the DOAPC for HIV early intervention services for drug abusers for SFY 1991, SFY 1992, and SFY l993 using the methodology described above. The two year average of the sum of the expenditures for the two State Fiscal Year periods of SFY 1991 and SFY 1992 is listed on line 4, and totals $165,583. This amount is prepopulated annually in Web BGAS as the base table on Table 8c. It included all nonfederal funds expended by the DOAPC for providing HIV counseling and testing, HIV Case Management, Comprehensive Risk Counseling and Services (CRCS), Interventions Directed to Groups (IDG) to a caseload of 35 injection drug users (IDUs), per case manager. Funds in the former years are broken down by expenditures for case management (CM) activities on line 1 reflecting the calculation described earlier, by expenditures for counseling and testing activities (CT) on line 2, and by the sum of State expenditures on line 3.

Table I
Calculation of the HIV MOE Base for Early Intervention Services

SFY	1991	1992	1993	2014
Case Management	$ 80,954	$133,211	$171,438	$0
Counseling & Testing	$ 63,000	$ 54,000	¬0¬	¬0¬
Total State Expenditure	$143,954	$187,211	$171,438	$533,000

HIV 2 Year Average Expenditure, SFY 1991/92 (HIV MOE Base): $165,583

In sum, as documented in Table I above, New Jersey has expended nonfederal funds in excess of the HIV MOE base of $165,583. The New Jersey DHSTS expended $533,000 of nonfederal funds in SFY 2014. This information is presented on HIV EIS MOE Table 8c of the application.

Consistently, for the last seven (7) years, DHSS has entered into a single Health Services Grant (HSG) with the Lennard Clinic in Essex County. The HSG purchases services for the provision of comprehensive HIV EIS under a programmatic concept, titled, Patient Incentive Program (PIP). Core aspects of service provision include HIV counseling and testing, interventions directed to groups and ongoing case management for drug treatment patients. The PIP grants funded by DHSTS during SFY 2014 totaled $533,000.

During September 2014, **DHSTS**, our partner agency in the DOH, provided to DMHAS the non-federal SFY 2014 expenditures cited above for the implementation of the PIP in order to document compliance with the SFY 2014 HIV EIS MOE. This amount is displayed on the SFY 2014 Column on Table 1, above, and on the Maintenance Row on Table 8c.

DESCRIPTION OF THE AMOUNTS AND METHODS USED TO CALCULATE THE BASE AMOUNT FOR SERVICES TO PREGNANT WOMEN AND WOMEN WITH DEPENDENT CHILDREN (PW/WDC)

As documented initially on page 23 of the FFY 1995 SAPT Block Grant Application, the Division of Addiction Services (DAS), now the Division of Mental Health and Addiction Services (DMHAS), established $2,752,187 in FFY 1992 Alcohol Drug Abuse and Mental Health Services (ADMS) Block Grant funds as the revised base for FFY 1993 SAPT Block Grant expenditures, for the provision of services for pregnant women and women with dependent children. This base was established by reviewing all grantees which were funded with FFY 1992 ADMS Block Grant funds, and which primarily provided treatment services designated for pregnant women and women with dependent children (PW/WDC). The review encompassed: (1) the actual amount of FFY 1992 ADMS Block Grant funds obligated/expended by each program; and, (2) the actual services provided by these grantees/entities consistent with those specified in 45 CFR 96.124(e), i.e., primary medical care and referrals, child care, primary medical pediatrics, gender specific treatment, child care, interventions for children, case management and transportation, and simultaneous treatment for children.

The final base amount applicable to the FFY 1994 SAPT BG Award (and all subsequent awards) was derived specifically as follows: (1) to the FFY 1992 PW/WDC expenditure base of $2,752,187: (2) add five percent of the FFY 1993 SAPT Block Grant award (i.e., 5% X $37,452,980, or $1,872,649) in order to establish the FFY 1993 PW/WDC base of $4,624,836; (3) add five percent of the FFY 1994 SAPT Block Grant award (i.e., 5% X $37,452,980, or $1,872,649) to the FFY 1993 PW/WDC base of $4,624,836, resulting in a FFY 1994 PW/WDC expenditure baseline of $6,497,485; and (4) continue to maintain the FFY 1994 PW/WDC expenditure baseline amount of $6,497,485 as the minimum required amount to be expended for PW/WDC in 1995 and thereafter. This amount is prepopulated and locked in the SFY 1994 Row for SFY 1994 on Table 8d.

Prior to FFY 2008, DAS reported only SAPT Block Grant expenditures expended from a single SAPT BG Award as the revenue source for meeting the PW/WDC. Thereafter, consistent with the implementing rule and SAMHSA policy, DMHAS has utilized a mix of State and SAPT BG funds to report a complete calculation of expenditures comprising the PW/WDC expenditure requirement. Consistent with the operative instructions for Table 8d, DMHAS continues to report these expenditures on a State Fiscal Year (SFY) basis, i.e. SFY 2014.

Definition of Accounts Used to Verify Pregnant Women and Women with Dependent Children MOE

At beginning of the State Fiscal Year, available resources from all identified accounts cited below are calculated to project the total amount for the PD/WDC MOE. Any changes in direct appropriations, MOA/MOU with other state agencies, and financial recording methodologies could impact the calculation are reviewed. The resultant projections are updated and reported on the Divisions quarterly spending plan reports to DHS. At the conclusion of the SFY, an MOE analysis is conducted based on year to date encumbrance and expenditures, and future projections; it is monitored periodically to ensure MOE compliance.

At the end of the State Fiscal Year, expenditures and unliquidated encumbrances are downloaded from the NJCFS (New Jersey Comprehensive Financial System). The report is generated by fund source and cost center to include costs that are defined in the above.

The calculation for New Jersey's PW/WDC MOE includes expenditures from both State and Federal SAPT BG dollars made during the prior 12-month SFY (7/1 through 6/30) time period. State accounts Include funds transferred from the Department of Children and Families (100-054-7700-159) and Substance Abuse Treatment for DCP and P/Work First Mothers account (100-054-7700-161). The Federal SAPT Block Grant (BG)MOE also includes SAPT BG PW/WDC account set aside funds(100-054-7700-168) with lower level organization 4221.

The DMHAS combined SAPT Block Grant and State expenditures specifically includes funds classified and targeted to services for PW/WDC during SFY 2014 to meet the set-aside requirement, based on identified coding within DMHAS' categorical expenditure records totals. For SFY 2014, it totals $16,353,612, as documented on Table 8d in WebBGAS.