Texas

UNIFORM APPLICATION
FY2011

SUBSTANCE ABUSE PREVENTION AND TREATMENT
BLOCK GRANT

42 U.S.C.300x-21 through 300x-66

OMB - Approved 07/20/2010 - Expires 07/31/2013

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Substance Abuse and Mental Health Services Administration

Center for Substance Abuse Treatment

Center for Substance Abuse Prevention

Introduction:

The Substance Abuse Prevention and Treatment Block Grant represents a significant Federal contribution to the States' substance abuse prevention and treatment service budgets. The Public Health Service Act [42 USC 300x-21 through 300x-66] authorizes the Substance Abuse Prevention and Treatment Block Grant and specifies requirements attached to the use of these funds. The SAPT Block Grant funds are annually authorized under separate appropriation by Congress. The Public Health Service Act designates the Center for Substance Abuse Treatment and the Center for Substance Abuse Prevention as the entities responsible for administering the SAPT Block Grant program.

The SAPT Block Grant application format provides the means for States to comply with the reporting provisions of the Public Health Service Act (42 USC 300x-21-66), as implemented by the Interim Final Rule (45 CFR Part 96, part XI). With regard to the requirements for Goal 8, the Annual Synar Report format provides the means for States to comply with the reporting provisions of the Synar Amendment (Section 1926 of the Public Health Service Act), as implemented by the Tobacco Regulation for the SAPT Block Grant (45 CFR Part 96, part IV).

Public reporting burden for this collection of information is estimated to average 454 hours per respondent for Sections I-III, 40 hours per respondent for Section IV-A and 42.75 hours per respondent for Section IV-B, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to SAMHSA Reports Clearance Officer; Paperwork Reduction Project (OMB No. 0930-0080), 1 Choke Cherry Road, Room 7-1042, Rockville, Maryland 20857. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is OMB No. 0930-0080.

The Web Block Grant Application System (Web BGAS) has been developed to facilitate States' completion, submission and revision of their Block Grant application. The Web BGAS can be accessed via the World Wide Web at http://bgas.samhsa.gov.

Form 1

DUNS Number: 807391321-

Uniform Application for FY 2011-13 Substance Abuse Prevention and Treatment Block Grant

1. State Agency to be the Grantee for the Block Grant:

Agency Name:	Department of State Health Services	
Organizational Unit:	Mental Health & Substance Abuse Services	
Mailing Address:	P. O. Box 149347 MC: 2053	
City:	Austin	Zip Code: 78714-9347

2. Contact Person for the Grantee of the Block Grant:

Name:	Mike Maples, Asst. Commissioner, Mental Health/Substance Abuse Svcs.	
Agency Name:	Department of State Health Services	
Mailing Address:	P. O. Box 149347, MC: 2053	
City:	Austin	Code: 78714-9347
Telephone:	(512) 206-5968	FAX: (512) 206-5718
Email Address:	mike.maples@dshs.state.tx.us	

3. State Expenditure Period:

From: 9/1/2007 To: 8/31/2008

4. Date Submitted:

Date: 9/30/2009 6:02:56 PM Original: ◉ Revision: ○

5. Contact Person Responsible for Application Submission:

Name:	Mary Sowder	Telephone:	(512) 206-5814
Email Address:	mary.sowder@dshs.state.tx.us	FAX:	(512) 206-5718

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FORM 3: UNIFORM APPLICATION FOR FY 2011 SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT
Funding Agreements/Certifications
as required by Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act

c ***Title XIX, Part B, Subpart II and Subpart III of the PHS Act, as amended, requires the chief executive officer (or an authorized designee) of the applicant organization to certify that the State will comply with the following specific citations as summarized and set forth below, and with any regulations or guidelines issued in conjunction with this Subpart except as exempt by statute.***
SAMHSA will accept a signature on this form as certification of agreement to comply with the cited provisions of the PHS Act. If signed by a designee, a copy of the designation must be attached.

I. Formula Grants to States, Section 1921

Grant funds will be expended "only for the purpose of planning, carrying out, and evaluating activities to prevent and treat substance abuse and for related activities" as authorized.

II. Certain Allocations, Section 1922

- **Allocations Regarding Primary Prevention Programs, Section 1922(a)**
- **Allocations Regarding Women, Section 1922(b)**

III. Intravenous Drug Abuse, Section 1923

- **Capacity of Treatment Programs, Section 1923(a)**
- **Outreach Regarding Intravenous Substance Abuse, Section 1923(b)**

IV. Requirements Regarding Tuberculosis and Human Immunodeficiency Virus, Section 1924

V. Group Homes for Recovering Substance Abusers, Section 1925
Optional beginning FY 2001 and subsequent fiscal years. Territories as described in Section 1925(c) are exempt.

The State "has established, and is providing for the ongoing operation of a revolving fund" in accordance with Section 1925 of the PHS Act, as amended. This requirement is now optional.

VI. State Law Regarding Sale of Tobacco Products to Individuals Under Age of 18, Section 1926

- **The State has a law in effect making it illegal to sell or distribute tobacco products to minors as provided in Section 1926 (a)(1).**
- **The State will enforce such law in a manner that can reasonably be expected to reduce the extent to which tobacco products are available to individuals under the age of 18 as provided in Section 1926 (b)(1).**
- **The State will conduct annual, random unannounced inspections as prescribed in Section 1926 (b)(2).**

VII. Treatment Services for Pregnant Women, Section 1927

The State "…will ensure that each pregnant woman in the State who seeks or is referred for and would benefit from such services is given preference in admission to treatment facilities receiving funds pursuant to the grant."

VIII. Additional Agreements, Section 1928

- **Improvement of Process for Appropriate Referrals for Treatment, Section 1928(a)**
- **Continuing Education, Section 1928(b)**
- **Coordination of Various Activities and Services, Section 1928(c)**
- **Waiver of Requirement, Section 1928(d)**

FORM 3: UNIFORM APPLICATION FOR FY 2011 SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT Funding Agreements/Certifications As required by Title XIX , Part B, Subpart II and Subpart III of the PHS Act (continued)	
IX.	**Submission to Secretary of Statewide Assessment of Needs, Section 1929**
X.	**Maintenance of Effort Regarding State Expenditures, Section 1930**
	With respect to the principal agency of a State, the State "will maintain aggregate State expenditures for authorized activities at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant."
XI.	**Restrictions on Expenditure of Grant, Section 1931**
XII.	**Application for Grant; Approval of State Plan, Section 1932**
XIII.	**Opportunity for Public Comment on State Plans, Section 1941**
	The plan required under Section 1932 will be made "public in such a manner as to facilitate comment from any person (including any Federal person or any other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary."
XIV.	**Requirement of Reports and Audits by States, Section 1942**
XV.	**Additional Requirements, Section 1943**
XVI.	**Prohibitions Regarding Receipt of Funds, Section 1946**
XVII.	**Nondiscrimination, Section 1947**
XVIII.	**Services Provided By Nongovernmental Organizations, Section 1955**
	I hereby certify that the State or Territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act, as amended, as summarized above, except for those Sections in the Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.
State: Texas	
Name of Chief Executive Officer or Designee: Mike Maples	
Signature of CEO or Designee:	
Title: Asst. Commissioner, Mental Health & Substance Abuse	**Date Signed:**
If signed by a designee, a copy of the designation must be attached	

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 C.F.R. Part 76, and its principals:

(a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;

(b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

(c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and

(d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, In eligibility, and Voluntary Exclusion – Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with sub-grantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 C.F.R. Part 76.

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 45 C.F.R. Part 76 by:

(a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

(b) Establishing an ongoing drug-free awareness program to inform employees about –
(1) The dangers of drug abuse in the workplace;
(2) The grantee's policy of maintaining a drug-free workplace;
(3) Any available drug counseling, rehabilitation, and employee assistance programs; and
(4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

(c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;

(d) Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will –
(1) Abide by the terms of the statement; and
(2) Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

(e) Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

(f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted –

(1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or

(2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

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

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

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

3. CERTIFICATION REGARDING LOBBYING

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

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

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the under signed, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities, "in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

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

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

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of

his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result
in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Service strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE Asst. Commissioner, Mental Health and Substance Abuse
APPLICANT ORGANIZATION Department of State Health Services	DATE SUBMITTED

DISCLOSURE OF LOBBYING ACTIVITIES

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure.)

1. Type of Federal Action:

☐ a. contract
b. grant
c. cooperative agreement
d. loan
e. loan guarantee
f. loan insurance

2. Status of Federal Action

☐ a. bid/offer/application
b. initial award
c. post-award

3. Report Type:

☐ a. initial filing
b. material change

For Material Change Only:

Year _____ Quarter _____
date of last report

4. Name and Address of Reporting Entity:

☐ Prime ☐ Subawardee

Tier _____, if known: _____

Congressional District, *if known:* _____

5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:

Congressional District, *if known:* _____

6. Federal Department/Agency:

7. Federal Program Name/Description:

CFDA Number, *if applicable:* _____

8. Federal Action Number, if known:

9. Award Amount, if known:
$

10. a. Name and Address of Lobbying Entity
(if individual, last name, first name, MI):

b. Individuals Performing Services *(including address if different from No. 10a.) (last name, first name, MI):*

11. Information requested through this form is authorized by title 31 U.S.C. Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Signature: _____

Print Name: _____

Title: _____

Telephone No.: _____ **Date:** _____

Federal Use Only:

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Standard Form - LLL (Rev. 7-97)

DISCLOSURE OF LOBBYING ACTIVITIES
CONTINUATION SHEET

Reporting Entity: **Page** **of**

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

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

1. Identify the type of covered Federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered Federal action.

2. Identify the status of the covered Federal action.

3. Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered Federal action.

4. Enter the full name, address, city, state and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants and contract awards under grants.

5. If the organization filing the report in item 4 checks “subawardee”, then enter the full name, address, city, state and zip code of the prime Federal recipient. Include Congressional District, if known.

6. Enter the name of the Federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation, United States Coast Guard.

7. Enter the Federal program name or description for the covered Federal action (item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.

8. Enter the most appropriate Federal identifying number available for the Federal action identified in item 1 [e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract, grant, or loan award number; the application/proposal control number assigned by the Federal agency]. Include prefixes, e.g., ‘‘RFP-DE-90-001.’’

9. For a covered Federal action where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in item 4 or 5.

10. (a) Enter the full name, address, city, state and zip code of the lobbying entity engaged by the reporting entity identified in item 4 to influence the covered Federal action.

    (b) Enter the full names of the individual(s) performing services, and include full address if different from 10(a). Enter Last Name, First Name, and Middle Initial (MI).

11. Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (item 4) to the lobbying entity (item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

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

ASSURANCES – NON-CONSTRUCTION PROGRAMS

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

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

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

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

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L.88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE Asst. Commissioner, Mental Health and Substance Abuse
APPLICANT ORGANIZATION Department of State Health Services	DATE SUBMITTED

1. Planning

THREE YEAR PLAN, ANNUAL REPORT, and PROGRESS REPORT:
PLAN FOR FY 2011-FY 2013 PROGRAM ACTIVITIES

This section documents the States plan to use the FY 2011 through FY 2013 Federal Substance Abuse Prevention and Treatment (SAPT) Block Grant. For each SAPT Block Grant award, the funds are available for obligation and expenditure for a 2-year period beginning on October 1 of the Federal Fiscal Year (FY) for which an award is made. States are encouraged to incorporate information on needs assessment, resource availability and States priorities in their plan to use these funds over the next three fiscal years. In the interim years (FY 2012 and FY 2013), updates to this 3-year plan are required; however, if the plan remains unchanged, additional narrative is not necessary. This section requires completion of needs assessment forms, services utilization forms and a narrative description of the States planning processes.

1. Planning

This section provides an opportunity to describe the State's planning processes and requires completion of needs assessment data forms, utilization information and a description of the State's priorities. In addition, this section provides the State the opportunity to complete a three year intended use plan for the periods of FY 2011-FY 2013. Finally this section requires completion of planning narratives and a checklist. These items address compliance with the following statutory requirements:

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

The State is to develop a 3-year plan which covers the three (3) fiscal years from FFY 2011-FY 2013. In a narrative of **up to five pages,** describe:

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

Describe how your State evaluates activities related to ongoing substance abuse prevention and treatment efforts, such as performance data, programs, policies and practices, and how this data is produced, synthesized and used for planning. A general narrative describing the States planned approach to using State and Federal resources should be included. For the prevention assessment, States should focus on the SEOW process. Describe State priorities and activities as they relate to addressing State and Federal priorities and requirements.

• 42 U.S.C. §300x-51 and 45 C.F. R. §96.123(a)(13) require the State to make the State plan public in

such a manner as to facilitate public comment from any person during the development of the plan.

In a narrative of **up to two pages**, describe the process your State used to facilitate public comment in developing the State's plan and its FY 2011-FY 2013 application for SAPT Block Grant funds.

For FY 2012 and FY 2013, only updates to the 3-year plan will be required. In the Section addressing the Federal Goals, the States will still need to provide Annual and Progress reports. Fiscal reporting requirements and performance data reporting will also be required annually.

The Prevention component of your Three Year Plan Should Include the Following:

Problem Assessment (Epidemiological Profile)

Using an array of appropriate data and information, describe the substance abuse-related problems in your State that you intend to address under Goal 2. **Describe the criteria and rationale for establishing primary prevention priorities.**

(See 45 C.F.R §96.133(a) (1))

Prevention System Assessment (Capacity and Infrastructure)
Describe the substance abuse prevention infrastructure in place at the State, sub-State, and local levels. Include in this description current capacity to collect, analyze, report, and use data to inform decision making; the number and nature of multi-sector partnerships at all levels, including broad-based community coalitions. In addition, describe the mechanisms the SSA has in place to support sub-recipients and community coalitions in implementing data-driven and evidence-based preventive interventions. If the State sets benchmarks, performance targets, or quantified objectives, describe the methods used by the State to establish these.

Prevention System Capacity Development
Describe planned changes to enhance the SSA's ability to develop, implement, and support—at all levels —processes for performance management to include: assessment, mobilization, and partnership development; implementation of evidence-based strategies; and evaluation. Describe the challenges associated with these changes, and the key resources the State will use to address these challenges. Provide an overview of key contextual and cultural conditions that impact the State's prevention capacity and functioning.

Implementation of a Data-Driven Prevention System
Describe the mechanism by which funding decisions are made and funds will be allocated. Explain how these mechanisms link funds to intended State outcomes. Provide an overview of any strategic prevention plans that exist at the State level, or which will be required at the sub-State or sub-recipient level, including goals, objectives, and/or outcomes. Indicate whether sub-recipients will be required to use evidence based programs and strategies. Describe the data collection and reporting requirements the State will use to monitor sub-recipient activities.

Evaluation of Primary Prevention Outcomes
Discuss the surveillance, monitoring, and evaluation activities the State will use to assess progress toward achieving its capacity development and substance abuse prevention performance targets. Describe the way in which evaluation results will be used to inform decision making processes and to modify implementation plans, including allocation decisions and performance targets.

Planning

The Planning Process – Needs Assessment

The Texas Department of State Health Services (DSHS), which combines its precursor agencies responsible for public health, mental health, and substance abuse prevention and treatment services, has conducted different surveys through dedicated funding from the State Treatment Needs Assessment Program and the Prevention Needs Assessment Program since 1988. These surveys provide data on adults in the general population, elementary and secondary school students, college students, Texans living on the Mexico border, and parents and their children. These surveys and other national surveys, along with other indicator data, assist the state agency in identifying areas of need and provide overall information for the planning process.

The Texas Survey of Substance Use Among Adults had been used to assess the needs of adults in treatment services in Texas since 2000. However, because this survey has been discontinued, the state estimates from the multiple-year data of National Survey on Drug Use and Health (NSDUH) are currently used to access adult treatment needs in Texas. For example, the combined 2004-2008 NSDUH data for Texas were used to estimate the adult treatment needs in Texas in 2008 for FFY 2011 application. This national survey, conducted annually by the Office of Applied Studies (OAS) at the Substance Abuse and Mental Health Services Administration (SAMHSA), uses in-person interviews to collect data that produces drug and alcohol use incidence and prevalence estimates. Survey data are also collected periodically on special topics of interest such as serious mental illness, criminal behaviors, substance abuse treatment, and attitudes about drugs. The 2008 estimates for adult treatment needs were based on a sample of 11,878 Texans age 18 and over in the 2004-2008 NSDUH data. The prevalence rates of adults needing treatment by gender, age category, and racial/ethnic group for the State as a whole and for 11 sub-State planning areas are requested and obtained from the OAS every year.

The statewide Texas School Survey of Substance Use Among Students (TSS) is used to assess prevention and treatment youth needs in Texas and has been conducted biennially since 1988. The TSS is a joint project of DSHS and the Public Policy Research Institute at Texas A&M University. Substance use treatment and prevention youth needs are calculated by using prevalence rates from TSS and the youth population aged 12 to 17 in Texas. The 2008 TSS data with a sample of 98,898 Texas students in grades seven through twelve was used to assess youth needs in 2008 for FY2011 application. Students are randomly selected from school districts throughout the State using a multi-stage probability design. School districts along the Texas-Mexico border are over-sampled to allow statistically valid comparison to the rest of the State. The TSS asks students about the use of tobacco, alcohol, inhalants, dextromethorphan, codeine cough syrup, marijuana, and other illicit drugs. Other questions pertain to the behavioral and demographic correlates of substance abuse, including risk and protective factors, sources of information about substance-related problems, perceptions of peer values and attitudes, and the perceived safety of the home, neighborhood, and school environment.

The estimated needs for prevention services for universal, selective, and indicated populations at the State and sub-State level have been calculated by applying parameters derived from responses to the statewide TSS. These need estimates are used to guide programming decisions

in prevention, and providers are expected to identify and serve these populations appropriately. All Texas youth are included in the universal prevention population. Youth are defined as needing selective prevention if they were at risk in their environments (including youths who feel unsafe at school/home/neighborhood, have all/most of peers who carry weapons, drop out of school or belong to a gang, have no peers who feel close to their parents or care about good grades, perceived parents' approval of using beer/marijuana, perceived no/less danger of using marijuana, or perceived easy availability of marijuana). Youth are defined as in need of indicated prevention if they were at high risk in their environments (including youths who have used any substance during the past school year plus had at least one alcohol- or drug-related social problem during the past school year such as attending class while under the influence of drugs, driving while under the influence of drugs, or getting into trouble with teachers/police/peers/dates due to substance use).

The NSDUH data for Texas will continue to be used to assess the adult treatment needs for FFY 2012 and FFY 2013. And the TSS data will continue to be used to assess the youth treatment and prevention needs for FFY 2012 and FFY 2013.

The data-driven need estimates help guide planning decisions, identify substance abuse service gaps, promote evaluation of program effectiveness, and support funding allocation. To ensure that this data and other quantitative information is used in allocating funds, the Texas legislature enacted Section 461.0124, *Texas Health and Safety Code* in 1997, which required TCADA (and now DSHS) to develop a service funding process that ensures equity in the availability of chemical dependency services across the State and within each of the 11 health and human service regions established under Section 531.024, *Texas Government Code*. These need estimates are factored into the funding formula described below.

Funding Allocation Formula

DSHS is committed to maintaining a system that promotes reasonable access to services by individuals in need throughout the state. As such, DSHS continues to allocate funds through a system that ensures a stable service environment, and one that produces equity in funding across and within all regions of the state. To address this priority and guide funding allocation decisions across the state's regions and sub-regions, DSHS uses a funding formula that was revised by TCADA in 2001 and is reviewed annually by the DSHS-MHSA leadership to ensure continued applicability as population changes occur over time. The revised formula that was adopted by the TCADA governing board to better define and weigh the impact of changes on the existing service delivery system includes three factors listed in order of weighted priority: 1) population; 2) poverty; and 3) need. Population is the most heavily weighted factor, representing 75 percent of the total formula, poverty represents 20 percent of the formula, and need is 5 percent. Funding decisions will continue to be guided by this formula as new or underutilized funding becomes available.

DSHS' rules for funded programs (Chapter 144.411 and 144.511) require every funded program to specify its target population, to develop strategies and activities that are appropriate to the target population and to report on a monthly basis on its performance and activity measures defined for the target population. Licensure guidelines, capacity management and waiting lists

enable DSHS to monitor the capacity of programs and levels of utilization. Noncompliance with the rules for funded programs can lead to sanctions by DSHS. In order to ensure that communities with the highest prevalence and need are served, funds are allocated by region based on the needs assessment. The funding cycle for treatment services is every five years. However, as part of the monitoring process, each year data that drives the needs assessment is reviewed to ensure that a continuum of treatment programs is funded in each region and at levels that will address prevalence and need.

Definition of 11 Sub-state Planning Areas in Texas-

The 11 sub-State planning areas are defined as the 11 Texas Health and Human Services Regions. The graph below shows the counties included in each region.

Region	Counties Serviced
Region 1: High Plains	Armstrong, Bailey, Briscoe, Carson, Castro, Childress, Cochran, Collingsworth, Crosby, Dallam, Deaf Smith, Dickens, Donley, Floyd, Garza, Gray, Hale, Hall, Hansford, Hartley, Hemphill, Hockley, Hutchinson, King, Lamb, Lipscomb, Lubbock, Lynn, Moore, Motley, Ochiltree, Oldham, Parmer, Potter, Randall, Roberts, Sherman, Swisher, Terry, Wheeler, Yoakum
Region 2: Northwest Texas	Archer, Baylor, Brown, Callahan, Clay, Coleman, Comanche, Cottle, Eastland, Fisher, Foard, Hardeman, Haskell, Jack, Jones, Kent, Knox, Mitchell, Montague, Nolan, Runnels, Scurry, Shackelford, Stonewall, Stephens, Taylor, Throckmorton, Wichita, Wilbarger, Young
Region 3: Metroplex	Collin, Cooke, Dallas, Dallas, Denton, Ellis, Erath, Fannin, Grayson, Hood, Hunt, Johnson, Kaufman, Navarro, Palo Pinto, Parker, Rockwall, Somervell, Tarrant, Wise
Region 4: Upper East Texas	Anderson, Bowie, Camp, Cass, Cherokee, Delta, Franklin, Gregg, Harrison, Henderson, Hopkins, Lamar, Marion, Morris, Panola, Rains, Red River, Rusk, Smith, Titus, Upshur, Van Zandt, Wood
Region 5: Southeast Texas	Angelina, Hardin, Houston, Jasper, Jefferson, Nacogdoches, Newton, Orange, Polk, Sabine, San Augustine, San Jacinto, Shelby, Trinity, Tyler

Region 6: Gulf Coast	Austin, Brazoria, Chambers, Colorado, Fort Bend, Galveston, Harris, Liberty, Matagorda, Montgomery, Walker, Waller, Wharton
Region 7: Central Texas	Bastrop, Bell, Blanco, Bosque, Brazos, Burleson, Burnet, Caldwell, Coryell, Falls, Fayette, Freestone, Grimes, Hamilton, Hays, Hill, Lampasas, Lee, Leon, Limestone, Llano, Madison, McLennan, Milam, Mills, Robertson, San Saba, Travis, Washington, Williamson
Region 8: Upper South Texas	Atacosa, Bandera, Bexar, Calhoun, Comal, DeWitt, Dimmit, Edwards, Frio, Gillespie, Goliad, Gonzales, Guadalupe, Jackson, Karnes, Kendall, Kerr, Kinney, La Salle, Lavaca, Maverick, Medina, Real, Uvalde, Val Verde, Victoria, Wilson, Zavala
Region 9: West Texas	Andrews, Borden, Coke, Concho, Crane, Crockett, Dawson, Ector, Gaines, Glasscock, Howard, Irion, Kimble, Loving, Martin, Mason, McCulloch, Menard, Midland, Pecos, Reagan, Reeves, Schleicher, Sterling, Sutton, Terrell, Tom Green, Upton, Ward, Winkler
Region 10: Upper Rio Grande	Brewster, Culberson, El Paso, Hudspeth, Jeff Davis, Presidio
Region 11: Lower South Texas	Aransas, Bee, Brooks, Cameron, Duval, Hidalgo, Jim Hogg, Jim Wells, Kenedy, Kleberg, Live Oak, McMullen, Nueces, Refugio, San Patricio, Starr, Webb, Willacy, Zapata

State Priorities

The needs assessments, funding formula and sub-state/ regional planning activities assist the state in determining allocation of funds. Other statewide planning efforts and federal and state mandates drive the priorities that are documented in this application. These are the priorities that will be addressed in 2011-1013. The planning efforts that have been implemented and are ongoing include: the state's Health and Human Services Strategic Plan strategic plan which is driven by state legislative priorities; a treatment recovery initiative plan; and a bi annual statewide services delivery plan. All these ongoing plans have been developed with stakeholder input. Plans have also been affected by federal guidance. More recently, this federal guidance has included SAMHSA's eight strategic initiatives. Priorities listed in this document were previously identified in one or more of these documents.

In FY 2011, most of the priorities will be addressed through the provision of funded services. Both the treatment and prevention funding cycles will continue through FY 2013 with an annual

renewal. The services that are currently funded and will continue, are addressing the state's priorities that include: substance abuse prevention, specialized female services, medication assisted treatment; statewide tobacco services; border services; services for injecting drug users. Additional funding for expanded border services, recovery oriented systems of care, recovery services and Screening, Brief Intervention, and Referral for Treatment (SBIRT) have been requested although to date no additional funds for these activities has been obtained for FY 2011 or beyond. The state will continue to seek additional funds in FY 2011-2013 to secure these services. A new housing initiative is planned to begun in early FY 2011 and continue to increase each year of 2012-2013. Addressing all of the service priorities will lead to the development of the continuum of care that is part of the planning process for each region of the state. There are two additional parts of the state's overall plan that will assist in development of that continuum. The continuation of a recently implemented Substance Abuse Medicaid Benefit and an increase in the number of tele-health providers each year in FY's 2011-2013 will complement the service delivery system across the state.

Monitoring the progress on each of the plans mentioned above is an ongoing process. Each year achievements and progress are reviewed and documented in the overall DSHS strategic plan. The Treatment Recovery Initiative is an ongoing and "living" activity with at least quarterly meetings to review what progress has been made to move the state toward a more recovery oriented system of care. Likewise the state wide service delivery plan is updated every two years and reviews progress from the previous plan and includes any changes in service delivery that are anticipated. These activities will continue in FY 2011-2013. Additionally, The Substance Abuse Medicaid Benefit will be reviewed by the state's Medicaid office in FY 2013 to ensure effectiveness. While plans for FY 2011 are fairly concrete, the additional years FY 2012-2013 could be affected by the state's funding shortfalls and the Federal Healthcare Reform. Plans to address both of these issues will most likely be in future applications.

Prevention Component

Problem Assessment (Epidemiological Profile)

Currently, the Mental Health and Substance Abuse (MHSA) Division funds community-based organizations to deliver comprehensive prevention services through evidence-based curriculum and effective CSAP strategies through the Behavioral Health Prevention Framework. The state administers the statewide Texas school survey every 2 years and uses this data to determine the priorities for prevention services. The priorities for the state follow the Institute of Medicine (IOM) Model of Prevention that recognizes the importance of the full array of services that include universal, selective, and indicated strategies. The 2008 school survey indicates that 51% of Texas students in grades 7-12 reported that they had started using alcohol before the age of 13. At least 42% of the youth in Texas reported initiating tobacco use before age 13, and 28% reported first use of marijuana before age 13. Research shows that the earlier a child starts using drugs, the more likely he or she will be to develop a substance abuse problem. The state has determined that a priority population for services is youth, ages 0-17 in order to begin prevention efforts during early childhood development. It is more cost effective for the state to prevent possible future need for treatment services. If a child does not start using drugs or alcohol by the teen years, he or she is much less likely to initiate or develop a substance abuse problem later in

life. The secondary population identified by the state as a priority is adults, ages 18-65 that include the parents, guardians, and grandparents that are targeted through family-focused curricula, family-oriented alternative activities, and successful referrals to support services.

Prevention System Assessment (Capacity and Infrastructure)

Within the 225 prevention awards there are 77 programs targeting the universal population, 60 programs targeting the selective population, and 54 programs targeting the indicated population. In addition, there are 23 community coalitions that serve over 25 million people through environmental change, media campaigns, and community policies. There are also 11 regional prevention resource centers (PRC) that implement in population based strategies through health fairs, disseminating brochures on ATOD and mental health issues, and media awareness activities. The tobacco specialists within the 11 statewide regions that serve 254 counties also ensure Synar compliance through various merchant education and tobacco activities. A single training entity coordinates the delivery of best practice and evidence-based prevention training across the state. DSHS is involved with several partnerships across of the state. Currently, the state works closely with the Texas Collaborative Prevention Committee which includes the executive management and direct care staff of the funded programs, the DSHS Prevention Team, and state management representatives. This committee meets on a quarterly basis through teleconferences and webinars to address programmatic trends and contract issues across the state. The Texas Certification Workgroup is comprised of providers in the field that include members of the Association of Substance Abuse Professionals (ASAP), other funded providers, DSHS staff, higher education, and the Texas Certification Board representatives. This Workgroup addresses the staff competencies and trainings that are required for DSHS funded prevention providers. This group meets on a quarterly basis through teleconference. DSHS partners with other state agencies through the Texas State Incentive Advisory Committee (TSIP) and the Drug Demand Reduction Advisory Committee (DDRAC). The TSIP focuses on underage drinking and college binge drinking. TSIP's membership includes representatives from state agencies and higher education that meet on a quarterly basis to discuss prevention activities across the state and to review outcomes in Texas. Additionally, a state level prevention strategic plan will be developed with multiple agency participation. This may be established through the current Texas State Incentive Program (TSIP) Advisory Committee which meets on a quarterly basis. The name and focus of the committee would be redefined with the new role for prevention activities across the state. This committee would be involved with the development of the prevention strategic plan and the FY14 Behavioral Health Prevention Framework RFP. The DDRAC committee has 16 MOUs with state agencies to develop legislative recommendations and coordinate statewide strategies that will reduce drug demand in Texas. The state supports environmental change by funding community coalitions that serve 254 counties and targeting over 25 million people statewide. Each of these coalitions is required to use epidemiological data to support decision-making. Most coalitions use an organized epidemiological workgroup (EWG) to identify data and gaps and also to ensure that analysis and reporting of data are accurate.

Prevention System Capacity Development

Due to a competitive Behavioral Health Prevention Framework RFP in FY09 for a five year fund cycle, the state does not anticipate any significant changes to the current provider infrastructure. The state will maintain the current prevention infrastructure during the FY11-FY13 fund cycle.

The prevention providers will continue to deliver evidence-based programs and strategies. One significant change that will occur in the Fall of FY11 is the transition from the Behavioral Health Integrated Provider System (BHIPS) to the Clinical Management for Behavioral Health Services System (CMBHS). This system will allow for a more integrated data reporting system with mental health services. The data components required for the national outcome measures will still be collected through the CMBHS system. Due to the new definition of population based strategies and activities, the state may need to enhance current data elements in CMBHS in order to depict the actual numbers served based on the Census Bureau data for media campaigns and one time activities such as health fairs, information dissemination, and school assemblies.

In addition, in light of budget constraints, the state anticipates some changes to the mode of delivery for the Substance Abuse Prevention Specialist Training (SAPST) and Ethics training in order to better serve the needs of the providers. The state would like to implement a consistent training system that will allow staff to acquire prevention credentials that are transferable across the state. This training will ideally include distance learning through Web-based technologies, training of trainers at a regional level, powerpoints, ethics training, and examination prep courses available on Southwest Regional CAPT website for the public.

Implementation of a Data –Driven Prevention System

The mechanism in which funding decisions are made for prevention services begins with a competitive procurement process through a request for proposals (RFP). Programs are funded for a five year cycle through a procurement process with annual renewals. A regional allocation has been and will continue to be used to determine the amount of dollars available for each of the 11 Health and Human Service Regions. The regional allocation is based on population, poverty and need. The percentage of funding includes 33% for Universal programs, 30% for Indicated programs, 23% for Selective programs and 14% for Universal Indirect programs. The programs will be monitored through the prevention monitoring system on a quarterly basis. Monthly reviews on the key performance measures and expenditures are conducted on all prevention contracts. The Quality Management staff conduct site visits and desk reviews to ensure that each contractor is in compliance with programmatic and fiscal standards. The Texas Health and Human Services Strategic Plan and the DSHS Statewide Substance Abuse Service Delivery Plan focus on the use of evidence-based strategies to address priority substance-related problems, on identifying and reducing gaps in services, on building capacity to strengthen Texas' prevention system, and on increasing accountability. Currently, the Statewide Substance Abuse Service Delivery Plan's first goal has an emphasis on substance abuse prevention and integration with public health. The plan addresses the expansion of the existing foundation through the new behavioral health framework that uses the State's prevention resources to address risk factors and increase protective factors common to mental health, substance use, and tobacco. The objectives for this goal include increasing the use of effective health promotion and prevention strategies to achieve reduced drug and alcohol demand, promote mental health, and prevent harmful consequences of substance abuse. The second objective is to increase the use of strategies that address risk behaviors and enhance protective factors to avert costly treatment later. Finally, the third objective is to increase the use of effective tobacco prevention and control strategies to reduce the prevalence of tobacco use among adults and youth thereby decreasing the burden of tobacco-related disease and death in the State.

Evaluation of Primary Prevention Outcomes The Behavioral Health Integrated Provider System (BHIPS) is a web-based system accessed via the Internet by DSHS substance abuse providers used to report monthly performance measures and quarterly program outcomes. The outcome data reports are submitted by the provider include: service sites, curriculum name, number of sessions and curriculum cycles implemented, number of participants enrolled, number of participants that completed the pre test, number of participants that completed the post test, number of participants that completed the program, and the number of participants successfully completed the program. The number of participants that successfully completed the program reflects the number of participants that completed 80% of the curriculum sessions and improved or maintained in their post test scores. Data reported monthly and quarterly from the prevention providers can be used to assess provider's program implementation and progress and the effectiveness of the evidence-based curriculums being implemented. Evaluation results can be used in FY14 to determine the most cost effective curriculum for the state's target population.

Facilitation of Public Comment

In the *Texas Register* on July 9, 2010, the Department of State Health Services (DSHS) published its intention to submit a state plan. Directions regarding how and when to obtain a draft of the intended use plan were included in the announcement. The draft plan was made available electronically on the DSHS website and by mail upon request on August 9th, 2010, and the public was given a 30-day comment period. An electronic mailbox was established specifically to receive comments on the plan. The published announcement included the electronic address as well as a physical mailing address for submission of comments. More than 2,800 stakeholders and other interested persons/groups who regularly receive announcements of updates on the DSHS substance abuse webpage were directly contacted via e-mail regarding the availability of the plan and opportunity to make comments. An update e-mail one week prior to the 30 day deadline was sent to remind stakeholders to provide comment. Additionally, the planner attended a stakeholder meeting during the annual Behavioral Health Institute to discuss the plan and provide directions on how to make comments. The specific stakeholders that were targeted for input about the substance abuse service delivery system and the SAPT Block Grant application include but are not limited to the legislatively-mandated Drug Demand Reduction Advisory Committee (DDRAC), the federally-required State Incentive Grant Advisory Committee and professional groups and associations such as the Association of Substance Abuse Programs (ASAP). Also the Synar Report was sent directly to over 40 specific stakeholders (both individuals and groups) for public comment.

Comments were received through the electronic mailbox and e-mails to DSHS staff. Information and suggestions were considered, and incorporated into the plan when appropriate, prior to submission. In general, comments received were related to treatment and prevention services and included:

- provider funding levels and the expectation of "doing more" with the same or less money
- continuing and improving upon use of stakeholders in planning processes
- finding more ways to address the mentally ill substance abuser
- developing more and different housing options rather than group homes
- implementation of the electronic health record

Planning Checklist

Criteria for Allocating Funds

Use the following checklist to indicate the criteria your State will use how to allocate FY 2011-2013 Block Grant funds. Mark all criteria that apply. Indicate the priority of the criteria by placing numbers in the boxes. For example, if the most important criterion is 'incidence and prevalence levels', put a '1' in the box beside that option. If two or more criteria are equal, assign them the same number.

1 Population levels, Specify formula:

75%, regional population as a percent of total population

3 Incidence and prevalence levels

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

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

Problem levels as estimated by social indicator data

Problem levels as estimated by expert opinion

Resource levels as determined by (specify method)

Size of gaps between resources (as measured by)

and needs (as estimated by)

2 Other (specify method)

Poverty, Indigence as a % of regional population

Allocating Funds Checklist Footnotes
The formula equals .75 x population + .20 x Poverty + .05 x Prevalence (Need).
See Planning Narrative in this application.

Form 4 (formerly Form 8)

Treatment Needs Assessment Summary Matrix

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		Calendar Year: 2008 6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other:	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
High Plains	827,733	71,161	7,112	12,183	1,218	24,947	4,725	4,196	5,072		1	6	2

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		Calendar Year: 2008 6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other:	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
Northwest Texas	556,727	37,600	1,428	9,797	372	11,354	951	2,317	3,726		3	7	2

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		Calendar Year: 2008 6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other:	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
Metroplex	6,613,465	447,103	22,154	82,442	4,085	157,489	7,585	22,277	31,548		3	13	6

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		Calendar Year: 2008 6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other:	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
Upper East Texas	1,092,400	53,196	2,804	10,089	532	13,238	1,500	5,034	6,393		2	8	3

1. Substate Planning	2. Total Population	3. Total Population in need	4. Number of IVDUs in need	5. Number of women in need	Calendar Year: 2008 6. Prevalence of	7. Incidence of communicable diseases

Area		in need		in need		women in need		substance- related criminal activity			communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other:	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
Southeast Texas	771,055	56,834	4,490	5,711	451	18,384	3,415	2,209	4,463		2	12	3

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		Calendar Year: 2008 6. Prevalence of substance- related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other:	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
Gulf Coast	5,741,451	494,623	32,891	31,278	2,080	149,626	2,369	16,848	41,517		1	18	8

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		Calendar Year: 2008 6. Prevalence of substance- related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other:	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
Central	2,722,915	236,767	7,237	45,141	1,380	86,172	2,733	15,803	11,945		2	9	4

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		Calendar Year: 2008 6. Prevalence of substance- related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other:	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
Upper South Texas	2,434,420	192,160	5,200	54,928	1,486	56,688	2,614	11,301	19,180		5	9	6

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		Calendar Year: 2008 6. Prevalence of substance- related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other:	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
West Texas	548,889	41,823	2,096	6,984	350	14,121	500	2,755	3,958		2	3	2

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		Calendar Year: 2008 6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other:	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
Upper Rio Grande	782,856	41,412	7,251	7,866	1,377	15,432	770	3,675	5,172		4	8	9

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		Calendar Year: 2008 6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other:	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
Lower South Texas	2,086,269	149,358	2,829	29,831	565	33,076	2,509	7,832	11,979		1	5	11

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		Calendar Year: 2008 6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other:	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
State Total	24,178,180	1,822,037	95,492	296,251	13,896	580,527	29,671	94,247	144,953		2	12	6

Form 5 (formerly Form 9)

Treatment Needs by Age, Sex, and Race/ Ethnicity

AGE GROUP	A. Total	B. White		C. Black or African American		D. Native Hawaiian / Other Pacific Islander		E. Asian		F. American Indian / Alaska Native		G. More than one race reported		H. Unknown		I. Not Hispanic Or Latino		J. Hispanic Or Latino	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
17 Years Old and Under	172,642	35,314	19,864	15,106	7,287									58,280	36,791	53,056	29,073	55,644	34,868
18 - 24 Years Old	492,348	142,699	107,826	33,808	10,046									122,712	75,257	180,412	125,649	118,807	67,480
25 - 44 Years Old	809,820	227,845	118,173	66,250	29,535									295,192	72,825	305,639	160,377	283,647	60,157
45 - 64 Years Old	322,412	105,965	70,506	38,739	8,068									86,220	12,914	145,167	78,829	85,757	12,660
65 and Over	15,958	5,776	10,182																
Total	1,813,180	517,599	326,551	153,903	54,936	0	0	0	0	0	0	0	0	562,404	197,787	684,274	393,928	543,855	175,165

Since the Form 5 on WEBBGAS only allows an input of numeric values, some N/A values due to low precision of needs estimation in C/H/I/J cells of Age 65&Over cannot be properly presented in the Form per se. That's why the total number of Age 65&Over in the Form 5 doesn't show correctly, neither are the "Totals" for A, C, H, and I-J columns.

Below please find the original completed data file for Form 5 in Texas (* shows the N/A values that are not available via the needs estimation. A note below the table explains the reason):

Treatment Needs By Age, Sex, and Race/Ethnicity (Form 5: FFY2011)
State: Texas

Age Group	A. Total		B. White		C. Black		D. Native Hawaiian/Pacific Islander		E. Asian		F. American Indian/Alaska Native		G. More Than One Race Reported		H. All Other or Unknown		I. Not Hispanic or Latino		J. Hispanic or Latino	
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
1. 17 & Under	172,641	35,314	19,864	15,106	7,287								58,280	36,791	53,056	29,073	55,644	34,868		
2. 18--24	492,348	142,699	107,826	33,808	10,046								122,712	75,257	180,412	125,649	118,807	67,480		
3. 25--44	809,820	227,845	118,173	66,250	29,535								295,192	72,825	305,639	160,377	283,647	60,157		
4. 45--64	322,413	105,965	70,506	38,739	8,068								86,220	12,914	145,167	78,829	85,757	12,660		
5. 65 & Over	24,816	5,776	10,182	*	*								*	*	*		*	*	*	
6. Total	1,822,037																			

[Note]* A treatment need estimate cannot be determined here due to low survey sample size for this demographic group from the 2004-2008 NSDUH for Texas, the prevalence rate of which is used to estimate treatment need.

[Sources] 1. 2008 Population Projections for Texas, Texas State Data Center and Texas Health and Human Services Commission, Oct. 2006 version. 2. 2004-2008 National Survey on Drug Use and Health (NSDUH) for Texas, Office of Applied Studies/SAMHSA, June 2010.
3. 2008 Texas School Survey of Substance Use Among Students in Grades 7-12, DSHS, April 2010. 4. "Secondary School Completion and Dropouts in Texas Public Schools 2006-07", Texas Education Agency, August 2008 (Dropout rates were used to adjust the Chemical Dependence rates among in-school youth).

How your State determined the estimates for Form 4 and Form 5 (formerly Form 8 and Form 9)

How your State determined the estimates for Form 4 and Form 5 (formerly Form 8 and Form 9)

Under 42 U.S.C. §300x-29 and 45 C.F.R. §96.133, States are required to submit annually a needs assessment. This requirement is not contingent on the receipt of Federal needs assessment resources. States are required to use the best available data. Using **up to three pages**, explain what methods your State used to estimate the numbers of people in need of substance abuse treatment services, the biases of the data, and how the State intends to improve the reliability and validity of the data. Also indicate the sources and dates or timeframes for the data used in making these estimates reported in both Forms 4 and 5. This discussion should briefly describe how needs assessment data and performance data is used in prioritization of State service needs and informs the planning process to address such needs. The specific priorities that the State has established should be reported in Form 7. State priorities should include, but are not limited to the set of Federal program goals specified in the Public Health Service Act. In addition, provide any necessary explanation of the way your State records data or interprets the indices in columns 6 and 7, Form 4.

How Your State Determined the Estimates for Form 4 and Form 5 (BG FFY2011):

I. Estimates for Adult Treatment Needs in Texas

The state estimates from the multi-year 2004-2008 National Survey on Drug Use and Health (NSDUH) were used to assess the adult treatment needs in Texas. The substance abuse treatment needs for adults were estimated by multiplying the 2008 adult population aged 18 and older by the percentage of those needing treatment for an alcohol or drug use problem if they met the diagnostic criteria for dependence on, or abuse of, alcohol or illicit drugs in the past 12 months, or received specialty treatment for alcohol or illicit drug use in the past 12 months from NSDUH. The number of individuals who would seek treatment was based on the percentage of persons who did not receive, but felt they needed, treatment for an illicit drug or alcohol problem, and persons who received treatment at a location other than a specialty facility but felt they needed additional treatment from NSDUH.

The NSDUH, conducted annually by the Office of Applied Studies (OAS) at the Substance Abuse and Mental Health Services Administration (SAMHSA), uses in-person interviews to collect data from which drug and alcohol use incidence and prevalence estimates are developed. Survey data are also collected periodically on special topics of interest such as serious mental illness, criminal behaviors, substance abuse treatment, and attitudes about drugs. The 2008 estimates for adult substance abuse treatment needs were based on a total sample of 11,878 Texans aged 18 and over in the 2004-2008 NSDUH data. The percentages of adults needing treatment by gender, age category, and racial/ethnic group for the State as a whole and for 11 sub-State planning areas were requested and obtained from the OAS in June.

As one of the eight large states sampled in NSDUH, the direct survey-weighted estimates were available for Texas. The direct design-based estimates for these eight states had relatively small standard errors, so that these estimates were assumed to be the "true values" for the purpose of validating the modeled estimates. To develop a good relative summary measure, the absolute value of the difference between the modeled estimate and the direct-weighted estimate for each of the eight states was divided by the direct-weighted estimate and averaged across the eight states to obtain an overall estimate of relative bias for each of the substance use measures. The overall standard errors of percentages were 0.34 percent for needing treatment prevalence and 0.07 percent for seeking treatment prevalence based on the 2004-2008 NSDUH data in Texas.

II. Estimates for Youth Treatment Needs in Texas

The statewide Texas School Survey of Substance Use Among Students (TSS) has been conducted biennially since 1988 and used to assess youth treatment needs in Texas. Youth substance abuse treatment needs were calculated by using the prevalence rates from TSS and the youth population aged 12 to 17 in Texas. Since the sampling design of TSS (a multi-stage cluster approach) is not based on regional strata, the method of census-based synthetic estimation is applied to measure the youth treatment needs in 11 sub-State planning areas. The basic logic of this form of synthetic estimation is extrapolation from estimated rates of demographic groups at the state level to the same demographic groups at the small area (e.g., county) levels of analysis. The synthetic estimate for the county is then calculated as the weighted average of the state rates

for each demographic group (the weights being the relative size of each demographic group within the county). In addition, since the TSS results can be generalized only to in-school students, the fact that school dropouts may have a higher prevalence of substance use is taken into account when estimating the treatment needs of youth population in Texas.

Youth are considered to be in need of treatment if they were chemically dependent. Based on TSS questions, a proxy parameter of chemical dependence is derived. Chemical dependence is defined as using a substance (except tobacco) daily or more than once per week and having had any of the following problems during the past school year: attended class high; gotten into trouble with teachers or police due to substance use; had difficulties with friends or dates due to substances; or driven while high on substances.

The 2008 TSS data was used to estimate the youth treatment needs in 2008. This survey included a sample of 98,898 Texas students in grades seven through twelve. Students were randomly selected from school districts throughout the State using a multi-stage probability design. Stage one was the selection of districts; stage two, the selection of classes within the sampled districts; and stage three, the selection of classes within the sampled schools. School districts along the Texas-Mexico border were over-sampled to allow statistically-valid comparison to the rest of the State. The survey asks students about the use of tobacco, alcohol, inhalants, and illicit drugs. Other questions pertain to the behavioral and demographic correlates of substance abuse, including risk and protective factors, sources of information about substance-related problems, and perceptions of peer values and attitudes. The TSS is a joint project of DSHS and the Public Policy Research Institute at Texas A&M University.

The TSS is compatible with the national Monitoring the Future Survey. To ensure the quality of the statewide survey data, a number of internal checks were put into place to guide the process. First, a quality control analyst oversaw the implementation of all pre- and post-analysis quality control procedures—from the initial mailing to the production of the final report. Also, the litho-coding is used to confirm that data from every survey instrument read was associated with the correct school district. Programming checks were also incorporated into the data analysis program by cross-analysis for data consistency. Exaggerated responses, such as those claiming to use a false drug or extremely high levels of drug and alcohol use, were identified and dropped from the analyses. If students failed to report both their grade level and age, the data were dropped from the analyses as well.

Weights were applied to the final TSS estimates so that the samples of students in each campus, district, and stratum reflected their proportions in the actual district, campus, and stratum populations. The 95 percent confidence interval for estimates regarding the Texas secondary school population as a whole in the 2008 survey was at most plus or minus 2.3 percent for lifetime alcohol use. Actual confidence intervals on most substances were smaller.

III. Data Sources for Need Estimates in Texas

[1]. 2008 Population Projections for Texas, Texas State Data Center and Texas Health and Human Services Commission, Oct. 2006 version.
[2]. 2004-2008 National Survey on Drug Use and Health for Texas, OAS/SAMHSA, June 2010.

[3]. 2008 Texas School Survey of Substance Use Among Grades 7-12, DSHS, April 2010.
[4]. "Secondary School Completion and Dropouts in Texas Public Schools 2006-07," Texas Education Agency, August 2008 (dropout rates were used to adjust the prevalence rates among in-school youths).
[5]. 2008 Behavioral Health Integrated Provider System Client Data, DSHS (for the percentage estimates of users of IV drugs among treatment clients).

IV. State Records Data for Columns 6 and 7 in Form 4

Column 6:
The 2008 numbers of Driving While Intoxicated (DWI) arrests and drug-related arrests were directly recorded and provided by the Uniform Crime Reporting (UCR), Texas Department of Public Safety. In UCR, crime reports are obtained from law enforcement agencies throughout the nation based on uniform classifications and procedures of reporting. Each contributing agency compiles and submits its own crime reports to the UCR program on a monthly basis. To maintain quality and uniformity in the data received, UCR field representatives provide training on detailed procedures for scoring and classifying offenses. The county-reported data was used to generate the regional data annually, which included both juvenile and adult arrests.

The DWI arrests are those offenses of driving under the influence. The drug-related arrests include those offenses of: (1) sale-manufacturing of opium/cocaine, marijuana, narcotics, and other drugs; and (2) possession of opium/cocaine, marijuana, narcotics, and other drugs. The arrest data is published annually.

Column 7:
The incidence data of Hepatitis B, AIDS, and Tuberculosis is recorded and provided by DSHS annually. The Hepatitis B data was based on the 2008 reported cases of vaccine-preventable disease statistics from Immunization Branch of DSHS. The AIDS data was from the 2008 Texas HIV/STD Surveillance Report by HIV/STD Epidemiology and Surveillance Branch of DSHS and the Tuberculosis data was based on the 2008 Tuberculosis cases by public health region from Tuberculosis Elimination Division of DSHS. The case definition for these surveillance data has been used on the basis of the recommendation of the Center for Disease Control and Prevention.

The 2008 population projection numbers in Texas were used to calculate the incidence rate per 100,000 population for each index.

Form 6 (formerly Form 11)

INTENDED USE PLAN

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

SOURCE OF FUNDS

	(24 Month Projections)					
Activity	**A.SAPT Block Grant FY 2011 Award**	**B.Medicaid (Federal, State and Local)**	**C.Other Federal Funds (e.g., Medicare, other public welfare)**	**D.State Funds**	**E.Local Funds (excluding local Medicaid)**	**F.Other**
Substance Abuse Prevention* and Treatment	$ 88,696,517	$ 0	$ 900,000	$ 30,364,502	$ 0	$ 415,314
Primary Prevention	$ 34,114,045		$ 0	$ 11,944,960	$ 0	$ 0
Tuberculosis Services	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0
HIV Early Intervention Services	$ 6,822,809	$ 0	$ 0	$ 1,106,276	$ 0	$ 0
Administration: (Excluding Program/Provider Lvl)	$ 6,822,809		$ 0	$ 2,434,034	$ 0	$ 0
Column Total	**$136,456,180**	**$0**	**$900,000**	**$45,849,772**	**$0**	**$415,314**

***Prevention other than Primary Prevention**

Form 6ab (formerly Form 11ab)

Form 6a. Primary Prevention Planned Expenditures Checklist

Activity	Block Grant FY 2011	Other Federal	State Funds	Local Funds	Other
Information Dissemination	$ 0	$ 0	$ 0	$ 0	$ 0
Education	$ 0	$ 0	$ 0	$ 0	$ 0
Alternatives	$ 0	$ 0	$ 0	$ 0	$ 0
Problem Identification & Referral	$ 0	$ 0	$ 0	$ 0	$ 0
Community Based Process	$ 0	$ 0	$ 0	$ 0	$ 0
Environmental	$ 0	$ 0	$ 0	$ 0	$ 0
Other	$ 0	$ 0	$ 0	$ 0	$ 0
Section 1926 - Tobacco	$ 0	$ 0	$ 203,219	$ 0	$ 0
Column Total	**$0**	**$0**	**$203,219**	**$0**	**$0**

Form 6b. Primary Prevention Planned Expenditures Checklist

Activity	Block Grant FY 2011	Other Federal	State Funds	Local Funds	Other
Universal Direct	$ 11,399,843	$ 0	$ 3,923,722	$ 0	$ 0
Universal Indirect	$ 4,819,511	$ 0	$ 1,658,831	$ 0	$ 0
Selective	$ 8,232,554	$ 0	$ 2,833,570	$ 0	$ 0
Indicated	$ 9,662,137	$ 0	$ 3,325,619	$ 0	$ 0
Column Total	**$34,114,045**	**$0**	**$11,741,742**	**$0**	**$0**

Form 6c (formerly Form 11c)

Resource Development Planned Expenditure Checklist

Did your State plan to fund resource development activities with FY 2011 funds?

◉ Yes ○ No

Activity	Treatment	Prevention	Additional Combined	Total
Planning, Coordination and Needs Assessment	$ 0	$ 0	$ 0	$ 0
Quality Assurance	$ 2,026,761	$ 792,713	$ 0	$ 2,819,474
Training (post-employment)	$ 318,177	$ 124,447	$ 0	$ 442,624
Education (pre-employment)	$ 0	$ 0	$ 0	$ 0
Program Development	$ 1,046,426	$ 409,281	$ 0	$ 1,455,707
Research and Evaluation	$ 0	$ 0	$ 0	$ 0
Information Systems	$ 761,822	$ 297,966	$ 0	$ 1,059,788
Column Total	**$4,153,186**	**$1,624,407**	**$0**	**$5,777,593**

Purchasing Services

This item requires completing two checklists.

Methods for Purchasing

There are many methods the State can use to purchase substance abuse services. Use the following checklist to describe how your State will purchase services with the FY 2011 block grant award. Indicate the proportion of funding that is expended through the applicable procurement mechanism.

☑ Competitive grants	Percent of Expense: 85.70 %
☑ Competitive contracts	Percent of Expense: 9.40 %
☑ Non-competitive grants	Percent of Expense: 4.60 %
☑ Non-competitive contracts	Percent of Expense: 0.10 %
☑ Statutory or regulatory allocation to governmental agencies serving as umbrella agencies that purchase or directly operate services	Percent of Expense: 0.20 %
☐ Other	Percent of Expense: %

(The total for the above categories should equal 100 percent.)

☐ According to county or regional priorities	Percent of Expense: %

Methods for Determining Prices

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

☑ Line item program budget

Percent of Clients Served: %
Percent of Expenditures: 42 %

☐ Price per slot

Percent of Clients Served: %
Percent of Expenditures: %

Rate: $	Type of slot:
Rate: $	Type of slot:
Rate: $	Type of slot:

☑ Price per unit of service

Percent of Clients Served: %
Percent of Expenditures: 51 %

Unit:	Rate: $
Unit:	Rate: $
Unit:	Rate: $

☑ Per capita allocation (Formula:)

Percent of Clients Served: %
Percent of Expenditures: 7 %

☐ Price per episode of care

Percent of Clients Served: %
Percent of Expenditures: %

Rate: $	Diagnostic Group:
Rate: $	Diagnostic Group:
Rate: $	Diagnostic Group:

Program Performance Monitoring

☑ On-site inspections

Frequency for treatment: OTHER See Footnotes -Performed as needed, based on performance-based assessment system

Frequency for prevention: OTHER See Footnotes-Performed as needed, based on performance based assessment

☑ Activity Reports

Frequency for treatment: MONTHLY

Frequency for prevention: OTHER Monthly, Quarterly and Annually

☑ Management Information System

☑ Patient/participant data reporting system

Frequency for treatment: MONTHLY

Frequency for prevention: MONTHLY

☑ Performance Contracts

☑ Cost reports

☑ Independent Peer Review

☑ Licensure standards - programs and facilities

Frequency for treatment: EVERY TWO YEARS

Frequency for prevention: NOT APPLICABLE

☑ Licensure standards - personnel

Frequency for treatment: EVERY TWO YEARS

Frequency for prevention: NOT APPLICABLE

Other:

☑ Specify: See Footnotes-Internal CMBHS Reviews and Focused CMBHS Reviews

ONSITE INSPECTIONS: A performance-based assessment system was created to select and monitor contractors. This performance-based assessment system includes 16 indicators grouped into four clusters. This system assesses all state funded contractors of substance services. The number of contractors varies from year to year.

The performance of each contractor in each of the 16 indicators is given a percentile ranking compared to other contractors providing the similar services. The four clusters are: Financial; Contract and Quality Management; Discharge Reason; and Treatment Outcome. Quarterly reports are generated showing the contractor rankings by cluster and by indicators. At the end of each fiscal year, a comprehensive analysis of the indicators is completed to assess the predictive validity of this value assignment and the need for possible adjustments. A similar analysis is completed for the clusters.

Each quarter a cross-functional meeting is held with representatives from Substance Abuse Contracts; Quality Management and Program Compliance; Decision Support; and Program Services. The cross-functional workgroup discusses the results of the most recent quarterly performance-based assessment report. Current and historical information about contractors identified in a group representing contractors at risk of poor performance is shared by the members of the cross-functional workgroup. The group determines which contractors would benefit from technical assistance, increased monitoring or quality management review of services based upon the discussion, analysis of the quarter, the trend analysis of prior quarters.

Within the DSHS organizational structure, the MHSA Quality Management and Program Compliance Unit provides oversight by performing onsite or desk reviews of contractors chosen by DSHS senior management or selected by the cross-functional team that reviews the performance-based assessment report and trend analysis. DSHS senior management may request statewide or focused reviews in an effort to gain information about targeted areas.

OTHER: Internal CMBHS Reviews and Focused CMBHS Reviews
Treatment: Based on Performance Based Assessment System
Prevention: Based on Performance Based Assessment System

Internal CMBHS reviews are conducted based on provider rating determined through quarterly risk assessment on all providers (which places
providers in low, moderate or high-risk categories).

Form 7

State Priorities

	State Priorities
1	Recovery Services: Recovery Services are those services that contribute to an individual's ability to obtain or maintain a clean and sober lifestyle. These services include, but are not limited to: stable housing, transportation, childcare, employment, and the establishment of a recovery community.
2	Substance Abuse Prevention: Prevention services follow a behavioral health prevention framework that incorporates evidence based programs and strategies. There is a comprehensive system that matches services to the interlinked problems of substance abuse and mental health needs of youth and adults, and local communities. Prevention programs provide the six CSAP prevention strategies, which include education, information dissemination, alternative activities, problem ID & referral, community-based process, and environmental strategies. These six strategies target the Institute of Medicine (IOM) classifications of Universal, Selective, and Indicated populations.
3	Specialized Female Services: In addition to their constituting a federal priority population, Texas also has given service admission preference to women with children who are involved with the Department of Family and Protective Services. residential and outpatient specialized female services programs provide or access to childcare, transportation, case management, gender specific counseling and other specialized services for pregnant and parenting women, including women seeking to regain custody of their children. The programs coordinate access to pediatric, perinatal and reproductive health care. Service integration and cross-system collaboration are priorities with the goal to ensure that this population receives access to the services they need.
4	Integrated Health Services: The Department of State Health Services will embrace the implementation of Recovery Oriented Systems of Care (ROSC) throughout the state. The concept primarily focuses on integrating health care services for the public through a coordinated approach. The ROSC will provide behavioral health services such as primary health care, mental health services, substance abuse services, and other services in a coordinated effort.

5	Medication Assisted Therapy: Medication Assisted Treatment (MAT) is pharmacotherapy relating to substance misuse. It combines pharmacological intervention with counseling and behavioral therapies. This model provides the patient with a comprehensive approach in the treatment of substance misuse disorders related to all funded levels of care. The most effective uses of MAT have shown to improve outcomes, increase retention in treatment, decrease illicit opiate use, decrease hepatitis and HIV infections, decrease criminal activities, increase employment, and improve birth outcomes for clients.
6	Statewide Tobacco Services: The statewide service delivery for tobacco prevention and control is a coordinated effort to establish smoke-free policies and social norms, assist tobacco users to quit, and to prevent initiation of tobacco use. This approach combines educational, clinical, regulatory, economic, and social strategies to reduce the personal and societal burden of tobacco-related deaths and illnesses. The use of media campaigns, cessation programs, and the implementation of smoke free ordinances are examples of the tobacco prevention efforts in the State.
7	Border Services: These services are provided to both adults and youth. The prevention programs use evidence based curricula that address gang violence, substance abuse prevention, and access to diversion services. Border services also include counseling intervention, and mental health and substance abuse treatment services. In addition, Texas participates in a bi-national effort that includes community mobilization, media campaigns, and organizing strategies that strengthen the border counties' responses against drug trafficking and youth involvement in gang activities.
8	Housing Services: In FY 2011, Texas will enter into a contract with Oxford House for the development of six residences in one of five metropolitan areas of the state. A revolving loan fund will be established to assist with initial housing expenses. This renewed emphasis on housing for persons who have completed treatment is consistent with guiding principles and our interest in reducing homelessness for this population. It ensures that Texas is consistent with SAMHSA's Strategic Initiative number five regarding housing assistance and homelessness. This effort is a beginning step to address housing issues for substance abusers.
	Coordination of Levels of Care: The Department of State Health Services will continue to develop a system to

9	enhance coordination of levels of care. The intent is to build a seamless continuum of care, and to build upon and implement the concepts of Recovery Oriented Systems of Care. Currently, funded services originate with ambulatory and residential detoxification. The array of services also includes residential and outpatient treatment services to the target population statewide. Other services are specialized services for women in treatment, adolescent treatment, co-occurring disorders, and persons with HIV related illnesses. A focus of attention will be to initiate recovery oriented systems of care in areas throughout the state and provide a service continuum that will allow a “whole person” approach to treatment.
10	Services for Injecting Drug Users (IDU’s): IDU’s are a targeted population in the state. Services are made available to IDUs in all 11 regions of the state. . IDU’s are given admission priority to treatment. Pharmacotherapy specifically targets the needs of persons addicted to opiates/narcotics. Outreach services target IDU’s and help persons to access treatment. Specialized female services are made available to IDU’s and their children.
11	Tele-health: Tele-health has been practiced in Texas for years; however it has not been used widely in the substance abuse field. The Department of State Health Services will be piloting this concept in rural areas around the state in collaboration with several stakeholders. The tele-health approach will complement the state’s implementation and development of Recovery Oriented Systems of Care. Making this practice available is another key element to the service delivery system, and will extend treatment services to more consumers across the state.
12	SBIRT–Implementation Services: Screening, Brief Intervention, and Referral to Treatment (SBIRT) is a comprehensive and integrated public health approach to identification, early intervention, and delivery of treatment services for persons at risk for, or suffering from, substance misuse disorders. SBIRT may be conducted in a variety of settings that include primary care centers, trauma centers, emergency departments, and other medical, social service, and criminal/justice settings.

Goal #1: Improving access to Prevention and Treatment Services

The State shall expend block grant funds to maintain a continuum of substance abuse prevention and treatment services that meet these needs for the services identified by the State. Describe the continuum of block grant-funded prevention (with the exception of primary prevention; see Goal # 2 below) and treatment services available in the State (See 42 U.S.C. §300x-21(b) and 45 C.F.R. §96.122(f)(g)).

Note: In addressing this narrative the State may want to discuss activities or initiatives related to: *Providing comprehensive services; Using funds to purchase specialty program(s); Developing/maintaining contracts with providers; Providing local appropriations; Conducting training and/or technical assistance; Developing needs assessment information; Convening advisory groups, work groups, councils, or boards; Providing informational forum(s); and/or Conducting provider audits.*

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

GOAL # 1. Improving access to prevention and treatment services

Overview of Plan: This Substance Abuse Prevention and Treatment Block Grant application provides a description of the public substance abuse prevention and treatment system in Texas. This application also includes the documentation of the states past compliance with federal requirements, current progress in meeting treatment and prevention goals, and the intended use of federal resources to support the delivery of community substance abuse services.

In Texas, health and human service agencies are consolidated into four departments under the Health and Human Services Commission, one of which is the Department of State Health Services (DSHS). DSHS is the single agency that administers public health services, mental health services, and substance abuse services. Specifically, mental health and substance abuse services are administered throughout the state through the Mental Health and Substance Abuse Services Division of DSHS. Because DSHS is assigned responsibility for public health in Texas, the state promotes activities to accomplish integration among all the public health services. Historically, substance abuse has been treated as separate from other health and public concerns rather than as a part of a continuum of overall health and wellness. With the interest in a system of integrated health care, DSHS has adopted a substance abuse service delivery system that promotes overall health and the prevention of disease through early intervention and intensive treatment. Use of a recovery-oriented system of care and evidence-based models are key attributes of the DSHS approach to developing an integrated health care system.

A variety of data and information sources were used to develop the information included in this application. These data and information sources include but are not limited to: DSHS agency strategic plan which is driven by legislative priorities; a recent treatment recovery initiative plan; a bi-annual statewide substance abuse service delivery plan; statewide needs assessment outcomes; stakeholder input; and federal guidance. Most recently, this federal guidance includes SAMHSA's ten strategic initiatives. Throughout this plan, DSHS's actions to address many of SAMHSA's strategic initiatives can be seen.

This application provides an up-to-date picture of the intended use plans for treatment and prevention services in the state, as of the time this plan was written. There are, however, several overarching activities that could lead to changes that could affect this plan. These activities are listed below:

- the implementation of a state Substance Abuse Medicaid Benefit;
- a treatment rate study to be conducted during state fiscal year 2011;
- the state Legislature will meet during the state fiscal year 2011; and
- the implementation of Federal Healthcare Reform

Continuum of Services: The Texas Department of State Health Services (DSHS) contracts with state licensed treatment programs and other community providers to deliver services to adolescents (13-17) and adults (18 and over). This is in accordance

with the block grant guidelines, the Texas Legislature, and the agency strategic plan. A funding formula determines the amount of funding allocated for each of the 11 Health and Human Service (HHS) regions in Texas, including the state's behavioral healthcare contract, NorthSTAR, which serves the Northeast Texas area. Each region provides a continuum of the services described below.

Treatment services for adults and youth engage the client and the family in recovery efforts from outreach through treatment and continuing care. Treatment addresses the client's psychosocial and familial needs along with treating the substance abuse or dependency. Treatment approaches are research-based, holistic in design, and emphasize coordination of care across the continuum. Service modalities include residential and ambulatory detoxification (for adults), intensive and supportive residential, and outpatient programs with varying intensities to meet client needs and preferences. Services include family, group, and individual counseling, as well as educational presentations and other support services. Adolescent services also include in-home and school-based counseling when appropriate and psychiatric consultation if deemed necessary via an assessment and/or interview. Recovery maintenance services are designed to assist individuals in completing treatment and sustaining gains made during treatment. These services include referrals for vocational training and child care. There is also one residential facility specifically designed to serve HIV positive substance abusing persons.

Specialized female treatment services (SFS) promote individual, familial, and economic self-sufficiency for pregnant and parenting women, including women attempting to regain custody of their children. Service intensities and types include detoxification, specialized residential treatment for women, residential services for women and their dependent children, and outpatient services. Treatment is designed to promote stable recovery from addiction, reduce the number of infants born drug- or alcohol-dependent or affected, and improve family functioning, academic success, and employment rates. Specialized services that contribute to the successful attainment of these goals include gender-specific and trauma-informed counseling that addresses issues of abuse and neglect, childcare, transportation, parenting education, and reproductive health care.

Pharmacotherapy services, referred to as opioid substitution therapy, is an adult treatment strategy that provides a client with the choice to use methadone or buprenorphine to facilitate higher functioning and to relieve symptoms associated with addiction to opiates. DSHS has worked to reduce the stigma associated with opioid substitution therapy, encourage the development of new clinical strategies, and promote individualized treatment planning. Particular attention is given to ensuring this treatment population has access to a continuum of services and is not restricted from full participation in mainstream treatment settings.

Co-occurring Psychiatric and Substance Abuse Disorders (COPSD) services are additional modalities provided to adult and adolescent clients with active psychiatric and substance use disorders who are receiving services in existing mental health and substance abuse treatment programs. These services are targeted to clients who require

crisis resolution and/or specialized support in treatment as a result of their co-occurring diagnosis. COPSD services address both psychiatric and substance use disorders and employ stabilization, coordination, and engagement strategies to help clients benefit from treatment.

Intervention Services are activities instrumental in the continuum of services. These services include Outreach, Screening, Assessment, and Referral (OSAR) which provides referral to treatment and other appropriate services. The OSAR provider assists with movement of block grant priority populations through the continuum of care, including being the link between treatment and community-based support services. Additional intervention services include: Pregnant Post Partum Intervention (PPI), HIV Early Intervention (HEI), and the Rural Border Initiative.

Prevention Services, more specifically described in Goal #2, are also an integral part of the continuum of substance abuse services. DSHS uses *The Strategic Prevention Framework* to guide prevention planning and activities in the state. Additionally, funding is made available to address the three classifications of prevention activities under the Institute of Medicine (IOM), which are universal, selective and indicated. And the six effective strategies outlined by CSAP are incorporated into all prevention programs.

Special Services: Any provider who serves an individual who has a severe hearing impairment may access a qualified interpreter for that person. Interpreter services are made available to providers through an interagency agreement with the Deaf and Hard of Hearing Division of the Texas Department of Assistive and Rehabilitative Services (DARS), which subcontracts with qualified interpreters throughout the state.

FY 2011 – FY2013 (Intended Use): DSHS will continue efforts to increase efficiency, improve access, and enhance the quality and outcomes of behavioral health services. Emphasis will be placed on strengthening use of research-based practices, improving integration of physical and behavioral health services, and expanding utilization of recovery support services.

In FY 2011, a continuum of treatment services will be maintained for adults and adolescents in all 11 regions throughout the state. Any treatment provider serving a deaf client will be able to access a qualified interpreter for the hearing-impaired client during services. Cultural diversity and competence will continue to play a critical role in all project development efforts. Clearer definitions for individual services have been added to FY 2011 contracts. Tobacco cessation services will be a contract requirement. Performance measures for treatment have been redesigned to align with National Outcome Measures. Investigation of potential uses of telemedicine will continue through all 3 fiscal years as funds and a qualified workforce continue to shrink. Federal healthcare reform activities will be a focal point for much of what the state and DSHS will do. Activities in this area will increase in each successive fiscal year.

As a result of recent legislation, the Texas Health and Human Services Commission (HHSC) and DSHS will continue to collaborate on development/implementation of the

substance abuse benefit package being added to the Texas Medicaid program. As mentioned in the progress section, outpatient services were implemented on September 1, 2010 and residential services are projected to being in January, 2011.

DSHS will focus on increased flexibility for reimbursement of youth treatment services. Enhanced quality management, training, and technical assistance will be provided for youth treatment providers who implement the Cannabis Youth Treatment Model that was first offered in FY 2007 in outpatient settings. DSHS plans to expand this research-based treatment modality to youth residential services in an effort to yield improved outcomes in both outpatient and residential treatment settings. DSHS will continue to implement the *Seeking Safety* program for pregnant women and women with dependent children. In addition, DSHS will continue its statewide training initiative on Motivational Enhancement Therapy (MET), Cannabis Youth Treatment (CYT), Trauma Informed Services/*Seeking Safety,* and Co-occurring Psychiatric and Substance Abuse Disorders (COPSD) to all substance abuse and mental health professionals. The goal is to improve skills and competencies, and strengthen the integrated service delivery system. Booster training and follow-up for staff that had prior training in Motivational Interviewing (MI) will continue to assess progress and continued advancement in the use of MI techniques.

Integration of physical and behavioral health into pilot sites and development of further integrated services will continue and expand throughout the state based on regular assessment of results.

Plans are underway to add transitional housing to the service continuum through the Oxford House concept. The Clinical Management Behavioral Health System (CMBHS) will be fully deployed by the end of FY 2010 thus providing improved accountability as well as more extensive data elements for research, monitoring, oversight, and reporting. The continued effort to secure additional dollars for all services is an ongoing activity. Assisting providers to secure local funding resources grows more important everyday.

In FY 2012, all of the above activities will continue. Quality Improvement and monitoring activities will continue as vital components of DSHS' ongoing efforts to determine which initiatives are effective and which need modification. Modification efforts will have designated time limits, and a diverse group of stakeholders will carefully consider the value of each less effective initiative before cessation.

Activities initiated in 2011 and 2012 will continue in FY 2013 based on their level of effectiveness. The Medicaid benefit, implemented in FY 2011, will be studied by the Texas Legislative Budget Board for cost effectiveness in early 2013. Under the direction of the Rider that authorized the benefit, the State may not provide those treatment services if the Legislative Budget Board determines that their utilization has resulted in an increase in overall Medicaid spending for adults. It is anticipated that the Medicaid benefit will generate cost savings to Medicaid that will offset the expense of the new benefit. Activities surrounding healthcare reform should increase in preparation for many components that are scheduled to begin in 2014.

GOAL # 1. Improving access to prevention and treatment services

FY 2008 (Compliance): In 2008, DSHS provided an array of detoxification, residential, and outpatient treatment services for adults and residential and outpatient treatments services for youth. These services were performed in each of the 11 Health and Human Service Commission regions through contracts with 142 treatment and 59 intervention programs. Ambulatory detoxification services for adults continued to be an important part of the continuum of care, specialized female programs were funded in every major population center, and at least one Co-occurring Psychiatric and Substance Abuse Disorder (COPSD) provider was funded in each region. Twelve of the 78 licensed opioid substitution therapy programs in Texas were funded by the Department of State Health Services (DSHS). These state-funded pharmacotherapy programs were available in major population centers in 8 of the 11 HHSC regions. In FY 2008 reimbursement rates for some services were increased to reflect the actual cost of these services. However, a gap still exists between covered and actual service costs.
Approximately $90,456,885 or 66.7% of the substance abuse block grant funds, and an additional $16,223, 219 in state general revenue (GR), were spent on substance abuse treatment services. The following table shows the number of adults and youth receiving treatment services and those successfully completing treatment services in FY 2008, as indicated by level of service:

	Detoxification	*Intensive Residential*	*Supportive Residential*	*Outpatient*
Adults receiving treatment	*10953*	*11,938*	*1974*	*21,567*
Adults completing treatment	*7,540*	*8,393*	*1,485*	*10,945*
Youth receiving treatment	*NA*	*1,770*	*258*	*4,683*
Youth completing treatment	*NA*	*1,090*	*221*	*2,475*

The table includes data for the following program types:

- Treatment Adult (TRA) and Treatment Youth (TRY): Services are provided by community-based organizations through DSHS contracts.
- NorthSTAR: A program serving adults and youth in seven counties in the Dallas area that uses Medicaid, substance abuse and mental health block grant, and local funding to provide coordinated behavioral health services through a behavioral health organization for adults and youth
- Texas Department of Criminal Justice (TDCJ): State general revenue-funded treatment services provided to adult probationers in the Treatment Alternative to Incarceration Program through the Community Justice Assistance Division of TDCJ
- Texas Youth Commission (TYC): State general revenue-funded treatment services provided to adolescents committed to TYC in four state facilities.

GOAL # 1. Improving access to prevention and treatment services

FY 2010(Progress): In SFY 2010, there are 133 treatment services contracts and 60 intervention services contracts renewed to maintain the treatment services for adults and youth in all 11 Health and Human Service Commission regions of the state. The number of contracts has remained fairly constant from several previous years.

Rates for many treatment services were slightly raised during SFY08; however, there is still a gap in costs covered for services. The state continues to make deaf interpreter services available to treatment providers who are serving the hard-of-hearing or deaf clients through the interagency agreement with DARS.

The treatment continuum consists of residential and ambulatory detoxification services (for adults only), intensive and supportive residential services, outpatient services, and opioid replacement therapy services. Within the treatment continuum, services and programs are designed to meet the specialized needs of pregnant women and women with dependent children, individuals with co-occurring disorders (COPSD services), intravenous drug users (IVDUs), individuals who are addicted to opiates, and individuals at risk for or with HIV, and other communicable diseases. Specialized female and pharmacotherapy services and programs are funded in every major population center. At least one Co-occurring Psychiatric and Substance Abuse Disorder (COPSD) provider is funded in each region.

During the Texas 81st Texas Legislative Session (2009), an appropriation rider was passed that directed the Texas Health and Human Services Commission (HHSC) to provide coverage for comprehensive substance abuse treatment services under Medicaid to persons who qualify for Medicaid. As a result of the rider, HHSC and DSHS have been working collaboratively on development of a comprehensive substance abuse benefit package to be added to the Texas Medicaid program. Much work has gone into getting these services operational and has involved many stakeholders around the state as well as staff. Services may include detoxification, limited residential treatment, outpatient detoxification, medication assisted treatment, specialized residential services for women, and outpatient chemical dependency counseling. The implement of outpatient services began on September 1, 2010 and residential services are projected to being in January, 2011.

A number of work groups and advisory groups have been initiated or have had their mission expanded to help DSHS to respond to many issues – some ongoing and some new. It must be noted that they are many, many more advisory groups, committees, task forces with widely varied charges. Only a few were selected for discussion in this section. These are:

- **Texas Recovery Initiative** (TRI) Task Force was formed in 2007 to implement a multi-phased project to gather information and develop recommendations for addiction treatment protocols that are evidence-based and recovery-oriented. The task force includes stakeholders such as services providers, academic groups, recovery support groups, advocacy groups and other state agencies. The first phase of

meetings, research, public hearings and task force discussions resulted in a final report of recommendations regarding the overall structure, development and implementation of the Texas Recovery Initiative. DSHS committed to continue addressing a number of issues that may impact implementation of the TRI such as workforce development, quantity and competency of Licensed Chemical Dependency Counselors, and limitations of the current services system including barriers to timely treatment and insufficient capacity. The Task Force reconvened in March 2010 and will meet again in August to continue its work. The TRI is viewed as an on-going collaboration that will have the ultimate goal of changing the substance abuse treatment and recovery system statewide.

- **Integration of Health and Behavioral Health Workgroup:** This workgroup, created during the 81st Legislative Session, was charged with recommending, back to the Legislature, best practices in policy, training, service delivery, and public education in order to promote the integration of physical and behavioral health services throughout Texas. The group is expected to gather information on barriers to integration and to implementing best practices. Three subcommittees were formed to focus on the areas of policy, training and public education, and service delivery. A stakeholder forum that brought together experts in the field of integration was held in March 2010. The committee's report to the Legislature was submitted August 1, 2010.

Youth outpatient treatment services include the Cannabis Youth Treatment Model. The target population for this model is adolescents with cannabis use disorders of abuse or dependence. The youth must be between the ages of 12-18 and assessed as appropriate for treatment in outpatient settings. This model of treatment is effectively implemented with adolescents who have mixed demographic characteristics such as race, age, socioeconomic group and gender, and from different geographic regions. The Cannabis Youth Treatment Model consists of Motivational Enhancement Therapy (MET) and Cognitive Behavioral Therapy (CBT). This includes two MET individual sessions that focus on factors that motivate clients to change. Depending on their need, clients participate in either five or twelve CBT sessions in which they learn skills to cope with their problems. The Family Support Network (FSN) components of the model consist of additional support for families. This includes home visits, parent education meetings, parent support groups, aftercare and case management.

Finally, *Seeking Safety* is utilized to improve access and outcomes for pregnant women and women with dependent children. *Seeking Safety* is an evidence-based, trauma-informed treatment model. In 2011, the use of this model is a contractual requirement for all residential specialized female contractors. The following table reveals the number of adults and youth receiving treatment services and those successfully completing treatment services as of June 30, 2010, indicated by level of service. This includes data for TRA, TRY, NorthSTAR, TDCJ, and TYC programs.

	Detoxification	*Intensive Residential*	*Supportive Residential*	*Outpatient*

Adults receiving treatment	*7,825*	*6,784*	*1,167*	*11,493*
Adults completing treatment	*5,446*	*4,601*	*858*	*5,978*
Youth receiving treatment	*NA*	*1,168*	*205*	*2,463*
Youth completing treatment	*NA*	*718*	*181*	*1,368*

Goal #2: Providing Primary Prevention services

An agreement to spend not less than 20 percent of the SAPT Block Grant on a broad array of primary prevention strategies directed **at individuals not identified to be in need of treatment**. Comprehensive primary prevention programs should include activities and services provided in a variety of settings for both the general population, and targeted sub-groups who are at high risk for substance abuse.

Specify the activities proposed for each of the six strategies or by the Institute of Medicine Model of Universal, Selective, or Indicated as defined below: (See 42 U.S.C.§300x-22(a)(1) and 45 C.F.R. §96.124(b)(1)).

Primary Prevention: Six (6) Strategies

• **Information Dissemination** – This strategy provides knowledge and increases awareness of the nature and extent of alcohol and other drug use, abuse, and addiction, as well as their effects on individuals, families, and communities. It also provides knowledge and increases awareness of available prevention and treatment programs and services. It is characterized by one-way communication from the source to the audience, with limited contact between the two.

• **Education** –This strategy builds skills through structured learning processes. Critical life and social skills include decision making, peer resistance, coping with stress, problem solving, interpersonal communication, and systematic and judgmental abilities. There is more interaction between facilitators and participants than in the information strategy.

• **Alternatives** –This strategy provides participation in activities that exclude alcohol and other drugs. The purpose is to meet the needs filled by alcohol and other drugs with healthy activities, and to discourage the use of alcohol and drugs through these activities.

• **Problem Identification and Referral** –This strategy aims at identification of those who have indulged in illegal/age-inappropriate use of tobacco or alcohol and those individuals who have indulged in the first use of illicit drugs in order to assess if their behavior can be reversed through education. It should be noted however, that this strategy does not include any activity designed to determine if a person is in need of treatment.

• **Community-based Process** –This strategy provides ongoing networking activities and technical assistance to community groups or agencies. It encompasses neighborhood-based, grassroots empowerment models using action planning and collaborative systems planning.

• **Environmental** –This strategy establishes or changes written and unwritten community standards, codes, and attitudes, thereby influencing alcohol and other drug use by the general population.

Institute of Medicine Classification: Universal, Selective and Indicated:

o ***Universal:*** Activities targeted to the general public or a whole population group that has not been identified on the basis of individual risk.
o ***Universal Direct. Row 1*** —Interventions directly serve an identifiable group of participants but who have not been identified on the basis of individual risk (e.g., school curriculum, after school program, parenting class). This also could include interventions involving interpersonal and ongoing/repeated contact (e.g., coalitions)

o ***Universal Indirect. Row 2***—Interventions support population-based programs and environmental strategies (e.g., establishing ATOD policies, modifying ATOD advertising practices). This also could include interventions involving programs and policies implemented by coalitions.
o ***Selective:*** Activities targeted to individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than average.
o ***Indicated:*** Activities targeted to individuals in high-risk environments, identified as having minimal but detectable signs or symptoms foreshadowing disorder or having biological markers indicating predisposition for disorder but not yet meeting diagnostic levels. *(Adapted from The Institute of Medicine Model of Prevention)*

• *Note:* In addressing this narrative the State may want to discuss activities or initiatives related to: *Disseminating information to stakeholders; Providing education; Providing training/TA Discussing environmental strategies; Identifying problems and/or making referrals; Providing alternative activities; Developing and/or maintaining sub-state contracts; Developing and/or disseminating promotional materials; Holding community forums/coalitions; Using or maintaining a management information system (MIS); Activities with advisory council, collaboration with State Incentive Grant (SIG) project; Delivering presentations; Data collection and/or analysis; Toll-free help/phone line provision; Procuring prevention services through competitive Request for Proposals (RFPs); Site monitoring visits*

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

GOAL 2 – 20% For Primary Prevention

FY 2011- 2013 (Intended Use) Overview Summary:
The Department of State Health Services issued the *DSHS Behavioral Health Prevention Services Request for Proposals* (RFP): SA-PREV-242.1, on December 21, 2007, and the *Coordinated Training Services Request for Proposals*: RFP#SA-PREV-242.1, on November 14, 2007, to solicit proposals for the procurement of prevention services in Texas. The contract awards made under each RFP are renewable for up to five years, contingent on funding availability and remain at the sole discretion of DSHS. The services outlined for FY11 for Intended Use will be very similar for the 3 remaining years of this funding cycle.

In FY11, the DSHS prevention staff will work with Center for Substance Abuse Prevention (CSAP) on the development of a strategic prevention plan for the state of Texas. This plan will provide the direction for the next Prevention Request for Proposal (RFP) for the procurement of Behavioral Health Prevention Services. This initiative is scheduled to begin in FY12 for funding in FY14. In FY12, DSHS will continue to assess the federal vision and direction of service delivery for substance abuse prevention services. Additionally, DSHS will continue to stay abreast of the federal direction of Health Reform and the potential impact on prevention services and funding. DSHS will complete the development of the scopes of work for youth prevention services in Texas and host Request for Information (RFIs) Public Hearings. Such hearings assist DSHS to obtain input and information from the provider field regarding the delivery of future prevention services. The information also will be used to guide the development of the FY14 RFP for prevention services. DSHS anticipates issuing a new Behavioral Health Prevention Services RFP for delivery of services in FY14.

In FY11 – FY13, DSHS projects to fund over 70 prevention providers through a renewal process. The providers will provide primary prevention services through the implementation of evidence-based curriculum in school and community sites, and population-based services through evidence-based strategies implemented via coalition partnerships and the Prevention Resource Centers. This is anticipated to include 77 programs for Universal Direct Services, 60 programs for Selective Services, 50 programs for Indicated Services, and 36 programs for Universal Indirect Prevention Services. All programs will continue to be structured and planned according to the Strategic Prevention Framework (SPF) model and will implement the six CSAP prevention strategies to ensure comprehensive continuum of prevention services in their communities. Contractors will continue to provide universal, selective, and indicated prevention services to youth (0-17) and adult (18 and older) target populations throughout the 11 HHSC Regions that encompass Texas.

In FY11 – FY13, DSHS projects spending approximately 25% of the total Block Grant funds on primary prevention services. This distribution of funds is consistent with the federal set-aside requirement (including expenditures for the Tobacco Synar Survey).

DSHS will continue to monitor the expenditures of SAPT Block Grant funds. The purpose of the monitoring process is to ensure that prevention activities are appropriately and effectively implemented. This includes ensuring that prevention activities increase protective factors, reduce risk factors, provide prevention education, and implement comprehensive strategies. The ultimate goal of the prevention activities is to promote resiliency to deter or reduce the use and abuse of alcohol, tobacco, and other drugs among Texas youth and their families.

DSHS will continue to implement a behavioral health framework that allows for efficient, cost-effective, and culturally-appropriate prevention services for substance abuse and other mental health related disorders. The behavioral health framework will enhance the state's ability to provide a comprehensive continuum of services and promote individual, family, and community health. Services are designed to prevent substance abuse, promote mental health, support resilience, foster recovery, promote treatment, and prevent relapse.

FY 2011 - FY 2013 Intended Use: Direct Services for Universal, Selective, and Indicated Programs: DSHS will fund universal, selective, and indicated prevention contracts through a contract renewal process. Please see Table A below for the projected number of youth and adults to be served between through direct programs, services, and activities.

DSHS projects to serve the following participants through direct service programs, strategies, and activities in FY11 –FY13: (YPU, YPS, and YPI)

Year	Youth	Adults
FY 2011	209,658	8,886
FY 2012	211,126	8,948
FY 2013	212,064	9,011

The DSHS funded ***Universal (Direct) prevention programs*** will target the general population in the state of Texas. The strategies will address the entire population with messages and programs designed to prevent or delay the onset of alcohol, tobacco, and other drug use. The goal of universal prevention is to deter the onset of substance abuse by providing all individuals with the information and skills necessary to prevent the problem. All members of the population share the same general risk for substance abuse, although specific individual risk may vary greatly. Universal prevention programs will be delivered to large groups without any prior screening for substance abuse risk. The entire population is assessed as at-risk for substance abuse and capable of benefitting from prevention programs.

The DSHS funded ***Selective prevention programs*** will provide services to subsets of the total population who are considered to be at risk for substance abuse based on identified risk factors in specific population segments. Examples of at-risk subsets include, but are not limited to, children of alcoholics, drop-outs, and students struggling academically. Risk groups may be identified on the basis of biological, psychological, social, or environmental risk factors known to be associated with substance abuse (IOM 1994). Targeted subgroups may be defined by age, gender, family history, place of residence

(such as high drug-use or low-income neighborhoods) and victimization by physical and/or sexual abuse. Selective prevention programs will target the entire subset, taking into consideration the degree of risk of all individuals within the group. The selective prevention programs will be presented to the entire subgroup, because the subgroup as a whole is at higher risk for substance abuse than the general population.

The DSHS funded ***Indicated prevention programs*** also will provide services to subsets of the general population. The Indicated prevention services will target individuals who exhibit early signs of substance abuse, such as experimentation and other problem behaviors associated with substance abuse, but who do not meet the DSM-IV criteria for addiction. These indicated programs will address risk factors associated with the individual. The goals of indicated prevention programs are to reduce first-time substance use/abuse, reduction in the length of time that indicators or risks continue, delay of onset of substance abuse, and/or reduction in the severity of substance abuse. Individuals may be referred to the indicated prevention programs by parents, teachers, school counselors, school nurses, youth workers, friends, or the courts. In some cases, individuals refer themselves for participation in indicated prevention programs.

DSHS-funded indicated prevention services contractors will implement strategies such as indicated prevention counseling and, when necessary, referrals to appropriate support services. These strategies will ensure that individual participant's needs are identified, and that referrals are provided for the appropriate support services. These services may include referrals to the DSHS funded Outreach, Screening, Assessment and Referral (OSAR) programs, where a substance abuse screening and assessment may determine the need for treatment or other services.

The prevention programs will deliver evidence-based curricula and implement the six effective CSAP strategies in schools and community sites. These strategies include: *Prevention Education, Information Dissemination, Alternative Activities, Community-Based Processes, Environmental Approaches, and Problem Identification and Referral.*

The full array of prevention services will be implemented to reach the diverse populations of Texas, and will utilize the most appropriate Institute of Medicine (IOM) type for the specific targets. These prevention services will be offered in public and private schools, charter and alternative schools, and numerous types of community sites, including homeless shelters, housing projects, and juvenile justice academy programs. The newest target population for the universal-direct, selective, and indicated programs is the military population. Texas has large military communities and the DSHS funded prevention providers are aware of many needs that have developed among the military families due to the war, ongoing deployment, or loss of parents and/or family members. Based on these needs, more prevention providers are reaching out to the military communities to inform them of the services that are available in the general community. DSHS funded contractors will continue to work with schools located on military bases to provide prevention services that are predicated on identified needs in an effort to make services available to military children and families.

The providers will continue to implement other key prevention strategies. These will include prevention presentations for youth and adults regarding issues such as minors and tobacco, and substance free activities that promote safe and healthy alternatives for youth. These prevention services are offered to children and adults in various school and community settings.
The providers will continue to participate in DSHS-funded and non DSHS-funded community coalition partnerships and in population based activities hosted by their program or coalition. These strategies are targeted at the general population to increase awareness about alcohol, tobacco, and other drug issues in their communities, and the need for laws, policies, and changes in social norms to prevent the use of substances. The prevention providers also will continue to collaborate with the Local Mental Health Authorities (LMHAs) to promote the prevention of substance abuse and other mental health related disorders. The prevention programs will continue to build on established relationships to maintain ongoing communication and stay abreast of mental health services available for children and families in Texas.
The entire state population is expected to be served through universal-direct, universal-indirect, selective, and indicated prevention programs. DSHS-funded providers will continue to report key performance measures monthly, outcome measures quarterly, and to submit required reports. DSHS will continue to use data and reports to assess the successes, challenges, and effectiveness of these programs, and to help identify and provide technical assistance when necessary.

DSHS also will continue to monitor current issues and trends across Texas that may determine service needs for special target populations, such as the military population and populaces affected by disasters. Additionally, DSHS will continue to stay abreast of the ongoing and increasing border violence in the communities located along the Texas/Mexico border, and their increased needs for services due to the effects of border violence.

FY 2011 – FY 2013 Intended Use: Rural Border Intervention (RBI): The Rural Border Intervention project is an intervention within the Substance Abuse Treatment services and is not funded by the block grant prevention set aside. The RBI is included only to reflect the continued prevention services and efforts projected to be delivered through this RBI as one of the components of the project. The RBI program implements family focused evidence based curriculum as part of the prevention strategies of the project. The purpose of the Rural Border Intervention projects is to develop and implement a comprehensive behavioral health model that promotes and embraces culturally competent prevention, intervention, and treatment for youth and adults in rural border communities including Colonias. This model is designed to make services more accessible in the rural border areas in Texas.

In August and September of 2010, one of the five RBIs "unveiled" two new Border Violence and Disaster Prevention curricula at two conferences on the Border. The first conference focused on families (approximately 200 attendees), and the second was for service providers and Promotoras/Community Health Workers (CHWs). All five RBIs contributed to the new curricula and served on the task force, so that training and

information would be relevant to all the parts of the Texas border. The focus of the curricula is to support the RBI programs' substance abuse prevention efforts related to substance abuse and mental health issues. All RBI staff will be trained in the delivery of the curricula during this year. The staff then will disseminate appropriate information to families in their communities. In conjunction with the five RBI projects, DSHS will examine the effectiveness of the Border Violence and Disaster Prevention curricula. Presently, this will not consist of a formal research based assessment; instead, it will be an anecdotal review and report.

The DSHS RBI Program Coordinator, who is a certified Promotora Instructor, will partner with a Texas A&M University (TAMU) Promotora Instructor to train and certify border area CHWs on these curricula so that they may utilize the materials in their work with Colonia families. This training will provide services directly to members of the community, and will enhance the skills of the CHW workforce. A goal of the initiative is to train at least 25 CHWs in the first year.

DSHS will continue to work closely with the RBI programs to monitor substance abuse issues related to drug trafficking and violence, and the subsequent impact on their programs and communities. Quarterly calls with the RBI programs and their quarterly narrative reports will aid with monitoring and with generating strategies to continue support of the programs and communities. DSHS will encourage RBI bi-national partnerships and collaborations, and will develop stronger connections with the Texas Office of Border Health and DSHS MH (behavioral health) services through Local Mental Health Authorities (LMHAs).

DSHS-funded RBI programs will participate in bi-national health promotion activities with the DSHS Office of Border Health. This collaboration will promote substance abuse service awareness, and will encourage HIV testing in border communities through local, state, and federal initiatives. DSHS will continue to search for resources and methods to expand these programs to serve more people and support strategies that will help the RBIs with continued sustainability. DSHS will request additional funds from the State Legislature for this initiative.

Advocacy for increased funding for these services will focus on the growing needs of the area, and the continuing violence and drug trafficking that creates significant problems for families and individuals. Additional and specialized RBI services for the El Paso area will be supported in recognition of the violent and complex nature of this region of the Border, and the effectiveness of the RBIs. More effort will be placed on community mobilization and community building. With RBI services expanding to urban El Paso, there will be an increased need for TA and program support from the state. Program adjustments will be considered to allow for an easy transition of the expansion of the rural program model to the urban model. The focus will be on the Colonias of El Paso County.

DSHS will combine and update two curricula that have been developed to train certified CHWs on the Border. The first curriculum is, "Behavior Change with SA and MH"

(2006), and the second is entitled, "Border Violence and Disaster Prevention," (2010). By combining these two-four hour curricula, DHS can better train and leverage the programs for use in border communities.

FY 2011 – FY 2013 Intended Use - Universal Indirect Services:
DSHS will fund 36 universal indirect prevention contracts through a contract renewal process to provide Indirect prevention services. The contracts will include 11 Prevention Resource Centers (PRCs), 23 Community Coalition Partnerships, 1 Prevention Media Campaign, and 1 Prevention Statewide Coordinated Training Service. Please see the table below for the projected numbers to be served through the indirect services. The Universal Indirect Services are described below the table.

DSHS projects to serve the following participants through universal indirect service programs, services, and activities in FY2011 – FY2013: (PRC and CCP)

Year	Youth	Adults
FY 2011	2,264,934	4,099.380
FY 2012	2,280,789	4,128,076
FY 2013	2,296,754	4,156,972

FY 2011 – FY 2013 Intended Use - Prevention Resource Centers (PRCs)
DSHS will fund one Prevention Resource Center (PRC) in each of the 11 HHS regions through a contract renewal process. The PRC will support information dissemination statewide to schools, communities, prevention providers, Local Mental Health Authorities (LMHAs), churches, professional associations, colleges and universities, and other interested groups throughout the year. The PRCs will continue to collaborate with the statewide prevention Coordinated Training Services (CTS) to provide accessible prevention training in their respective regions. The intended target population for each PRC will be the residents in its respective HHSC Region, ensuring coverage of the entire population of Texas.

Each PRC will maintain a web site with state-of-the-art prevention resources and information. Additionally, the PRCs will serve as a prevention literature and material clearinghouse, and as a book and video lending library. PRCs will maintain a statewide toll-free number to provide information about prevention resources, training, and services. The DSHS web page will provide a comprehensive base of information regarding substance abuse that will include federal, state, and local resources, research, needs assessment data, media campaigns, and information in English and Spanish.

The PRCs will update their needs assessments annually for their region and make it accessible to all service providers and the general population on their website. Service enhancements and delivery for each region will be structured and based on the results of the updated needs assessment. The PRCs will to establish memorandums of agreement with community based organizations in an effort continue to reduce gaps in services and expand the prevention infrastructure to enhance service delivery in Texas. The PRCs will coordinate the training services provided by the statewide prevention Coordinated Training Services (CTS) contractor, and will work with the CTS contractor to ensure that the service

providers participate in the updates or developments of CTS regional training needs assessment.

The PRCs will provide tobacco prevention strategies for minors that include community education, retail merchant education, media awareness, and tobacco prevention coalition building within a region. The PRCs' Tobacco Prevention Specialists will provide support for other DSHS youth prevention program providers in their efforts to create awareness and to provide updated and current information on tobacco prevention, cessation, laws, and long-term and short-term harmful health consequences of tobacco use.

The PRCs will support community providers with the implementation of tobacco prevention activities to create awareness and provide helpful information in the prevention of tobacco use, as well as information on quit lines and other cessation programs. The PRCs will continue to support school and community events such as Red Ribbon, Tobacco Kids Free Day, health fairs, and other activities. The PRC will provide literature, brochures, bookmarks, and other materials that will enhance the information dissemination strategy that is required of all DSHS funded prevention contractors.

The PRCs will continue with tobacco prevention strategies, such as retailer compliance checks, and retailer and community educational presentations that have reduced the buy rate in Texas. The PRCs have been an integral partner in tobacco prevention activities that have helped Texas to reduce or maintain the buy rate as required by the federal government. The PRCs, along with all the DSHS funded direct service prevention programs (YPU, YPS and YPI), will continue to implement tobacco prevention strategies to create awareness of the laws related to minors and tobacco, as well as retailer compliance, and general education.

The PRCs will participate in the DSHS-coordinated quarterly conference calls and attend the Annual Prevention Provider Meeting, the Fall Meeting, and the Spring Meeting that are designed to provide additional training, technical assistance, and support to all the PRCs. These calls and meetings will provide the PRCs and their staff with an opportunity to meet, network, and share the successes of program implementation in their communities.

The chart below indicates the anticipated number of participants served/ activities completed by the PRCs.

Activity Type	FY 2011	FY2012	FY2013
Youth and Adults receiving ATOD information	Youth – 584,437 Adults – 199,649	Youth – 588,528 Adults – 01,047	Youth – 592,648 Adults – 202,454
Media Awareness Activities - ATOD	1,366	1,376	1,386
Tobacco Presentations pertaining to minors and tobacco Youth and Adults attending minors and tobacco presentations	2,366 Youth – 69,405 Adults – 16,830	 Youth –69,891 Adults –16,947	 Youth –202,454 Adults –17,066
Media Contacts pertaining to tobacco	854	860	866
Tobacco Retailer Compliance Checks	12,984	13,074	13,166

Written Community Agreements	486	489	493

FY 2011 – FY 2013 Intended Use - Community Coalitions (CCP)
DSHS will fund contracts with 23 community coalitions through a contract renewal process. The coalitions will address community concerns regarding the prevention and reduction of the illegal and harmful use of alcohol, tobacco, and other drugs in the target counties across Texas. The primary emphasis is the reduction in youth and young adult use by promoting and conducting community-based and environmental strategies. In addition, DSHS will require all contractors to implement the Strategic Prevention Framework (SPF) model for evidence-based practices within community coalitions.

Activities of the CCP's will focus on the establishment or changing of laws, policies, and social norms within the community through environmental strategies. These evidence-based strategies include: assisting communities to monitor the enforcement of laws relative to the sale of alcohol and tobacco to minors, affecting the promotion and availability of substances in the community, and affecting social norms and community beliefs about alcohol, tobacco, and substance use. Other strategies include the development of comprehensive school policies, providing assistance to schools and community partners, and educating policy makers on the needs and gaps in substance abuse services.

The CCPs will participate in the DSHS coordinated quarterly conference calls and attend the Annual Prevention Provider Meeting, the Fall Meeting, and Spring Meeting that are designed to provide additional training, technical assistance and support to all the PRCs. These calls and meetings will continue to provide the CCPs and their staff with an opportunity to meet, network, and share the successes of program implementation in their communities.

FY 2011 – FY 2013 Intended Use- Coordinated Training Services (CTS):
CTS will provide statewide prevention training services and technical assistance. In years three through five of the funding cycle, the majority of the field will have been trained in the evidence based curriculum with the exception of the Provider's new hires. The number of curriculum trainings will be reduced over the next three years. CTS will schedule evidence based curriculum training as requested by the providers, based on need. CTS will increase new prevention training designed to meet the requirements for the specific Substance Abuse Prevention Specialist Certification domains, other ATOD prevention training, and workforce development training to enhance the skills of the prevention specialists who provide direct services and training on communicable diseases.

The CTS will work with DSHS, DSHS-funded providers, and the Education Service Centers in their respective regions to ensure the delivery of prevention training services that will maintain and strengthen the prevention infrastructure throughout Texas.

In FY11, CTS will update the FY09 Prevention Training Needs Assessment to determine new and future training needs of the DSHS funded prevention providers. The new Training Needs Assessment will assist CTS with the development of the annual Training Plan, Marketing Plan, and enhancement of the cadre of trainers that will help the state to meet the prevention training needs in Texas.

CTS will also maintain the toll-free phone number and provide the CTS and Coalition websites with the current training, conference, and resource information to make training easy and accessible to DSHS prevention providers. CTS will provide DSHS with monthly reports that include: evaluation information, curricula distribution, the number of the various types of prevention and curricula training, number of training hours provided, technical assistance activities, and evaluations.

CTS will provide DSHS with assistance and support in the coordination of the following activities: the DSHS Annual Prevention Provider Meeting; the Annual Fall Meeting; the Annual Spring Meetings for the Prevention Resource Centers (PRC) and Community Coalition Partnerships (CCPs); and the Texas Collaborative Prevention Committee webinars.

FY 2011 – FY 2013 Intended Use - Professional Development Events and Other Activities

DSHS will continue to sponsor the Annual Behavioral Health Institute (BHI) Conference. The BHI will continue to provide a comprehensive continuing education opportunity for the substance abuse and other social service field professionals. The BHI will include educational tracks in the following areas: *Prevention Leadership, Substance Abuse Treatment, Counseling Essentials, Mental Health, Family Issues, Youth Issues, and Technology*. The 40-hour Substance Abuse Prevention Specialist Training will continue to be offered at the Institute. In FY11 –FY13, DSHS expects the BHI to provide yearly training to more than 1,500 professionals in the fields of prevention, treatment, mental health, and related social service areas.

The state will continue the collaboration with other state agencies to sponsor the ***Partners in Prevention*** and the ***Strengthening Families Conferences***. These conferences will provide state agencies with the opportunity to pool resources to provide education for professionals in social service fields.

DSHS will maintain a relationship with the Southwest Center for Application of Prevention Technologies (CAPT) from Norman, Oklahoma. This continued partnership will support a Texas state liaison position to provide technical assistance for the Certified Prevention Specialist certification and other prevention related training. DSHS will provide office space, equipment, technical support, and oversight. The arrangement is expected to promote workforce development in Texas.

Annual Prevention Provider Meetings: Prevention Day in Texas

DSHS will host the Annual Prevention Provider Meeting: Prevention Day in Texas. The meeting will be facilitated by DSHS staff. Prevention Day in Texas and the meeting will

provide Contractors with continuing education/training opportunities, prevention best practices, and current trends in Texas. Other opportunities will include information sharing, questions and answers regarding the prevention contract requirements, general provisions, rules, performance measures, and definitions, in addition to information regarding any changes to the specific contracts from the previous years. Besides sponsoring Prevention Day in Texas, DSHS also facilitates Annual Fall and Spring Meetings for the PRC and CCP programs. These meetings provide learning, networking, and resource sharing opportunities to improve service delivery in Texas.

DSHS Texas Collaborative Prevention Committee
DSHS will continue to host quarterly Webinars/Conference calls or face to face meetings with the Texas Collaborative Prevention Committee (TCPC). The TCPC is comprised of representatives from each DSHS-funded prevention program type. DSHS will work with the TCPC members to establish new workforce standards that will apply to DSHS funded prevention programs across the state. The TCPC serves as a direct link for ongoing communication between DSHS and DSHS-funded providers. DSHS will work with the TCPC to enhance systems and strategies for the delivery of effective and accessible services to the children and families in Texas.

Prevention Media Campaign (PMC)
DSHS will fund the Partnership for Drug-Free Texas (PDFT), which is a statewide media campaign that is designed to shape attitudes about the use of alcohol, tobacco, and other drugs. Its goal is to reduce youth drug use in Texas by distributing research-based media messages that are created by the Partnership for a Drug-Free America, and supplementary marketing materials developed specifically for Texas. Through the Partnership for a Drug-Free Texas, the PMC will utilize Partnership for a Drug-Free America television and radio's public service announcements tagged with Texas-specific referral information.. PDFT is progressing toward digital PSA distribution and will continue to reach millions of Texans with these spots. The spots will be distributed via media outlets that donate air-time to promote these messages.

The PMC will provide news stories on substance use and abuse issues to radio stations across the state. The Texas Drug Free Radio News will provide access to 60-second prevention news stories to approximately 230 English and Spanish radio stations across the state. These spots are projected to reach 3.7 million listeners. Through the PMC, DSHS will produce and distribute culturally appropriate posters and other resources, and will continue to lead the annual State Red Ribbon Campaign. In addition, DSHS will provide a statewide toll-free number (1-877-9 NO DRUG) for information and referrals. Toll-free phone lines will be answered around the clock by professionals trained in crisis management. The toll-free number will be published on the PDFT materials, on the DSHS website, and as a tag line to the PMC public service announcements.

Drug Demand Reduction Advisory Committee (DDRAC)
The DDRAC is a legislatively established committee with a mandate to develop a comprehensive statewide strategy and make legislative recommendations to reduce drug demand in Texas. The state directed that 16 state agencies and five at-large members

from different geographical areas within the state participate in this effort. DDRAC will continue to conduct numerous initiatives to build on the legislatively-mandated statewide strategy to reduce drug demand in Texas. In FY 2011 – FY 2013, the DDRAC will focus on workforce development and training, border initiatives, and communications/media strategies. The committee will continue to foster interagency collaboration and seek federal support for legislative recommendations, particularly through ONDCP's Demand Reduction Interagency Working Group (IWG) and the newly established National Health Care Workforce Commission.

GOAL 2 – 20% For Primary Prevention

FY 2008 (Compliance): In FY 2008, DSHS funded 191 primary prevention programs throughout the 11 Health and Human Services Commission (HHSC) regions in Texas through a contract renewal process. DSHS spent $34,589,118.00 or approximately 25.5% of the block grant funds on primary prevention programs that provided services to children and youth ages, 0-17, and their families who did not require substance abuse treatment. DSHS required the use of evidence-based curriculum to increase awareness, knowledge, and skills and to foster resiliency to deter or reduce the use of alcohol, tobacco and other drugs among Texas youth and their families.

FY 2008 was the final year of a five year prevention funding cycle. In July 2008, DSHS announced the new prevention services awards for the *Behavioral Health Prevention Services* RFP #: SA-PREV-242.1 issued on December 21, 2007.

- In FY 2008, prevention service providers implemented strategies that included the six Center for Substance Abuse Prevention (CSAP) strategies. The goal was to provide comprehensive prevention services to reduce risk and increase protective factors. These strategies included ***prevention education*** using approved evidence-based curriculum aimed at affecting critical life and social skills, decision-making, and refusal skills; ***information dissemination*** was provided to participants and their families with information about prevention programs and services available, drug use and abuse, addiction and the effects on individuals, families, and communities; ***alternative activities*** were provided to individuals with opportunities to participate in activities that exclude drug use and promote healthy and constructive behaviors to offset the attraction to drugs; ***community-based processes*** were used by service providers to establish collaborative, networking, planning and organizing opportunities to deliver services more effectively and efficiently, the service providers participated in other DSHS funded coalition partnerships to work and support the efforts to establish or change community standards, attitudes, social and community norms as well as laws and policies impacting substance use or abuse to include ***environmental approaches*** in their prevention efforts; service providers included ***problem identification and referral*** as one of their strategies by identifying individuals in need of substance abuse prevention and other support services and then provided the necessary referrals for support services, or for formal substance abuse screening and assessments through the DSHS funded Outreach, Screening Assessment and Referral (OSAR) program located in their respective Health and Human Services Region.

  Prevention service providers reported monthly key performance measurement data on the six effective CSAP strategies implemented and quarterly outcome data to report the successful completion of the programs. This data was used to obtain an overview of the program successes and effectiveness by program type in diverse communities throughout the state of Texas.

- In FY 2008, DSHS implemented and reported substance abuse prevention strategies within the context of the Institute of Medicine (IOM) classifications, which included Universal Direct, Universal Indirect, Selective, and Indicated services.
- In FY 2008, DSHS maintained the Universal Direct and Universal Indirect as two separate sub-categories of the previous Universal classification. They are defined as follows:
    - **Universal (Direct)** - interventions that directly serve a group of participants who have not been identified on the basis of individual risk. Examples include school curriculum, after-school programs, and parenting classes.
    - **Universal (Indirect)** - interventions that support population-based programs and environmental strategies including the provision of information, technical assistance, establishing Alcohol, Tobacco and Other Drugs (ATOD) policies, and modifying ATOD advertising practices.

- In FY 2008, the prevention needs estimation methodology that was developed in FY 2004 continued to guide the Universal, Selective and Indicated allocations of the SAPT Block Grant funds. This represented an effort to balance best practices, effective prevention principles, resources, needs and expenditures for services. The regional allocation formula was applied to the IOM strategies and resulted in the following allocations for each of the 11 HHSC regions: 33.4% of prevention funds were directed to Universal Direct services, 14.1%were allocated to Universal Indirect and tobacco prevention, 24.1% were directed to Selective (direct) services, and 28.3% were directed to Indicated (direct) services.

The chart below shows the actual expenditures and number of persons served in Prevention Programs in FY 2008. The categories follow the IOM Classifications.

Target Population	Actual No. of Participants		Actual Expenditure
	Youth	Adults	
Universal Direct (individual based services)	144,195	2,407	$11,558,597
Universal Indirect (with Synar)	610,435	188,039	$4,886,627
Selective	36,637	2,955	$8,347,201
Indicated	38,928	3,720	$9,796,693

In FY2008, the Office of the State Attorney General initiated one time dollars to address the youth deaths caused by the Heroin based street drug named *Cheese* (a mixture of black tar heroin and Tylenol PM tablets) in Dallas County. This collaborative opportunity allowed the DSHS to award five contractors in Dallas a total of $315,456 to provide prevention education and prevention awareness services directed to the high-risk populations in Dallas County to address the *Cheese* problem. The contractors worked collaboratively to provide selective and indicated prevention services. The local DSHS

funded Prevention Resource Center (PRC) also received part of this funding and provided information and education during the epidemic.

The use of this new and inexpensive street drug caused a high number of deaths and overdoses among Dallas County youth. The funded contractors completed the delivery of evidence-based curricula to middle and high school students located in the zip codes identified with a high incidence of teen deaths and overdoses. The services included extensive community collaboration, informational presentations, town hall meetings, focus groups, alternative activities, information dissemination, and extensive collaboration to address the serious issue the community faced with the *Cheese* street drug. Other activities included the establishment of a "task force" designed to build communication among contractors, stakeholders and the community; an awareness campaign and public service announcements.

Universal Direct Services

In FY 2008, 56 programs provided universal direct prevention services to youth, ages 0 to 17, and adults, 18 and over, throughout Texas. Prevention providers were required to base their services and programs on logical, conceptually sound frameworks that showed evidence of effectiveness with the Universal Direct population.

Funded prevention programs provided activities that aimed at increasing protective factors, fostering resiliency, decreasing risk factors, and affecting critical life and social skills relative to substance abuse. All providers funded for Universal Direct services targeted the general population and provided education and skills training that focused on skills building and skills practice. This was part of a structured curriculum to enhance protective factors and reduce risk factors. Universal Direct activities and services included, but were not limited to, the following services and activities: life skills training series and sequential small group or classroom prevention education sessions. These sessions followed a structured evidence-based curriculum built on skills in a sequential manner and offered culturally and developmentally appropriate objectives for the target population. Sessions were delivered in appropriate and adequate duration and intensity according to the age, gender, ethnicity and other needs of the target population to maintain program fidelity.

Other key prevention strategies that were provided included prevention presentations concerning minors and tobacco, and alternative substance free activities to promote safe and healthy alternatives for youth. These services were provided in school and community based settings. These services were made available to children in the public and private schools as well schools on the military bases that allowed for the provision of outside prevention services.

Universal Indirect Services

In FY 2008, Universal Indirect services and activities were provided to the general population throughout Texas. DSHS funded 29 programs throughout the state including Prevention Resource Centers, Community Coalitions, and the Coordinated Statewide Training Services to provide universal indirect services in the 11 HHSC regions in Texas.

These entities incorporated an array of strategies: substance abuse awareness messages, media campaigns, training, and policy changes to impact the general community. The strategies were implemented to strengthen anti-drug use attitudes and norms. They were also intended to strengthen environmental support for anti-drug use attitudes by providing accurate information about substance abuse, encouraging substance-free activities, and enforcing laws and policies related to illicit drug use. The entities are as follows:

Prevention Resource Centers (PRC) DSHS funded one PRC in each of the 11 HHSC regions through a contract renewal process. Together the 11 PRCs worked together to support a statewide strategy to disseminate prevention information, resources, and training to communities throughout Texas. DSHS required that all materials and information distributed by the PRC be culturally, linguistically, and age appropriate. Each PRC provided a wide range of prevention education materials that were distributed to schools, communities, prevention providers, churches, professional associations, colleges, universities, and other interested groups. The PRCs also maintained a website, an educational material clearinghouse, a resource book and video lending library, and a statewide toll-free number to provide access to information about substance abuse prevention, resources, services, and training opportunities available in their communities. Additionally, PRCs disseminated and provided information to civic organizations, schools, and parent organizations, and at health fairs throughout the state. Services were delivered via speaking engagements, presentations, monthly or quarterly newsletters, resource directories, printed materials, telephone information, web, and electronic communications. In support of the PRCs, DSHS's library and clearinghouse and the DSHS website offered information on regional substance use and abuse, providing a comprehensive source of information. The DSHS website includes federal, state, and local resources as well as research, media campaigns, and information in both English and Spanish.

The PRCs served as a regional resource for all DSHS substance abuse prevention and treatment service providers in their respective regions. The DSHS funded prevention programs utilized the PRC as a resource to support their service delivery efforts and requirements. The programs used the PRC to obtain educational materials, data, and resources to make to provide to the children and families they served. Additionally, these programs used the PRCs to obtain information on local, statewide and national substance abuse training opportunities as well as information on evidence-based curriculum and training for the implementation of DSHS funded curriculums.

In FY08, the PRCs provided education for retail stores about the laws on minors and tobacco. This process resulted in a dramatic increase in the number of retail stores that were contacted and informed about the Texas Tobacco Laws pertaining to their establishments (12,574 retail stores were contacted in 2008). In addition, 2,297 presentations were conducted for youth and adults by the PRCs on the legal consequences and harmful health effects of tobacco upon youth. These presentations were attended by 70,567 youth and 16,114 adults. Additionally, PRCs conducted media awareness activities to create public awareness of ATOD-related issues. These activities

included, but were not limited to, public services announcements, television interviews, billboards, editorials, and news articles.

In 2008, the PRCs in each of the HHSC regions coordinated regional state participation in the Tar Wars tobacco free education program and poster contest. Tar Wars is a program of the American Academy of Family Physicians. The Tar Wars program which is a tobacco-free education program for fourth and fifth grade students includes a follow up poster contest conducted at the school, state and national level to reinforce the Tar Wars message. The PRCs began working with the DSHS funded youth prevention programs that were targeting the 4th and 5th graders to participate in the Tar Wars education program and poster contest. One of the Texas PRCs submitted a poster on behalf of a student and school in their region which received Special Recognition.

Other ongoing annual campaigns and activities conducted by DSHS and its funded prevention providers included the "2Young2Drink," Tobacco Free Kids and Red Ribbon statewide campaigns. The campaigns included billboard advertisements and a series of public awareness events, which targeted children, youth, and families within their schools and communities.

Each PRC assisted the statewide Coordinated Training Services (CTS) contracted entity with the collection of data and information to help develop a regional training needs assessment for substance abuse prevention and HIV. The PRC's provided space for staff and recruited volunteers to assist with surveys. Upon completion of the assessment, the PRCs assisted CTS with the logistics to host and conduct trainings in their respective regions based on the needs identified in the Prevention Training Needs Assessment.

The PRCs also participated in four conference calls that were conducted quarterly and facilitated by the state. The PRCs provided agenda items to help address needs for technical assistance, sharing of resources, ideas and implementation strategies that were proved to be effective. These calls were designed and facilitated to address the needs of the PRC, to address contract service requirements, performance goals, performance measures definitions and any other identified needs.

The PRCs submitted their monthly activities through the BHIPS electronic system and submitted quarterly reports to DSHS which were used by DSHS program staff to review the effectiveness of service delivery and provide technical assistance when necessary.

The PRCs participated in the Annual Prevention Provider Meeting: Prevention Day in Texas hosted by DSHS at the beginning of each fiscal year. The meeting was opened by the DSHS Assistant Commissioner with a welcome and overview of the states direction for the upcoming fiscal year. DSHS provides an overview of the contract, general provisions, performance measures and any requirements or changes in requirements and allows for contractors to ask questions and meet their contract managers and program oversight staff. This meeting also provides a networking and learning opportunity for contractors. Sessions are scheduled in the afternoon and continuing education units (CEUs) were provided for attendees.

In addition to the Annual Prevention Provider Meeting: Prevention Day in Texas, the PRCs also attended and participate in the Annual Fall and Spring Meeting hosted and facilitated by DSHS staff. These meetings provided learning and sharing opportunities. DSHS coordinated to secure trainers on topics of need or interest to the PRC and provided CEUs for attendees.

The chart below documents the breakout of PRC prevention activities for FY 2008.

Activity Type	No. of Participants Served or No. of Activities Completed
Youth and adults receiving ATOD information	Youth – 598,708 Adults – 219,087
Media Awareness Activities – ATOD	1802
Tobacco Presentation pertaining to minors and tobacco Youth and Adults attending minors and tobacco presentations	2207 Youth – 70,567 Adults – 16,114
Media Contacts pertaining to tobacco	1102
Tobacco Retailer Compliance Checks	12,574
Written Community Agreements	391

Community Coalitions (CCP) In FY 2008, the DSHS completed the last year of a five year funding cycle. DSHS funded 15 community coalitions through a contract renewal process. The primary mission of these coalitions was to reduce the illegal and harmful use of alcohol, tobacco, and other drugs with primary emphasis on reducing youth usage. The coalitions consisted of collaborative partnerships working towards prevention and reduction of illegal and harmful alcohol, tobacco and other drug use by implementing community and evidence based environmental prevention strategies. The coalitions implemented strategies that impacted the social, cultural, political, and economic processes of communities across Texas.

The coalitions' environmental strategies focused on establishing or changing standards, codes, and attitudes within communities. The activities included providing assistance to communities to monitor the enforcement of laws relative to the sale of alcohol and tobacco to minors, developing drug-free school zones, providing alcohol and tobacco education for retailers, developing local ordinances to restrict the location of establishments selling alcohol, creating messages for billboards, helping to develop comprehensive school policies, providing technical assistance and information to schools and businesses, and educating policymakers about the needs and gaps in substance abuse services.

The coalitions conducted a number of town halls, focus groups, presentations and media awareness campaigns to address the targeted environmental changes in their respective communities. In 2008, the coalitions also engaged the participation of the DSHS funded youth prevention providers to help support the efforts in their communities. This opportunity established a more collaborative approach by DSHS funded contractors to

help engage schools and communities linked to receiving services provided by the youth universal, selective and indicated programs to support the coalitions' efforts. Colleges and Universities were also targeted through the numerous activities conducted by the coalition which also increased the membership and engaged young adults to participate in the coalition and their activities.

Some of the coalition strategies that engaged other DSHS funded prevention programs included media and educational campaigns, the development of public service announcements, health fairs, town halls, focus groups and other activities to create awareness of the specific issues being addressed by the coalition.

The CCPs submitted their monthly activities through the BHIPS electronic system and submitted quarterly reports to DSHS which were used by DSHS program staff to review the effectiveness of service delivery and provide technical assistance when necessary.

The CCPs participated in the Annual Prevention Provider Meeting: Prevention Day in Texas hosted by DSHS at the beginning of each fiscal year. The meeting was opened by the DSHS Assistant Commissioner with a welcome and overview of the states direction for the upcoming fiscal year. DSHS provides an overview of the contract, general provisions, performance measures and any requirements or changes in requirements and allows for contractors to ask questions and meet their contract managers and program oversight staff. This meeting also provides a networking and learning opportunity for contractors. Sessions are scheduled in the afternoon and continuing education units (CEUs) were provided for attendees.

In addition to the Annual Prevention Provider Meeting: Prevention Day in Texas, the CCPs also attended and participate in the Annual Fall and Spring Meeting hosted and facilitated by DSHS staff. These meetings provided learning and sharing opportunities. DSHS coordinated to secure trainers on topics of need or interest to the PRC and provided CEUs for attendees.

The 15 coalitions funded included a target population of 5,500,000 residents in the 31 Texas counties served.

Coordinated Training Services (CTS) In FY 2008, DSHS renewed the contract with a single training entity to conduct regional statewide prevention trainings on evidence-based curriculum, HIV, community mobilization, and environmental strategies. The Prevention Training Services (PTS) is the substance abuse prevention training part of the Coordinated Training Services contract. CTS coordinated with the 11 regional PRCs and Education Service Centers (ESCs) to provide regional trainings as determined by the annual training needs assessment. The entity subcontracted with the developers of curricula and designated trainers to provide local training based on the needs of the Universal, Selective, and Indicated populations in Texas. This resulted in more cost effective management of evidence-based curricula training. In 2008, the training entity offered 237 trainings, which included 134 evidence-based program trainings attended by 2852 prospective instructors, and 49 coalition trainings attended by 835 adults. There

were also 54 Peer Assistance Leadership and Peers Making Peace programs for youth with a total of 3348 trained in these two programs. In addition, PTS offered sixteen 16-hour prevention staff trainings that were available to all the employees of DSHS-funded contractors. The trainings which were held in all 11 regions of the state periodically throughout the year were requested by the PRCs and DSHS-funded prevention programs based on the needs of their communities.

CTS coordinated with DSHS and provided registration, logistical assistance, and on-site support for the DSHS Fifth Annual Prevention Provider Meeting and the DSHS Annual PRC and CCP/SPF Coalition Fall and Spring Meetings. CTS also provided technical assistance and support of the DSHS Texas Collaborative Prevention Committee that was established by DSHS to enhance communication between the State and the field. These activities include the coordination of quarterly Webinars, conference calls and logistical support for DSHS activities.

The second part of the CTS contract, the HIV Statewide Training Services (HTS) provided trainings on HIV/AIDS, substance abuse, TB, Hepatitis and other Communicable Diseases. The HTS also provided trainings on issues related to working with persons at risk for or infected with communicable diseases. Additionally, the HTS coordinated for DSHS the annual HIV Conference, which was attended by over 188 people. More details related to the HTS are found in goals description 5 and 6.

The statewide CTS training system strengthened and expanded the prevention infrastructure throughout this funding cycle. CTS identified training needs and implemented trainings vital to the latest prevention technology, research and best practice approaches to encourage and support effective implementation of evidence-based programs throughout the state. This system also provided effective and accessible training at no cost to the DSHS funded contractors. When possible the trainings were scheduled in the regions where the training was requested to help reduce the costs for travel to attend trainings.

Selective Services

DSHS renewed contracts for 54 programs through a contract renewal process that provided services to targeted children and youth who were determined to be at higher than average risk for substance abuse (at-risk and high-risk children and youth). These programs were classified by the IOM system as Youth Prevention Selective (YPS). These programs provided a structured evidence based curriculum which included prevention education and other prevention services and activities within each of the six CSAP strategies. The purpose was to ensure comprehensive prevention program services in schools and communities. There were also mentoring, peer mediation, and violence prevention programs that targeted children with low school performance or behavioral problems and children of substance abusers who required one or more of these types of activities or services. Other key prevention strategies that were provided included prevention presentations concerning minors and tobacco, and alternative substance free activities to promote safe and healthy alternatives for youth.

These prevention services and strategies were provided in school and community based settings. These services were made available to children in the public and private schools as well schools on the military bases that allowed for the provision of outside services.

Indicated Services

DSHS renewed funding contracts for 51 programs to prevent chronic use and to target children and youth already using substances or engaged in other high risk behaviors (such as delinquency). These are classified by the IOM system as "Indicated". In the DSHS system these are designated as Youth Prevention Indicated (YPI) programs. They provided activities and services which included structured evidence-based curriculum, and one-on-one indicated prevention counseling sessions with participants. The indicated prevention counseling and referrals to support services were strategies that were also included in the service delivery for indicated services. These strategies were designed to help identify and address and additional needs the participant and or their family may have and ensure appropriate referrals to these services.

These prevention services and strategies were provided in schools and community based settings. These services were provided primarily in high schools, charter schools, alternative schools, and juvenile justice academy programs.

The Prevention contractors that were funded to provide universal, selective, and indicated prevention services also joined DSHS funded CCPs and participated in the activities coordinated by the coalition in their local community to implement community and evidence based strategies and assisted in the efforts to change policies, social norms and behaviors in their communities. These strategies included media and educational campaigns, the development of public service announcements, health fairs, town halls, focus groups and other activities to create awareness of the specific issues being addressed by the coalition.

All direct service prevention providers (universal, selective and indicated) attended and participated in the Annual Prevention Provider Meeting: Prevention Day in Texas hosted by DSHS at the beginning of each fiscal year. The meeting was opened by the DSHS Assistant Commissioner with a welcome and overview of the states direction for the upcoming fiscal year. DSHS provides an overview of the contract, general provisions, performance measures and any requirements or changes in requirements and allows for contractors to ask questions and meet their contract managers and program oversight staff. This meeting also provides a networking and learning opportunity for contractors. Sessions are scheduled in the afternoon and continuing education units (CEUs) were provided for attendees.

In 2008, the three Rural Border Intervention (RBI) funded contracts enabled providers to continue to offer a unique combination of programs and services along the rural Texas-Mexico border from El Paso-Ciudad Juarez to Brownsville-Matamoros. The RBIs had a total of three projects serving a total of 24 counties, including *Colonias* along the border. These unique programs involved a three-fold approach which included: primary

prevention and utilized evidenced-based school curriculums for prevention of substance abuse among youth, screening and intervention (short term) services for individuals abusing substances (i.e. youth and/or their parents), and a community-wide approach which enhanced local community action and established links to existing resources. These initiatives were closely linked to the Outreach and Substance Abuse Referral (OSAR) Centers funded by the DSHS and the CSAP Strategic Prevention Framework-State Incentive Grant (SPF-SIG) community coalitions. These projects continued to be unique in a number of ways and the relationship between the three projects and need for collaboration increased over this year. This year the Executive Directors of the five agencies met for the first time to network, develop agreements and discuss changing needs across the over 1200 sq. mile Texas Mexico Border.

The DSHS RBIs also continued to successfully develop resources and networks that created strong alliances among HHSC's *Colonias* Initiative, DSHS' Office of Border Health, and Texas A&M University's (TAMU) *Colonias* Projects (CHUDs). The agencies' combined efforts to leverage the quantity and quality of services available, and to increase access to health and social services in the rural border areas. The combined efforts raised the level of awareness and educated these communities about prevention. This promoted recovery and improved the quality of life within the community. Additionally, it increased the number of people in these communities who received treatment services and intervention counseling for issues related to alcohol, tobacco and other drug use.

Professional Development Events and Other Activities

In 2008, DSHS co-sponsored the "Partners in Prevention 8th Annual Conference" and the "Strengthening Families Conference" which were both held in Austin. These conferences were a result of a collaboration of various state agencies. The conferences were open to the public also provided and opportunity for the various participating state agency's representatives to attend as part of a community team. Additionally, DSHS sponsored its Annual Texas Behavioral Health Institute (BHI) in Austin, Texas. The week long Institute included a comprehensive prevention track that consisted of the basic 40-hour course for the Certified Prevention Specialist credential. In addition to the prevention tracks, the Institute provided sessions in the following tracks: Prevention Leadership, Substance Abuse Treatment, Counseling Essentials, Mental Health, Family Issues, Youth Issues and Technology. The BHI is so well attended by members in various social service fields which also provided attendees the opportunity to network and establish contacts and learn about other programs and services in Texas.

In FY 2008, DSHS continued a collaborative partnership with the Southwest Center for Application of Prevention Technologies (SWCAPT) in Norman, Oklahoma. This partnership included continued support of a Texas State Liaison position designed to provide training and technical assistance for prevention training in the State of Texas. DSHS provided office space, equipment, and technical support for the State Liaison. In 2008, this collaborative arrangement promoted workforce development goals across the prevention field.

In FY2009, DSHS initiated the beginning of the Texas Collaborative Prevention Committee (TCPC). The TCPC was designed to establish open lines of communication between the state

and the prevention service providers across Texas. All prevention programs were invited to participate. The Executive Directors for each organization that provides prevention services were invited to participate along with their program directors and they were asked to nominate one or two direct care service providers from each program type to be represented their organization on the committee. This ensured that each organization and program type would have a representative to work with the state on any identified issues, challenges or obstacles impacting service delivery. The TCPC members participated in quarterly webinars that were set up by the state based on the time and date recommendations of the providers. The TCPC and the State's first task addressed prevention training challenges impacting the state Staff Competency requirements. The state consulted with the TCPC and collected information based on the concerns with the training requirement and the time frame to complete the training to achieve the state contract requirements. The DSHS staff worked with the Coordinated Training Services contractor and the field to help resolve the issue and continue to work together to establish prevention staff competencies for the State of Texas.

Prevention Media Campaign (PMC). In FY 2008, DSHS continued to fund the Partnership for a Drug Free Texas (PDFT), which is a statewide media campaign designed to shape attitudes about the use of alcohol, tobacco and other drugs; stimulate public support for and development of community coalitions against alcohol, tobacco, and other drugs; and communicate the value and role of substance abuse prevention and treatment to the general public. The PDFT developed the prevention media campaign which included nationally produced public service television announcements that were tagged with local PRCs' contact information. These public service announcements were in English and Spanish.

The PMC also included radio news stories on substance use and abuse issues to radio stations across the state. The Texas Drug Free Radio News provided access to a weekly 60-second prevention news story to approximately 240 radio stations across the state that reached 1.2 million listeners. PDFT placed TV, print, cable, and radio spots on the air through donations of airtime from these media outlets – a value of over $5,000,000. The PMC also included the production and distribution of culturally-appropriate posters and other materials for statewide distribution, and provided leadership and logistical support for the annual state Red Ribbon Rally and campaign. In addition, DSHS provided a statewide toll-free number, 1-877-9 NO DRUG, for information and referrals. This number was published on PDFT materials, the DSHS website, and was included as a tag line to PMC public service announcements. In FY 2008, the hotline answered calls 24-hours a day, was staffed by professionals trained in crisis management, and received 11,814 calls.

The **Drug Demand Reduction Advisory Committee (DDRAC)** continued its efforts. The DDRAC is a legislatively established committee with a mandate to develop a comprehensive statewide strategy and make legislative recommendations to reduce drug demand in Texas. The State mandated that 16 state agencies and five at-large members from different geographical areas within the state participate in this effort. The DDRAC continued to conduct numerous initiatives. Member agencies reached a consensus on the mission, principles, philosophy, goals, and actions to meet the strategic objectives. This

effort demonstrated the effectiveness of a multi-faceted statewide strategy. Significant progress was made in strengthening community coalitions and building public and private partnerships involving community organizations, developing outcome-based services, and coordinating among community organizations.

GOAL 2 – 20% For Primary Prevention

FY 2010 (Progress): In FY 2010, DSHS funded 227 prevention contracts through a contract renewal process. In addition, one contract was renewed that included prevention services for a region that was set up under a network management organization that is set up to provide the full array of prevention, intervention, and treatment services. The prevention component was funded with the block grant set-aside dollars.

Currently, there are 71 youth prevention program providers that are serving 2418 school sites and 520 community sites to prevent the use and consequences of alcohol, tobacco, and other drugs (ATOD) among Texas youth and families. Service providers are implementing evidenced-based curricula and using the six CSAP strategies to ensure comprehensive prevention services in approximately 500 school districts. Providers are providing services that target the three Institute of Medicine (IOM) classifications of prevention services, including Universal, Selective, and Indicated interventions in an effort to provide a continuum of prevention services.

These prevention programs are currently delivering evidence-based curricula and implementing the six effective CSAP strategies in schools and community sites.. These strategies include ***prevention education*** using approved evidence based curriculum aimed at affecting critical life and social skills, decision-making, and refusal skills; ***information dissemination*** is being provided to participants and their families with information about prevention programs and services available, drug use and abuse, addiction and the effects on individuals, families, and communities; ***alternative activities*** are being conducted to provide individuals with opportunities to participate in activities that exclude drug use and promote healthy and constructive behaviors to offset the attraction to drugs; ***community-based processes*** efforts are ongoing and provide service contractors the opportunity to establish collaborative, networking, planning and organizing efforts to deliver services more effectively and efficiently, the service providers continue participate in other DSHS funded coalition partnerships and work to support the efforts to establish or change community standards, attitudes, social and community norms as well as laws and policies impacting substance use or abuse to include ***environmental approaches*** in their prevention efforts; service providers continue to ***problem identification and referral*** as one of their strategies by identifying individuals in need of substance abuse prevention and other support services and then provided the necessary referrals for support services, or for formal substance abuse screening and assessments through the DSHS funded Outreach, Screening Assessment and Referral (OSAR) program located in their respective Health and Human Services Region.

The full array of prevention services are currently implemented to reach the diverse populations of Texas utilizing the most appropriate IOM type for the specific targets. These prevention services are being offered in public and private schools, charter and alternative schools, numerous types of community sites, homeless shelters, housing projects, and juvenile justice academy programs. The newest target population for the universal-direct, selective, and indicated programs is the military population. Texas has large military communities and the DSHS funded prevention providers are aware of the

many needs that have developed among the military families due the war and ongoing deployment or loss of parents and/or family members. Based on this need more and more prevention providers are reaching out and creating awareness among the military communities to inform them of the services that are accessible to them in the general community. Some of the DSHS funded providers are currently working with schools located on bases to provide prevention services based on identified needs. The providers are continuing to establish relationships with the military bases and communities to provide additional prevention and support services for the military families in Texas.

The prevention providers are also working collaboratively with the Local Mental Health Authorities (LMHAs) in their efforts to promote the prevention of substance abuse and other mental health related disorders. The programs continue to build on the established relationship to maintain ongoing communication and stay abreast of mental health services available for children and families.

The prevention services incorporate evidence-based curriculum and prevention related strategies through a comprehensive system that matches services to the interlinked problems of substance abuse and behavioral health needs of the individuals and local communities. These curricula are approved through the National Registry of Evidence-based Programs and Practices (NREPP). They are designed to promote mental health and prevent related problems in a community by reducing the risk factors and increasing protective factors.

DSHS continues to use a needs assessment methodology to guide the allocation of block grant funds in each of the HHSC regions. The FY 2010 allocations are as follows: 33.1% of prevention funds are being directed to Universal Direct strategies and services, 13.7% on Universal Indirect, 23.2% of prevention funds are being directed to Selective services, and 29.1% of prevention funds are being directed to Indicated services.

In FY 2010, DSHS anticipates spending 25% of block grant funds for primary prevention activities that serve children and youth (0-17) and adults (18 and over). This will exceed the requirement to expend at least 20% of the SAPT BG on primary prevention activities. DSHS is funding 71 service providers to offer primary prevention services in each of the 11 HHSC service regions across the state, implementing Universal Direct, Selective, Indicated, and Universal Indirect prevention interventions. Based on performance and quality of services, the contracts will be renewed yearly for three additional years. DSHS service providers are implementing prevention programs aimed at increasing resiliency and deterring or reducing the abuse or use of alcohol, tobacco, and other drugs among Texas youth and their families. Prevention programs are using curricula that address risk and protective factors. The programs submit monthly performance measures to report the required activities within the six CSAP strategies, and quarterly outcomes to report successful completion of the program prevention education and skills training strategy for review by DSHS. Additionally, providers complete and submit a Quarterly Evaluation and Quality Improvement Plan to report on program activities within the six CSAP strategies. These reflect program successes, shortfalls and curriculum fidelity. DSHS continues to collect and review performance measure data and reports submitted monthly

by providers, to determine program successes and effectiveness. The reporting is also used to identify those programs in need of consultation and technical assistance to ensure successful curriculum and program implementation. DSHS prevention program staff continues to provide support and technical assistance through phone, email, in-person site visits, and through DSHS meetings and training opportunities.

The chart below shows the projected numbers served and expenditures through June, 2010 based on the IOM classifications.

The following information is annualized based on data available as of June, 2010.

Target Population	Projected No. of Participants		Projected Expenditure
	Youth	Adults	
Universal Direct	158,039	2,183	$11,223,719
Universal Indirect	666,458	164,709	$4,501,804
Selective	40,760	3,094	$7,652,838
Indicated	39,132	3,278	$9,577,401

In FY 2010, all DSHS funded prevention providers continue to base their programs on a logical, conceptually-sound framework that indicates evidence of effectiveness within the specific target population they serve. These programs continue to implement curriculum that is culturally, linguistically and developmentally appropriate for the target population(s) and their community. Programs were funded to provide 100% evidence-based programs to the Universal (Direct/Indirect), Selective, and Indicated target population throughout the 11 Health and Human Services Commission (HHSC) Regions across the state. The goal of these programs is to prevent the use and consequences of alcohol, tobacco, and other drugs (ATOD). The program requirements and activities included the tobacco Synar Survey and other activities that promoted tobacco prevention. The ongoing array of prevention services continues to expand and develop throughout Texas as providers continue to implement prevention services by offering a continuum of services that target 76 Universal Direct programs, 36 Universal Indirect programs, 60 Selective programs, and 54 Indicated programs. All these programs implemented the six CSAP strategies to ensure comprehensive prevention across Texas.

Additionally, funded prevention programs continue to provide multiple prevention activities and strategies aimed at increasing protective factors, fostering resiliency, decreasing risk factors, and affecting critical life and social skills relative to substance use and mental health related disorders. The implementation of these comprehensive services continues to increase resiliency and deter or reduce the use and abuse of alcohol, tobacco, and other drugs among Texas youth and their families.

The DSHS youth prevention contractors that were funded to provide universal-direct, selective, and indicated prevention services continue to participate in DSHS funded CCP coordinated activities and efforts in their local community to assist in creating change in their communities which include changing laws, policies, social norms and behaviors to reduce alcohol, tobacco and other drug use. These strategies include but are not limited

to media and educational campaigns, the development of public service announcements, health fairs, town halls, focus groups and other activities to create awareness of the specific issues being addressed by the coalition.

Universal Direct Services

In FY10 DSHS renewed through a contract renewal process These contactors continue to provide universal direct services that target the general population and provide education and skills training that focus on building and practicing skills as part of a structured curriculum to enhance protective factors and reduce risk factors. Universal Direct programs include, but are not limited to, the following activities: life skills training series, series of prevention education classroom lessons, and/or sequential small group sessions. These sessions follow a structured evidence-based curriculum, build on skills in a sequential manner, and offer culturally and developmentally appropriate objectives for the target population. Prevention education sessions are being delivered in an appropriate setting and with adequate duration and intensity according to the age, gender, ethnicity, and other needs of the target population. The providers are working collaboratively with other DSHS-funded providers and entities that provide adjunct support services for participants as deemed necessary.

The providers also continue to implement other key prevention strategies that included prevention presentations concerning minors and tobacco, and alternative substance free activities to promote safe and healthy alternatives for youth. These prevention services are offered to children in various types of schools and community settings. The services are also being offered to military families where providers have established relationships with the schools located on base and within the military communities. These contractors also continue to implement the six CSAP strategies and provide activities that continue to engage Texas youth in substance free activities and events.

The contractors also participate in coalitions and participate in population based activities hosted by their program or community coalition. These strategies are targeted at the general population to increase awareness about the alcohol, tobacco and other drug issues in their communities, the need for laws and policies and changes in social norms to help prevent the use of substances.

Indirect Services to the Universal Population

In FY10, DSHS renewed one contract previously funded under a network management organization which provides the full array of prevention, intervention and treatment services and funded 36 contracts through a contract renewal process.. These contracted service providers are implementing universal indirect activities and services in all the HHSC regions across Texas. These programs include: 11 Prevention Resource Centers (PRC), 23 Community Coalition Partnerships (CCP), one Coordinated Training Service (CTS) and one Prevention Media Campaign Service (PMC). Each of these universal indirect service programs and their prevention services are described below.

Prevention Resource Centers (PRC)

In FY10, DSHS funded one PRC in each of the 11 Health and Human Services (HHSC) regions through a contract renewal process. Each funded PRC is a member of the Regional Alcohol and Drug Awareness (RADAR) Network and is considered a State Associate Center. As State Associate sites, the PRCs continue to enhance the State Center (DSHS) ability to disseminate substance abuse prevention information by serving as a local/grassroots component for the state's information distribution and outreach plan.

Each PRC contractor continues to provide ongoing support to local and statewide prevention of alcohol, tobacco, and other drugs (ATOD), and mental health promotion by providing local communities with an array of prevention literature, brochure, materials, information, resources and expertise in the areas of prevention. The PRCs continue to distribute a wide range of substance abuse prevention education, brochures, literature, materials and resources to schools, communities, prevention providers, churches, professional associations, colleges and universities, and other interested stakeholders. All materials and resources are culturally, linguistically, and developmentally appropriate to meet the needs of all target populations. Additionally, each PRC continues to maintain a website, a literature clearinghouse, video and book lending library, community resources, data and a statewide toll-free number (1-888-PRC-TEXX) to provide information about ATOD prevention. PRCs are working collaboratively with DSHS-funded and non DSHS-funded service providers to disseminate information to communities throughout the state with a goal to reach as many individuals in communities located in their regions. The PRCs are using a variety of communication methods to ensure their services are accessible and are reaching everyone in their respective region. PRCs are conducting presentations to civic organizations, schools, parent organizations, and at health fairs. They are generating newsletters, resource directories, brochures, bookmarks, referral information resources, and maintaining an active speakers' bureau. All services are being marketed, promoted and made accessible to the general community.

Each State has one RADAR Network State Center that serves as a centralized information and distribution service. As the State Center, DSHS continues to maintain a library and clearinghouse that provides ongoing support to all the Texas PRCs. DSHS also has a web page dedicated to information on regional substance use and abuse, providing a comprehensive source of information. The web page includes federal, state, and local resources, as well as research, media awareness campaigns, and information in both English and Spanish.

Each PRC continues to work collaboratively with the statewide Coordinated Training Services provider (CTS) to identify training needs and coordinate training in their respective regions. The PRCs coordinate with PTS to host, market prevention trainings scheduled in their respective regions.

In 2010, the PRCs continue to conduct retail compliance checks and provide education regarding minors and tobacco laws, and legal consequences as they pertain to their establishments. The PRCs also received renewed contracts from DSHS Tobacco and Prevention Control to implement a smokeless tobacco initiative. The PRC contractors provide community education related to smokeless tobacco prevention and tobacco use

cessation that targets youth in rural areas of service as mandated by the Legislature for FY 2009. The PRCs continue to be successful in the many tobacco prevention efforts which directly impact SYNAR and conduct activities that contribute largely to the reduced buy rates in Texas.

The PRCs are also continuing to participate in quarterly conference calls, the Fall and Spring PRC Meetings hosted by DSHS. The PRCs also continue to report their monthly activities electronically and submit quarterly reports to report the progress of their service delivery.

The chart below will illustrate a breakout of PRC prevention activities through June 2010.

Activity Type	No. of Participants Served or No. of Activities Completed
Youth and adults receiving ATOD information	Youth –668,458 Adults –164,709
Media Awareness Activities - ATOD	625
Tobacco Presentation pertaining to minors and tobacco Youth and Adults attending minors and tobacco presentations	1932 Youth – 76,070 Adults – 14,642
Media Contacts pertaining to tobacco	738
Tobacco Retailer Compliance Checks	12,315
Written Community Agreements	591

Community Coalitions (CCP)

In FY10 DSHS renewed funding with community coalition partnerships to conduct environmental strategies in the 11 HHSC regions across the state. The primary mission of these coalitions is to prevent and reduce the illegal and harmful use of alcohol, tobacco, and other drugs in their unique target counties. The primary emphasis is on the reduction in youth use by promoting and conducting community-based and environmental strategies. DSHS required that each of these coalitions use the Strategic Prevention Framework (SPF) model for evidence-based practices within community coalitions. This model which is written directly into the contractual agreements with each coalition requires the use of a data-driven decision making and evaluation process.

Activities of the CCP continue to be concentrated on the establishment or changing of laws, policies, and social norms within the target communities. These evidence-based environmental strategies include: providing assistance to communities in monitoring the enforcement of laws relative to the sale of alcohol and tobacco to minors, affecting changes in the promotion and the availability of substances in the community, and affecting social norms and community beliefs about alcohol, tobacco, and substance use. Other strategies include the development of comprehensive school policies, providing assistance to schools and community partners, and educating policy makers of the needs and gaps in substance abuse services

The CCPs are also working collaboratively with other DSHS funded prevention providers to increase coalition partnership involvement in implementing activities targeting their goals for environmental strategies in their communities. These activities and strategies include media and educational campaigns, the development of public service announcements, health fairs, town halls, focus groups and other activities to create awareness of the specific issues being addressed by the coalition.

The CCPs also collaborate with DSHS funded contractors to implement some of the many population based efforts; activities and strategies conducted by other DSHS funded contractors. These activities include but are not limited to health fairs, educational and awareness campaigns, presentations and information dissemination at large community events and alternative activities.

The CCPs are also continuing to participate in quarterly conference calls, the Fall and Spring CCP Meetings hosted by DSHS. The CCPs also continue to report their monthly activities electronically and submit quarterly reports to report the progress of their service delivery.

Selective Services

In FY10 DSHS funded 60 contracts through a contract renewal process. The contractors will continue to provide services that target those at higher than average risk for substance abuse and are identified by the IOM Classifications as Selective. Providers offering selective programs provide the following services and activities: structured evidence-based prevention education curriculum in schools and communities, mentoring programs and activities to in the area of the six CSAP strategies aimed at children with low school performance or behavioral problems, and programs for children of substance abusers that include a combination of structured curricula for education and skills training, mentoring, peer mediation programs, and violence prevention programs and other relevant services. Providers use the SPF model to continue to provide the necessary services for a prevention continuum. The providers also work collaboratively with other DSHS-funded providers and entities that provide adjunct support services for participants.

The providers also continue to implement other key prevention strategies that included prevention presentations concerning minors and tobacco, and alternative substance free activities to promote safe and healthy alternatives for youth. These prevention services are offered to children in various types of schools and community settings. The services are also being offered to military families where providers have established relationships with the schools located on base and within the military communities. These contractors also continue to implement the six CSAP strategies and provide activities that continue to engage Texas youth in substance free activities and events.

The contractors also participate in coalitions and participate in population based activities hosted by their program or community coalition. These strategies are implemented in a comprehensive manner to increase awareness about the alcohol, tobacco and other drug

issues in their communities and the need for laws and policies and changes in social norms to help prevent the use of substances.

Indicated Services

In FY10 DSHS funded 54 contracts through a contract renewal process. These contractors continue to provide services which target individuals already using drugs or engaged in other high risk behaviors (such as delinquency), to prevent chronic use and are identified by the IOM classifications as Indicated. Service providers for these indicated programs provide services and activities, including structured evidence-based prevention education curricula and one-on-one indicated prevention counseling sessions with the participants. They also provide activities in the areas of all of the six CSAP strategies to ensure comprehensive services to the program participants. The providers also work collaboratively with other DSHS-funded providers and entities that provide adjunct support services for participants as deemed necessary.

The providers also continue to implement other key prevention strategies that included prevention presentations concerning minors and tobacco, and alternative substance free activities to promote safe and healthy alternatives for youth. These prevention services are offered to children in various types of schools and community settings. The services are also being offered to military families where providers have established relationships with the schools located on base and within the military communities. These contractors also continue to implement the six CSAP strategies and provide activities that continue to engage Texas youth in substance free activities and events.

The contractors also participate in coalitions and participate in population based activities hosted by their program or community coalition. These strategies are targeted at the general population to increase awareness about the alcohol, tobacco and other drug issues in their communities, the need for laws and policies and changes in social norms to help prevent the use of substances.

In FY10, DSHS funded five programs through a contract renewal process to provide services for the *Rural Border Intervention (RBI)* programs on the Texas Mexico Border. Even though the majority of the services are intervention related, the providers are required to deliver evidence based prevention curriculum to youth and their families. The projects provide alcohol and other drug prevention in the schools and community centers (in Colonias); assessments; short-term intervention counseling and referrals to services including OSAR's. This year their intervention focus was built upon using techniques related to motivational enhancement and the stages of change model. This is the first full year that Contractors provided quarterly narrative reports to the RBI Coordinator. These reports provided ongoing updates of program activities and experiences from the communities. This, along with site visits and review of current BHIPS data allowed for continuous quality monitoring of the five programs.

The Texas-Mexico Border regions have experienced a significant increase in drug trafficking, drug cartel activity, drug related violence and crime, and poverty. These factors place children and adults at increased risk for drug use, trauma related mental

health problems, homelessness, and victimization. The RBIs provided services to 2,579 adults and 2,424 youth. A total of 355 people received behavior change interventions with motivational interviewing techniques.

DSHS continues to look for additional federal funds to support these programs along the rural border due to the growing needs. DSHS provided SAMHSA with data and information related to the need for SA prevention, intervention and treatment of the Texas-Mexico Border communities. DSHS also wrote specific requests to ONDCP and SAMHSA requesting assistance with resources.

The five RBI Contractors for FY 2010, covering 24 rural border counties and three Texas regions (8, 10, and 11) continue to work closely together and have a very strong collaborative and cooperative working relationship. These programs cover an area from Pharr, Texas (Region 11) to Alpine, Texas (Region 10). Due to the addition of short term funds through SSBG monies, one of the 5 RBIs was able to add 3 additional counties (the 3 most southern Texas counties) to their service catchment area and provide augmented services from Feb. 15, 2010 through Sept. 30, 2010. DSHS staff continues to work closely with these projects to not only monitor the constant changes that occurs on the border related to increased violence but also to support programmatic changes that meet the special needs of these communities. These RBI contracts continue to emphasize workforce development with the use of Promotoras/Community Health Workers (CHWs) and trained volunteers.

Special One-Time Funding – Disaster Assistance in the Texas Gulf Coast and U.S. Mexico Border Communities

In January FY10, DSHS provided funds to implement universal, selective and indicated prevention services targeted at children and families in the Gulf Coast who were impacted by Hurricanes Ike and Dolly. This was one-time funding provided to the State through the Consolidated Security Disaster Assistance, and Continuing Appropriations Act of 2009, Social Services Block Grant (SSBG) program. These supplemental funds also addressed the needs of children and families by providing health and mental health services. The grant also provided for the repair, renovation, and construction of health facilities, child care centers, and other social service facilities. In addition, one Rural utilized some of these funds to assist in the development of two conferences on Border Violence and Disaster Prevention (the first of their kind in Texas and the US). These conferences were held in August and in September, 2010. Additionally, the provider utilized some of the funds to develop two new curricula for families, providers, and Promotoras/CHWs related to SA prevention and building resilient safe families. The delivery of services was to be completed by September 30, 2010.

Prevention Coordinated Training Services (CTS)

In 2010, DSHS funded one contract to a single training entity through a contract renewal process. The CTS entity continues to provide DSHS funded prevention contractors with statewide prevention training on evidence-based curricula, cultural competency, adolescent development, risk and protective factors, strengthening families, communicable diseases, community mobilization, environmental strategies, leadership

and management development, and other prevention training identified through the FY09 Training Needs Assessment and ongoing surveys and feedback. The entity continues to work and enhance relationships and processes with the 11 regional PRCs and regional Education Service Centers (ESCs) to provide regional prevention trainings as determined by the PRCs and the prevention training needs assessment. CTS subcontracts with the evidenced-based curricula developers and/or designated Texas trainers to provide training based on the regional needs of the Universal, Selective and Indicated populations in Texas. This training model continues to prove to be cost effective management of evidence-based curriculum and other prevention training required of the DSHS prevention contractors. This system continues to enhance the prevention infrastructure as it strives to coordinate and provide the prevention training in each of the HHSC regions to provide opportunities that save DSHS contractors training costs, and reduces their travel and lodging costs.

In FY10 CTS continues to expand training opportunities for the CCPs and the Tobacco Community Coalitions (TCC). The CCPs received numerous training opportunities in the Strategic Prevention Framework Model and other related trainings such community mobilization, fundraising and sustainability, tobacco prevention. The TCCs also continue to utilize CTS to acquire the Project Towards No Tobacco Use evidence based curriculum training. These trainings are coordinated for the Coalitions; however, they are open to all DSHS funded prevention providers.

As of June 2010, the CTS offered 152 evidence-based curriculum trainings attended by 4,743 prospective prevention facilitators, 45 coalition trainings attended by 832 adults and 22 Peer Assistance Leadership and 12 Peers Making Peace programs trainings attended by 3,431 youth participants. In addition, CTS also offered 15-hour prevention staff trainings that were available to employees of all DSHS funded providers. The trainings were held regionally as requested by the PRCs throughout the year based on needs of the communities. CTS will continue to provide prevention trainings through the end of FY 2010 as requested by the DSHS funded prevention providers. .

Other Support Provided by CTS:
CTS continues to provide support for the DSHS Annual Prevention Provider Meeting in October 2009 for all DSHS-funded prevention providers. CTS also provided support and coordination efforts in the logistics for the DSHS PRC and CCP Fall and Spring meetings. CTS worked with DSHS program staff to plan, coordinate space logistics, speakers, registration and on-site support. CTS also coordinated with DSHS to support the Texas Collaborative Prevention Committee webinars and conference calls.

Professional Development Events and Other Activities
In FY 2010, DSHS continues to work in a state agency collaborative to co-sponsor the Annual Partners in Prevention conference and the Strengthening Families Conference. . This conference collaborative is an effort between several state agencies. These partners include Texas Department of State Health Services, Texas Department of Family and Protective Services, Texas Department of Aging and Disability Services, Texas Department of Housing and Community Affairs, Texas Health and Human Services

Commission, Texas Department of Assistive and Rehabilitative Services, Texas Education Agency, Texas Youth Commission, Texas Workforce Commission, Texas Office of Attorney General, and the Texas Juvenile Probation Commission. Yearly attendance is approximately 400 participants.

DSHS continues to plan and sponsor the annual Texas Behavioral Health Institute (BHI). The BHI provides an avenue for substance abuse prevention, treatment and mental health professionals to enhance their knowledge and skills. This year several evidence-based prevention curriculum developers will present their curriculum and participate in a showcase opportunity that will also allow interested participants to ask questions about the curriculum at the conference. Each year this conference is attended by about 1300 or more participants. This conference has grown annually and is being moved to a larger site. Additionally, a comprehensive prevention track is being offered and it will consist of the basic 40-hour Substance Abuse Prevention Specialist Training for those interested in the Certified Prevention Specialist credential. Each year about 50 – 60 participants enroll to participate in this training at this conference alone. The conference provides continuing education hours including: HIV, Hepatitis C, Ethics, and numerous ATOD prevention, substance abuse treatment and mental health trainings, as well as pre-conference continuing education opportunities. The Institute will also offer a Coalition Track with a two day Coalition Summit which is attended by the DSHS funded Coalitions and some one of two of their community member. This track is usually attended by 90 to 100 participants.

In FY09, DSHS established the Texas Collaborative Prevention Committee (TCPC). This committee is comprised of DSHS staff and representatives from each of the DSHS-funded providers and represents all program types--Universal, Selective, Indicated and Universal Indirect. The TCPC continues to serve as a communication mechanism for DSHS and DSHS-funded providers. The TCPS and DSHS staff share information and discuss issues and opportunities relevant to local, state, and national prevention issues. The TCPC continues to provide DSHS with the necessary information that will allow staff to provide contractors with more specific technical assistance and program consultation. The TCPC also continues to serve as an essential partner with the State in the development of prevention staff competencies.

The TCPC continues to meet quarterly by program type to continue to work with the State to communicate issues, concerns, and challenges. The TCPC will continue to improve communication between DSHS and the Contractors that are funded to implement prevention services in Texas. The newly formed TCPC consists of Executive Directors, Program Directors, and direct care staff of DSHS funded programs and DSHS staff. The TCPS continues to meet via Webinar/Conference Call and in-person when possible to discuss the federal, state, and local direction of prevention services.

DSHS continues to provide office space, equipment, technical support and oversight to the Southwest Center for Application of Prevention Technologies (SWCAPT) of Norman, Oklahoma for the Texas State Liaison. The State Liaison continues to provide information and

technical assistance primarily on the Prevention Specialist Training module. The collaborative arrangement continues to enhance workforce development efforts for the prevention field.

As a result of this collaborative effort between DSHS and the Southwest CAPT, a total of 121 prevention specialists received the 40-hour state-required prevention specialist training in FY10. The participants, who were employees of contracted providers, continue to participate in training and are working to obtain the Prevention Specialist Certification.

Prevention Media Campaign (PMC)
DSHS continues to fund the Partnership for Drug Free Texas (PDFT), a statewide media campaign designed to shape attitudes about the use of alcohol, tobacco and other drugs. Its goal is to reduce youth drug use in Texas by distributing research-based media messages created by the Partnership for a Drug-Free America and supplementary marketing materials developed specifically for Texas. The PMC utilized the Partnership for a Drug Free America television and radio public service announcements tagged with Texas-specific referral information, and produced a number of public service radio announcements.

The PMC also continues to provide radio news stories on substance use and abuse issues to radio stations across the state. The Texas Drug Free Radio News provided access to 60-second prevention news stories to approximately 230 English and Spanish radio stations across the state, reaching 3.7 million listeners. PDFT placed TV, print, cable and radio spots on the air through donations of airtime from these media outlets, statewide – a value of over $5,000,000. The PDFT *YouTube* page, which features anti-drug PSAs, has had 321,084 visitors in FY10, while the Happy Bunny Campaign website www.drugfreebunny.org has had several thousand visitors. Through the PMC, DSHS also produced and distributed culturally-appropriate posters and other resources, and led the annual State Red Ribbon Campaign. In addition, DSHS provided a statewide toll-free number (1-877-9 NO DRUG) for information and referrals which is answered around the clock by professionals trained in crisis management. This number was published on the PDFT materials, the DSHS website and as a tag line to the PMC public service. The hotline answered over 11,800 calls. PDFT also unveiled a new Drug-Free Texas website, working with Partnership national to syndicate content. The website allows for daily updates by DSHS/PDFT, enhances PDFT's web presence, and compliment's PDFT's YouTube channel, drugfreebunny.org, and the PDFA website.

Drug Demand Reduction Advisory Committee
The **Drug Demand Reduction Advisory Committee (DDRAC**) is a legislatively established committee with a mandate to develop a comprehensive statewide strategy and make legislative recommendations to reduce drug demand in Texas continued its efforts. The State mandated that 16 state agencies participate in this effort, as well as five at-large members from different geographical areas within the state. The DDRAC continued to conduct numerous initiatives to build on the legislatively-mandated statewide strategy to reduce drug demand in Texas. In January 2011, the DDRAC will issue its report to state leadership, making several legislative recommendations including: removal of the exclusion clause for medical expenses from the Uniform Individual Accident and

Sickness Policy Provision Law (UPPL); supporting the recruitment and retention of quality service professionals in the field of substance abuse prevention and treatment by increasing funds to support wage adjustments, reducing barriers to entering the workforce and maintaining high standards of professional development; and providing additional treatment and prevention services, as well as increased security and support services for providers in the border region.

Goal #3: Providing specialized services for pregnant women and women with dependent children

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

Note: In addressing this narrative the State may want to discuss activities or initiatives related to the provision of: *Prenatal care; Residential treatment services; Case management; Mental health services; Outpatient services; Education Referrals; Training/TA; Primary medical care; Day care/child care services; Assessment; Transportation; Outreach services; Employment services; Post-partum services; Relapse prevention; and Vocational services.*

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

GOAL 3 – Providing specialized services for pregnant women and women with dependent children – Intended Use

FY 2011 (Intended Use): In FY 2011, DSHS intends to continue meeting or exceeding set-aside requirements for this population. Block Grant funds will be expended to make services available to pregnant women and women with dependent children.

In FY 2011, DSHS will begin a new funding cycle, with contractors selected as a result of the Request for Proposals released in Fiscal Year 2010. Resulting contracts will require Specialized Female residential treatment service providers to use the trauma-informed curriculum, short title, *Seeking Safety*. DSHS also will require programs to continue implementation of trauma-informed management systems. Training and technical assistance will be given to all contractors via monthly conference calls and scheduled trainings.

In FY 2011, a requirement of the RFP is for contractors to improve measures for performance that more closely align with the National Outcome Measures. There also will be much greater specificity in contracts related to the provision of specialized service for this population.

In FY 2011, Texas also will implement a Medicaid substance abuse benefit that will expand treatment capacity, particularly for the specialized female population. DSHS will closely monitor Block Grant expenditures as a result of the Medicaid benefit, and anticipates positive changes in the service structure for specialized female services.

In FY 2011, changes to the Pregnant and Postpartum Intervention (PPI) program Statement of Work will result in more uniform services across Regions. With deployment of the Clinical Management for Behavioral Health Services (CMBHS) System as the new electronic clinical management system, there will be customized screens available to the program that will allow more documentation than was possible previously. This will result in much improved data on PPI clients and their families.

Over the course of the next three fiscal years, cross-system collaboration at the regional and local level will be a high priority, with contractual requirements for documentation of such activities beginning in FY 2011. All contractors will be required to engage community resources and integrate services for the benefit of the client, as demonstrated by written agreements. Building on the work of the Texas Partnership for Family Recovery, DSHS will continue to collaborate at the state level with agencies that have a common interest in this population. Agencies such as the Department of Family and Protective Services and the "Permanent Judicial Commission for Children, Youth, & Families" will continue to work together closely.

Focus also will continue upon collaboration and integration of services that fall within the DSHS system, such as mental health services, and family and community health services. Additionally, collaboration will continue with entities within the Health and Human Services Commission "Enterprise" system. This will include such programs as the Nurse Family Partnership and the Texas Office for the Prevention of Developmental Disabilities. The anticipated result is that a specialized female treatment provider contracted by DSHS will be well informed of services available to its clients at the local level because of effective communication at the state level. DSHS' goal is for its partners to increase awareness within their own programs regarding the availability of these substance abuse services, with the result that they will identify women in

GOAL 3 – Providing specialized services for pregnant women and women with dependent children – Intended Use

need of treatment earlier, and have an effective referral system in place to assist with access to services.

The implementation of the substance abuse Medicaid benefit in Texas will impact this population of Texans and could impact the required set-aside expenditures. DSHS is aware of the need to closely monitor expenditures and to have plans in place for service redesigns if needed.

Health Care Reform efforts will be of the utmost interest to DSHS over the next three fiscal years, as implementation at the Federal level will affect operations at the state level. Given that the vast majority of current specialized female clients in Texas could be covered under Medicaid upon full implementation, Texas must be prepared and flexible to implement changes to block grant requirements, which could include new recovery support services, as well as coverage of the specific aspects of current block grant requirements that may not be included in a final Medicaid benefit.

FY 2012 (Intended Use): In FY 2012, DSHS intends to continue meeting or exceeding set-aside requirements for this population. Block Grant funds will be expended to make services available to pregnant women and women with dependent children.

In FY 2012, DSHS will have the first full year of data from the previous year that should reflect the impact various efforts have had on the quality of care for this population. DSHS will be using this data to inform further discussions with the intent to continually make needed improvements to treatment services.

In FY 2012, Texas also will continue the Medicaid substance abuse benefit, closely monitoring Block Grant expenditures as a result of the Medicaid benefit, and implementing positive changes in the service structure for specialized female services.

In FY 2012, DSHS will continue funding for 13 Pregnant and Postpartum Intervention (PPI) programs. The PPI programs provide outreach, intervention, screening and referral for perinatal women at risk for substance abuse. During 2012, DSHS will be actively collaborating with current PPI providers to make positive program design changes as preparations are made to release a Request for Proposals for prevention and intervention services across the state for the next five-year funding cycle for these services.

FY 2012 will be a busy time as Texas will need to prepare for Health Care Reform related to this population as when so many new Texas will be covered for treatment services under Medicaid, there could be renewed capacity problems as a result. Texas will need to engage, plan with and prepare providers (those funded by DSHS as well as those that are currently not funded by DSHS) as changes are made to the block grant requirements as a result of Health Care Reform to ensure that (regardless of a block grant requirement) pregnant women have immediately access to services they need.

FY 2013 (Intended Use): For the purpose of this Block Grant Application, the following assumes that the Block Grant will have similar requirements in 2013 as are in place currently. Healthcare Reform is anticipated to greatly affect the Block Grant uses and requirements. The Medicaid expansion will be implemented in 2013 and, in Texas; Medicaid is administered by another state agency. For this reason, it is difficult to say for certain what the roles and activities of DSHS will be.

GOAL 3 – Providing specialized services for pregnant women and women with dependent children – Intended Use

In FY 2013, DSHS intends to continue meeting or exceeding set-aside requirements for this population. Block Grant funds will be expended to make services available to pregnant women and women with dependent children.

In 2013, a report will be due to the Texas Legislature on the cost neutrality of the Substance Abuse Medicaid Benefit. This benefit may be continued in Texas at that time, or may be dismantled if shown not to be cost neutral. It is anticipated that pregnant women receiving Medicaid-funded treatment, who deliver drug-free and health babies, will substantially impact this outcome.

In FY 2013, DSHS will implement a new funding cycle for the Pregnant and Postpartum Intervention (PPI) programs. The PPI programs will likely continue to provide outreach, intervention, screening and referral for perinatal women at risk for substance abuse, along with a few additional services that will benefit the pregnant woman seeking treatment.

GOAL 3 – Providing specialized services for pregnant women and women with dependent children – Compliance

Compliance (FY 2008): In FY 2008, DSHS met the expenditure requirements for substance abuse services to pregnant women and women with dependent children, consistent with MOE requirements by the block grant. The amount of funds expended for services to this target population was $22,724,767.00 which exceeded the required amount of $13,987,893.00.

In FY 2008, a total of 1,126 pregnant adult women and 49 pregnant adolescent females were admitted to DSHS treatment programs. (1,498 pregnant women were served in treatment programs). Overall, women comprised 46.36% of adult admissions to treatment programs. Pregnant women and women with dependent children accounted for 26.19% of all adult admissions to treatment programs. Residential Specialized Female treatment services (SFS) were available in each of the eleven Health and Human Service Commission (HHSC) regions. There were 31 DSHS SFS treatment programs for women, 16 of which also provided women and children residential services.

DSHS also funded 11 Pregnant and Postpartum Intervention (PPI) programs for priority population women. PPI programs provided outreach, screening and referral to treatment services, education on the effects of Alcohol, Tobacco and Other Drugs (ATOD) on the fetus, case management and parenting education. PPI programs operated in perinatal clinics, Women, Infants and Children (WIC) sites, Department of Family and Protective Services (DFPS) offices, domestic violence shelters, and schools and classrooms for teen mothers.

In FY 2008, all DSHS residential and outpatient SFS programs were required to provide childcare, transportation, case management, gender specific counseling and other specialized services for pregnant and parenting women, including women seeking to regain custody of their children. The programs were also required to coordinate access to pediatric, perinatal and reproductive health care. Specialized female programs were also required to coordinate and integrate services with Workforce Centers, Sexually Transmitted Disease (STD) clinics and perinatal providers. Service coordination with DFPS continued to be a priority.

In FY 2008 DSHS continued to work with residential SFS programs in the implementation of trauma-informed management systems and *Seeking Safety,* an evidence-based, trauma-informed treatment curriculum. Preliminary data from the DSHS electronic clinical management system indicate that outcomes in women's treatment services improved when this effort began.

In FY 2008, The Access to Recovery II (ATRII) Grant made treatment and recovery support services available to women involved with the DFPS system in eighteen ATRII counties. Women using methamphetamine were also eligible for these services if residing in one of nine Health and Human Service Regions in Texas participating in ATRII. Often, ATR serves were used to bolster services already in place through the block grant.

GOAL 3 – Providing specialized services for pregnant women and women with dependent children – Progress

FY 2010 (Progress): By the end of FY 2010, Department of State Health Services (DSHS) projects total expenditures are estimated to be $22,692,214.00 on treatment services for pregnant women and women with dependent children, again exceeding the required target. To meet the federal requirements for capacity management, establishing new programs or expanding the capacity of existing programs, DSHS funds 13 Pregnant and Postpartum Intervention (PPI) programs (as of FY 2009). PPI programs provide outreach, intervention, education and support services in Women, Infant and Children (WIC) sites, alternative high schools, perinatal clinics and Department of Family and Protective Services (DFPS) offices, and coordinate services between delivery systems. PPI services are available in all of the eleven Texas Health and Human Service Commission (HHSC) regions except Region 2 and 5.

As of June 2010, Specialized Female Services (SFS) treatment programs, including women and children residential treatment programs, served a total of 7,586 women, of whom 2,665, or 35.13%, were referred by DFPS. SFS programs provide transportation, childcare, referral for pediatric and prenatal care, reproductive health services and gender specific counseling for relationship issues, including issues related to abuse and neglect.

As a result of an interagency effort, the Texas Partnership for Family Recovery Initiative (TPFRI), which included the Commission on Children, Youth and Families and the Department of Family and Protective Services (DFPS), these entities continued to partner with DSHS to strengthen Family Dependency Treatment Courts (FDTC), and improve services for clients involved for DFPS.

In FY 2010 DSHS continues to work with residential SFS programs in the implementation of trauma-informed management systems and *Seeking Safety,* an evidence-based, trauma-informed treatment curriculum.

DSHS released a Request for Proposals (RFP) for all treatment services that will be awarded for FY 2011. One major effort in the development has been to mandate use of trauma-informed services in all specialized female services, including outpatient. *Seeking Safety* will be required in all residential specialized female programs as a result of this RFP.

During FY 2010, the second Access to Recovery (ATR II) Grant continues to make treatment and recovery support services available to clients involved with a participating drug court in the 18 ATR counties; including FDTCs. ATR II services are also available to women with a recent history of methamphetamine use.

In FY 2010 DSHS continued monthly teleconference calls with all specialized female contractors to provide technical assistance and increase contractor collaborate and community collaboration with other DSHS-funded programs and programs funded by other sources.

Programs for Pregnant Women and Women with Dependent Children (formerly Attachment B)

(See 42 U.S.C. §300x-22(b); 45 C.F.R. §96.124(c)(3); and 45 C.F.R. §96.122(f)(1)(viii))

For the fiscal year three years prior (FY 2008; Annual Report/Compliance) to the fiscal year for which the State is applying for funds:

Refer back to your Substance Abuse Entity Inventory (Form 9 formerly Form 6). Identify those projects serving **pregnant women and women with dependent children** and the types of services provided in FY 2008. In a narrative of **up to two pages**, describe these funded projects.

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

In up to four pages, answer the following questions:

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

2. What did the State do to ensure compliance with 42 U.S.C. §300x-22(b)(1)(C) in spending FY 2008 Block Grant and/or State funds?

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

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

5. What did the State do with FY 2008 Block Grant and/or State funds to establish new programs or expand the capacity of existing programs for pregnant women and women with dependent children?

Programs for Pregnant Women and Women with Dependent Children (FY 2008)

The Substance Abuse Entity Inventory (Form 9) identifies the treatment programs/providers funded to meet the set-aside requirement for priority population females. In addition to the programs funded through the set-aside, all DSHS treatment programs, except male-only programs, were required to prioritize admission for pregnant women and to ensure, through referral or direct service provision, that pregnant women received prenatal care, information on the effects of alcohol, tobacco and other drugs on the fetus, and referral for HIV information and services. In addition, treatment programs were required to provide childcare while women were receiving treatment services.

All residential and outpatient DSHS SFS programs were required to provide specialized services for pregnant and parenting women, including women seeking to regain custody of their children. These specialized services included targeted outreach; referral, transportation, child development information, and case management and care coordination for all identified service needs. Specific service needs are identified as pediatric, prenatal and reproductive health care; referral and transportation of women and children for immunizations; gender-specific treatment to address relationship issues; parenting education, childcare referral and follow-up for early childhood intervention for children aged 0-3 years; and a *Strengthening Families* program for women and their children aged 6-10 years. Programs were also required to provide capacity management coordination, and when treatment slots were not immediately available, interim services for clients. Interim services include prenatal care, HIV and STD education and referral, and education on the effects of ATOD on the fetus.

The Pregnant and Postpartum Intervention (PPI) programs provide outreach intervention and prevention services in Women, Infants, and Children (WIC) sites, perinatal clinics and Department of Family and Protective Services (DFPS) offices. PPI programs identify pregnant women at risk for substance abuse and provided screening and referral, education on the effects of ATOD on the fetus, parenting education, alternative activities, home visitation, case management and family support services.

During FY 2008, DSHS contracted for two types of specialized female residential treatment programs (SFS) for pregnant and parenting women: programs for women seeking treatment without accompanying children and women and children residential services for women whose dependent children resided with them in the treatment program. Several of the contracted programs offered intensive and supportive levels of care. In compliance with DSHS and federal rules, the programs were required to provide directly or through referral, gender-specific services, which included transportation, childcare, parenting education, reproductive health education and care, and counseling for abuse and neglect.

The women and children residential programs allowed pregnant and parenting women to bring children up to age 12 into treatment with them, as reflected on Form 9. This modality supported services designed to improve bonding and family relationships. Family services and services for children included parenting assessment, behavioral and physical assessment, referrals for children, and pediatric referral and care. The length of stay for women and children residential programs was generally longer than SFS programs. SFS programs were required to coordinate with DFPS, Workforce Centers, Early Childhood Intervention (ECI) programs, perinatal and pediatric services, and WIC.

Programs for Pregnant Women and Women with Dependent Children (FY 2008)

Adult and Youth Outpatient programs receiving specialized female set-aside funds were required to ensure the provision of childcare and transportation and were required to provide gender-specific services, including parenting education and counseling for relationship issues. In addition, most residential SFS programs provided outpatient services for continuing care or for women who did not require inpatient care. Specialized female detoxification (both residential and ambulatory) programs were also required to meet the specific needs of this population by providing gender-specific services and specific referrals for women and their children.

During FY 2008, DSHS continued to work cooperatively with DFPS to ensure that all persons involved with the child welfare system were given priority admission behind the federal and state priority populations.

1. Block Grant (BG) and State General Revenue (GR) funded women's programs in FY 2008 including: capacity, level of care and expenditures

Programs for Pregnant Women and Women with Dependent Children: FY 2008 (BG and GR funded programs/services)

FY 2008 TABLE OF SPECIALIZED FEMALE PROGRAMS

Level of Care 1 : Intervention 2: W&C 3: Residential 4: Outpatient 5: Detoxification	Agency	City	Region	I-SATS ID#	Level of Care	Capacity (Persons Served)	Contracated
4	Amarillo Council on Alcoholism and Drug Abuse	Amarillo	1	110506	Specialized Female Outpatient	60	$32,905.00
1	Managed Care Center for Addictive/Other Disorders, Inc.	Lubbock	1	110241	Pregnant Post Partum Intervention	377	$121,076.00
3 4 5	Managed Care Center for Addictive/Other Disorders, Inc.	Lubbock	1	110241	Specialized Female Residential Specialized Female Outpatient Specialized Female Detox	368	$740,045.00
2	Plainview Serenity Center, Inc.	Plainview	1	905103	Women and Children's Residential	18	$129,417.00
3 4 5	Serenity Foundation of Texas	Abilene	2	902811	Specialized Female Residential Specialized Female Outpatient Specialized Female Detox	331	$571,641.00
4	STAR Council on Substance Abuse	Stephenville	2	111504	Specialized Female Outpatient	26	$60,574.00
3 4 5	Mental Health Mental Retardation of Tarrant County	Fort Worth	3	909675	Specialized Female Residential Specialized Female Outpatient Specialized Female Detox	932	$939,328.00
2 3 4	Nexus Recovery Center, Inc.	Dallas	3	902647	Women and Children's Residential Specialized Female Residential Specialized Female Outpatient	104	$560,541.00
4	Value Behavioral Health of Texas, Inc.	Dallas	3	N/A	Women and Children's Residential Specialized Female Residential Specialized Female Outpatient	186	$872.630.00
4	STAR Council on Substance Abuse	Stephenville	3	111504	Specialized Female Outpatient	271	$348,432.00
1	Tarrant County Hospital District	Fort Worth	3	0	Pregnant Post Partum Intervention	388	$374,195.00
1	University of Texas at Arlington	Arlington	3	N/A	Pregnant Post Partum Intervention	116	$441,658.00
2 3 4	Volunteers of America Texas, Inc.	Fort Worth	3	902928	Women and Children's Residential Specialized Female Residential Specialized Female Outpatient	103	$609,224.00
1	Longview Wellness Center, Inc.	Longview	4	N/A	Pregnant Post Partum Intervention	1,311	$154,403.00

Programs for Pregnant Women and Women with Dependent Children (FY 2008)

2 3 4	Sabine Valley Regional MHMR Center dba Coummunity Healthcore	Longview	4	902563	Women and Children's Residential Specialized Female Residential Specialized Female Outpatient	400	$966,834.00
2 3 4	South East Texas Regional Planning Commission	Beaumont	5	104574	Women and Children's Residential Specialized Female Residential Specialized Female Outpatient	320	$1,038,964.00
3 4	Gulf Coast Center, The	Galveston	6	100671	Specialized Female Residential Specialized Female Outpatient	221	$326,735.00
1	Houston Council on Alcoholism and Drug Abuse, Inc.	Houston	6	906200	Pregnant Post Partum Intervention	265	$747,470.00
2 3	Riverside General Hospital	Houston	6	100614	Women and Children's Residential Specialized Female Residential	203	$866,704.00
2 3 4	Santa Maria Hostel, Inc.	Houston	6	106736	Women and Children's Residential Specialized Female Residential Specialized Female Outpatient	765	$3,427,857.00
4	Unlimited Visions Aftercare, Inc.	Houston	6	113658	Specialized Female Outpatient	25	$30,992.00
2 3 4	Volunteers of America Texas, Inc.	Fort Worth	6	902928	Women and Children's Residential Specialized Female Residential Specialized Female Outpatient	226	$1,026,458.00
2 3 4	Austin Recovery, Inc.	Austin	7	301808	Women and Children's Residential Specialized Female Residential Specialized Female Outpatient	281	$926,172.00
5	Austin Travis County MHMR	Austin	7	100028	Specialized Female Detox	19	$16,320.00
4	Brazos Valley Council on Alcohol & Substance Abuse	Bryan	7	103105	Specialized Female Outpatient	109	$162,635.00
1	Central Texas Council on Alcoholism and Drug Abuse	Harker Heights	7	902431	Pregnant Post Partum Intervention	3	$31,073.00
2 3 4	Freeman Center, Inc. ,The	Waco	7	102867	Women and Children's Residential Specialized Female Residential Specialized Female Outpatient	316	$1,134,506.00
1	Alpha Home, Inc.	San Antonio	8	751259	Pregnant Post Partum Intervention	647	$338,177.00
3 4	Alpha Home, Inc.	San Antonio	8	751259	Specialized Female Residential Specialized Female Outpatient	250	$650,050.00
2 3 4	Patrician Movement, The	San Antonio	8	303366	Women and Children's Residential Specialized Female Residential Specialized Female Outpatient	505	$974,995.00
2 3 4	Volunteers of America Texas, Inc.	Fort Worth	8	902928	Women and Children's Residential Specialized Female Residential Specialized Female Outpatient	79	$337,815.00
2 3 4	Alcohol & Drug Abuse Council for the Concho Valley	San Angelo	9	904007	Women and Children's Residential Specialized Female Residential Specialized Female Outpatient	74	$261,013.00
1	Permian Basin Community Centers for MHMR	Midland	9	302962	Pregnant Post Partum Intervention	103	$100,000.00
4	Permian Basin Community Centers for MHMR	Midland	9	302962	Specialized Female Outpatient	191	$160,736.00
1	Aliviane NO-AD, Inc.	El Paso	10	300016	Pregnant Post Partum Intervention	103	$100,000.00
2 3 4	Aliviane NO-AD, Inc.	El Paso	10	300016	Women and Children's Residential Specialized Female Residential Specialized Female Outpatient	338	$1,691,652.00
4	Alice Counseling Center	Alice	11	101471	Specialized Female Outpatient	114	$93,848.00
3 4	Association for the Advancement of Mexican-Americans, Inc.	Houston	11	303093	Specialized Female Residential Specialized Female Outpatient	162	$234,591.00
2 3	Coastal Bend Alcohol and Drug Rehabilitation Center dba Charlie's Place	Corpus Christi	11	750350	Women and Children's Residential Specialized Female Residential	79	$464,220.00
1	Council on Alcohol and Drug Abuse - Coastal Bend, The	Corpus Christi	11	752265	Pregnant Post Partum Intervention	674	$203,507.00
1	Serving Children and Adolescents in Need, Inc.	Laredo	11	109177	Pregnant Post Partum Intervention	72	$131,060.00
4	South Texas Council on Alcohol and Drug Abuse	Laredo	11	109169	Specialized Female Outpatient	214	$447,516.00

[1] SE Regional Planning Commission is a managed care organization for Region 5.

2. What did the State do to ensure compliance with 42 U.S.C. 300x-22(b) (1) (C) in spending FY 2008 block grant funds and/or State funds?

Programs for Pregnant Women and Women with Dependent Children (FY 2008)

In FY 2008, DSHS continued to prioritize the use of funds for specialized female services (SFS) programs based on service needs, existing capacity and available funding. DSHS tracked the availability and provision of required specialized female services to ensure that expenditures were for authorized purposes and as required by the set-aside rules for use of block grant funds. Continuous review of utilization rates, program compliance and periodic grant fund analyses were performed to track services provision along with award and expenditure amounts for programs designed for women. All SFS programs were required to provide supportive services that augment treatment and/or contribute to improved treatment and intervention outcomes. The DSHS SFS Coordinator served as an information resource and provided technical assistance to several specialized female services programs.

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

In FY 2008, DSHS required funded providers, through contracts, to comply with all SAPT Block Grant and state rules related to the provision of services for pregnant women and women with dependent children. Along with priority admission for pregnant clients, DSHS required SFS providers to coordinate with the Department of Family and Protective Services (DFPS) and Temporary Assistance for Needy Families (TANF) programs, and required all contractors to provide integrated and coordinated family services. SFS providers were also required to refer infants and children aged 0-3 years for early intervention assessment and services. In addition, licensure and contract terms for specialized female and women and children's residential services continued to strengthened on-site care for dependent children. Specifically, facility and service requirements ensured that staff providing daycare completed educational courses in child development and increased standards for meals and physical safety of dependent children, consistent with DFPS licensing standards.

The Behavioral Health Integrated Provider System (BHIPS) database, which provided standardized intake, assessment, treatment planning and service tracking components, was used to monitor the adequacy of efforts by more accurately and comprehensively determining service needs, and service provision and treatment outcomes for priority population women. Data collected through BHIPS were used to identify gaps and begin planning to increase the number of pregnant, post-partum and specialized female treatment programs.

Resource and technical assistance materials were disseminated to SFS providers. The DSHS SFS Coordinator continued to provide on-site and telephone technical assistance to all SFS programs. The SFS Coordinator also maintained a listserv of managers and clinicians working in PPI or specialized female programs. This allowed for immediate dissemination of research materials, evidence based practices, funding announcements and other relevant materials.

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

In FY 2008, provider contracts specified service requirements for pregnant women and women with dependent children. DSHS continued to use data from BHIPS, the statewide drug and

alcohol survey, and available prevalence data to estimate treatment needs. Licensure information, billing, and capacity management data were also used to track service gaps and utilization rates. DSHS analyzed treatment admission and discharge data to determine the client population served in relation to the target population and the programs' relative effectiveness in meeting the needs of the population. The BHIPS database continued to be used to access critical information about capacity and service utilization for priority population women.

5. What did the State do with FY 2008 block grant and/or State funds to establish new programs or expand the capacity of existing programs for pregnant women and women with dependent children?

In FY 2008, DSHS did issue a Request for Proposals (RFP) for prevention and intervention services. This resulted in the addition of 2 new Pregnant and Postpartum Intervention contractors the following fiscal year. However, in FY 2008, actual funds were utilized to maintain the treatment and PPI programs funded in FY06. DSHS staff continued to engage in numerous interagency planning efforts to increase service integration and coordination with community resources, and to further consolidate interagency coordination efforts with DFPS. The DSHS SFS Coordinator participated in a variety of interagency activities to maximize the use of state and block grant funds and to expand the capacity to serve the target population in existing programs through a broader resource base. The Coordinator's interagency activities included being team lead for the Texas Partnership for Family Recovery, coordinating with the Texas Office of Women's Health, WIC, Title IV Maternal and Child Health staff and participating in the Baylor College of Medicine, Texas Women's Health Network.

Goal #4: Services to intravenous drug abusers

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

Note: In addressing this narrative the State may want to discuss activities or initiatives related to the provision of: *Interim services; Outreach Waiting list(s); Referrals; Methadone maintenance; Compliance reviews; HIV/AIDS testing/education; Outpatient services; Education; Risk reduction; Residential services; Detoxification; and Assessments.*

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

GOAL 4 – IVDU Services

FY 11-13(Intended Use): OSAR contract requirements will ensure priority populations identified by HIV Outreach programs are moved into treatment slots as quickly as possible and that interim services will be documented for any priority population client awaiting a bed or a treatment slot. Through the use of BHIPS and the substance abuse quarterly risk assessment tool, services will continue to be reviewed and verified by DSHS to ensure that priority populations are getting optimal opportunity to enter treatment and that interim services are offered in a timely manner. In FY 2010, DSHS in conjunction with the Health and Human Services Commission created a Medicaid substance abuse benefit package that would allow buprenorphine and medication assisted therapy services to be billed under this project, effective September 1, 2010. DSHS will purchase buprenorphine services in all DSHS-funded narcotic treatment programs, as well as detoxification services, through the RFP for services in FY 2011. DSHS expects to continue funding buprenorhine services for FY 2011-2013.

The new Clinical Management for Behavioral Health Services (CMBHS) electronic record system replaced BHIPS during FY 2010; this new system (CMBHS) will improve DSHS's ability to track data. Therefore, DSHS will have additional data regarding IVDU clients and pharmacotherapy programs for services in FY 2011-2013.

GOAL 4 – IVDU Services

FY 2008(Compliance): Substance abuse services were made available to IVDUs in all 11 regions of the state. These included pharmacotherapy services, intensive or supportive residential treatment, residential treatment for women, residential detoxification, ambulatory detoxification, and outpatient services. Pharmacotherapy specifically targeted the needs of persons addicted to opiates/narcotics, with the IVDU population as a subset of service recipients accessing opioid replacement therapy services. A total of 81 methadone or other alternative pharmacotherapy programs were licensed throughout all 11 Health and Human Service regions. In FY08, a total of 12 opioid replacement therapy programs were funded by the block grant.

In FY 2008, DSHS monitored IVDU access to all funded substance abuse treatment programs, following enhancements to the Behavioral Health Integrated Provider System (BHIPS) software that broadened reporting of IVDU activities beyond what was previously captured only in pharmacotherapy services. DSHS served 14, 407 IVDU clients in all substance abuse treatment-funded venues.

Through BHIPS, DSHS continued to monitor the following activities as part of the capacity management efforts:

(1) the time at which a contractor treating IVDUs reached 90 percent capacity;
(2) DSHS available bed/slot capacity and remaining funding available;
(3) the length of time an IVDU individual spends on a waiting list; and
(4) clients that received interim or other treatment services while on a waiting list for pharmacotherapy services. For example, potential clients could be referred to outpatient treatment, ambulatory detoxification, and other individualized services provided by the local community while the client waited for the pharmacotherapy service.

BHIPS enhancements also enabled DSHS to perform timely monitoring of client documentation, including admission, discharge planning, problem identification, individual counseling, and other activities to verify that quality services were being delivered as efficiently as possible.

HIV outreach programs identified actively-using IVDUs and continued to work in conjunction with the pharmacotherapy service providers to counsel the client on their risk for communicable disease, encouraging them to maintain their commitment to treatment, and make behavior changes. Providers are utilizing harm-reduction strategies and evidenced based practice models such as Motivational Interviewing and/or Motivational Enhancement Therapy, and Prochaska-DiClemente Stages of Change.

GOAL 4 – IVDU Services

FY 2010 (Progress): Capacity reporting among all funded contractors is being monitored daily. Outreach, Screening, Assessment and Referral (OSAR) providers play a key role in monitoring capacity for residential treatment services by region, with full authority to facilitate admission. They utilize severity guidelines specific to levels of care, and identification of priority populations at the time of assessment. DSHS funds 13 OSAR sites that monitor their regional wait list activity and maintain ongoing communication with individuals waiting for treatment. HIV outreach programs maintain service agreements with treatment providers and the regional OSARs to ensure that, once identified, an IVDU is prioritized for DSHS funded treatment services.

Programs for Intravenous Drug Users (IVDUs) (formerly Attachment C)

See 42 U.S.C. §300x-23; 45 C.F.R. §96.126; and 45 C.F.R. §96.122(f)(1)(ix))

For the fiscal year three years prior (FY 2008; Annual Report/Compliance) to the fiscal year for which the State is applying for funds:

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

2. 42 U.S.C. §300x-23(a)(1) requires that any program receiving amounts from the grant to provide treatment for intravenous drug abuse notify the State when the program has reached 90 percent of its capacity. Describe how the State ensured that this was done. Please provide a list of all such programs that notified the State during FY 2008 and include the program's I-SATS ID number (See 45 C.F.R. §96.126(a)).

3. 42 U.S.C. §300x-23(a)(2)(A)(B) requires that an individual who requests and is in need of treatment for intravenous drug abuse is admitted to a program of such treatment within 14-120 days. Describe how the State ensured that such programs were in compliance with the 14-120 day performance requirement (See 45 C.F.R. §96.126(b)).

4. 42 U.S.C. §300x-23(b) requires any program receiving amounts from the grant to provide treatment for intravenous drug abuse to carry out activities to encourage individuals in need of such treatment to undergo treatment. Describe how the State ensured that outreach activities directed toward IVDUs was accomplished (See 45 C.F.R. §96.126(e)).

Programs for IVDU

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

In FY 2008, DSHS defined an IVDU as any person who was actively involved in or had a history of injecting illicit or mind-altering substances. The need for treatment services was assessed through a process in which contract staff licensed by the state determined the appropriate level of care for client's needing substance abuse services. The process included adult and adolescent users, persons in treatment and persons not in treatment, substance users infected with HIV and substance users who were dually diagnosed and part of the mental health care system.

The substance abuse assessment identified individual drug preference, measured severity of addiction, frequency of use, and range of motivation. The individual needs of the client were determined and matched with appropriate services through a planning process conducted with the potential client and his/her family or significant other.

2. **What did the State do to ensure compliance with 42 U.S.C. 300x-22(a)(2) and 300x-23 of the PHS Act as such sections existed after October 1, 1992, in spending FY 2004 SAPT Block Grant funds** *(See 45 C.F.R. 96.124(a)(2) and 96.126(a))?*

In FY 2008, as in previous years, guidelines for Federal SAPT Grant Set-Asides were determined from percentages established by block grant legislation. The DSHS Budget Department determined the amounts to fulfill the requirement. It should be noted that DSHS, as a single state agency for substance abuse, did not separate funds based on amounts expended for treatment, prevention and intervention of alcohol abuse, and funds used for "other drugs." All funded providers are required to use funds for all substance abuse activities based upon their ability to do so, in accordance with administrative rules.

3. **What did the State do to ensure compliance with 42 U.S.C. 300x-31(a)(1)(F) of the PHS Act prohibiting the distribution of sterile needles for injection of any illegal drug** *(See 45 C.F.R. 96.135(a)(6))?*

On each contract issued in FY 2008, DSHS continued to include a statement that each provider must comply with all applicable federal and state laws, including 45 CFR 96.135, which prohibited the distribution of sterile needles. In addition, all contract budgets were scrutinized prior to being awarded to disallow any costs that indicated projected expenses for needle distribution.

Additionally, four trainings were held in January 2008 on the SAPT Block Grant requirements. Training was held in Austin for the state office staff, and four more trainings were held throughout the state for services providers. The training covered the requirement on prohibition of the distribution of sterile needles for injection of any illegal drug.

4. **42 U.S.C. 300x-23(a)(1) requires that any program receiving amounts from the**

grant to provide treatment for intravenous drug abuse notify the State when the program has reached 90 percent of its capacity. Describe how the State ensured that this was done. Please provide a list of all such programs that notified the State during FY 4444442003 and include the program's NFR ID number (formerly NDATUS) *(See 45 C.F.R. 96.126(a)).*

DSHS requires contracted providers to report funded and active bed or program slot capacity and wait list information for each level of care. This is provided via BHIPS on a daily basis by 11:00 am, Monday through Friday, except for state or federal holidays. In the event that extenuating circumstances prevent the submission of data, the funded provider must document in writing to DSHS a description of the problem and the data that otherwise would have been reported. Upon the providers' entry of capacity and wait list data into BHIPS, the system automatically calculated the percentage of each provider's capacity for a particular level of care on a daily basis, an overall report that reflected providers who reported reaching 90 percent of their capacity was generated monthly from the data entered into BHIPS. The following programs, through the use of the Capacity Management Program (CMP), reported they were at 90 percent capacity.

Programs Reporting 90 Percent Capacity for FY 2008

Date	*Facility*	*City*	*Clinic #*
October 07	STARS	Corpus Christi	100622
	TCMERF	Fort Worth	100234
	Austin-Travis County MHMR	Austin	100044
	Center for Health Care Services	San Antonio	100374
	Aliviane NO-AD, Inc.	El Paso	300982
	AAMA	Laredo	110399
	AAMA	Edinburg	112114
	Riverside General Hospital	Houston	116768
	Lubbock Regional MHMR	Lubbock	302822
	MHMR of Tarrant County	Fort Worth	904353
	Serenity Foundation Of Texas	Abilene	
	Permian Basin Community Centers for MHMR	Midland	
	Homeward Bound, Inc.	Dallas	120331
November 07	STARS	Corpus Christi	100622
	Riverside General Hospital	Houston	116768
	Austin-Travis County MHMR	Austin	100044
	Center for Health Care Services	San Antonio	100374
	Aliviane NO-AD, Inc.	El Paso	300982

Date	Facility	City	Clinic #
	AAMA	Laredo	110399
	AAMA	Edinburg	112114
	Lubbock Regional MHMR	Lubbock	302822
	TCMERF	Fort Worth	100234
	MHMR of Tarrant County	Fort Worth	904353
	Permian Basin Community Centers for MHMR	Midland	000000
	Gulf Coast Center	Galveston	
	Serenity Foundation of Texas	Abilene	902811
December 07	AAMA	Laredo	110399
	STARS	Corpus Christi	100622
	Riverside General Hospital	Houston	116768
	Lubbock Regional MHMR	Lubbock	302822
	Austin-Travis County MHMR	Austin	100044
	Center for Health Care Services	San Antonio	100374
	Aliviane NO-AD, Inc.	El Paso	300982
	TCMERF	Fort Worth	100234
	AAMA	Edinburg	110399
	Homeward Bound, Inc.	Dallas	120331
	MHMR of Tarrant County	Fort Worth	904353
	Permian Basin MHMR	Midland	000000
	Serenity Foundation of Texas	Abilene	902811
	Gulf Coast Center	Galveston	127890
January 08	Center for Health Services	San Antonio	100374
	Austin-Travis Co. MHMR	Austin	100044
	TCMERF	Fort Worth	100234
	Aliviane NO-AD, Inc.	El Paso	300982
	AAMA	Laredo	110399
	Lubbock Regional MHMR	Lubbock	302822
	AAMA	Edinburg	112114
	STARS	Corpus Christi	001083
	MHMR of Tarrant County	Fort Worth	904353
	Serenity Foundation of Texas	Abilene	902811
	Homeward Bound, Inc.	Dallas	120331
	Coast Bend Alcohol and Drug Rehab.	Corpus Christi	342568
	Gulf Coast Center	Galveston	127890
	Permian Basin Community Centers	Midland	000000
February 08	Austin-Travis County MHMR	Austin	100044
	Center for Health Care Services	San Antonio	100374
	Aliviane NO-AD, Inc.	El Paso	300982
	TCMERF	Fort Worth	100234
	AAMA	Laredo	110399
	AAMA	Edinburg	112114

Date	Facility	City	Clinic #
	STARS	Corpus Christi	001083
	Riverside General Hospital	Houston	116768
	Serenity Foundation of Texas	Abilene	902811
	Managed Care Center	Lubbock	123111
	MHMR of Tarrant County	Fort Worth	904353
	Coastal Bend Rehab. Center	Corpus Christi	342568
	Homeward Bound, Inc.	Dallas	120331
March 08	Center for Health Care Services	San Antonio	100374
	Austin-Travis County MHMR	Austin	100044
	TCMERF	Fort Worth	100234
	Aliviane NO-AD, Inc.	El Paso	300982
	AAMA	Laredo	110399
	AAMA	Edinburg	112114
	STARS	Corpus Christi	100622
	Riverside General Hospital	Houston	116768
	MHMR of Tarrant County	Fort Worth	904353
	Managed Care Center	Lubbock	123111
	MHMR of Tarrant County	Fort Worth	904353
	Sabine Valley Center	Marshall	001321
	Serenity Foundation of Texas	Abilene	902811
	Homeward Bound Inc.	Dallas	120331
	Permian Basin Community Center	Midland	00000
April 08	Austin- Travis MHMR	Austin	100044
	Center for Health Care Services	San Antonio	100374
	Aliviane NO-AD, Inc.	El Paso	300982
	TCMERF	Fort Worth	100234
	AAMA	Laredo	110399
	AAMA	Edinburg	100168
	STARS	Corpus Christi	100622
	Coastal Bend Drug Rehab.	Corpus Christi	342568
	MHMR of Tarrant County	Fort Worth	904353
	Homeward Bound, Inc.	Dallas	120331
	Gulf Coast Center	Galveston	127890
	Serenity Foundation of Texas	Abilene	902811
	TRS Behavioral	Houston	112347
May 08	Austin-Travis MHMR	Austin	100044
	Center for Health Care Services	San Antonio	100374
	Aliviane NO-AD, Inc.	El Paso	300982
	TCMERF	Fort Worth	100234
	AAMA	Laredo	110399

Date	Facility	City	Clinic #
	AAMA	Edinburg	112114
	STARS	Corpus Christi	100622
	Lubbock Regional MHMR	Lubbock	302822
	Managed Care Center	Lubbock	123111
	MHMR Permian Basin	Midland	000369
	Serenity Foundation of Texas	Abilene	001321
	MHMR of Tarrant County	Fort Worth	904353
June 08	Austin-Travis MHMR	Austin	100044
	Center for Health Care Services	San Antonio	100374
	Aliviane NO-AD, Inc.	El Paso	300982
	TCMERF	Fort Worth	100234
	AAMA	Laredo	110399
	AAMA	Edinburg	112114
	STARS	Corpus Christi	100622
	Lubbock Regional MHMR	Lubbock	302822
	MHMR of Tarrant County	Fort Worth	904353
	Serenity Foundation of Texas	Abilene	001321
	TRS Behavioral	Houston	112347
July 08	Austin-Travis MHMR	Austin	100044
	Center for Health Care Services	San Antonio	100374
	Aliviane NO-AD, Inc.	El Paso	300982
	TCMERF	Fort Worth	100234
	AAMA	Laredo	110399
	AAMA	Edinburg	112114
	STARS	Corpus Christi	100622
	Lubbock Regional MHMR	Lubbock	302822
	MHMR of Tarrant County	Fort Worth	904353
	Riverside General Hospital	Houston	116768
	Managed Care Center	Lubbock	123111
	Serenity Foundation of Texas	Abilene	902817
	TRS Behavioral	Houston	112347
August 08	TCMERF	Fort Worth	100234
	AAMA	Laredo	110399
	AAMA	Edinburg	112114
	STARS	Corpus Christi	100622
	Riverside General Hospital	Houston	116768
	Lubbock Regional MHMR	Lubbock	302822
	MHMR of Tarrant County	Fort Worth	904353
	Center for Health Care Services	San Antonio	100374
	Aliviane NO-AD, Inc.	El Paso	300982

Date	Facility	City	Clinic #
	Austin-Travis MHMR	Austin	100044
September 08	TCMERF	Fort Worth	100234
	AAMA	Laredo	110399
	AAMA	Edinburg	112114
	STARS	Corpus Christi	100622
	Riverside General Hospital	Houston	116768
	Lubbock Regional MHMR	Lubbock	302822
	MHMR of Tarrant County	Fort Worth	904353
	Austin-Travis MHMR	Austin	100044
	MHMR Permian Basin	Midland	000369
	Center for Health Care Services	San Antonio	100374
	Austin-Travis MHMR	Austin	100044
	Gulf Coast Center	Galveston	127890
	TRS Behavioral	Houston	112347
	Serenity Foundation of Texas	Abilene	001321

5. **U.S.C. 300x-23(a)(2)(A)(B) of the PHS Act requires that an individual who requests and is in need of treatment for intravenous drug abuse is admitted to a program of such treatment within 14-120 days? Describe how the State ensured that such programs were in compliance with the 14-120 day performance requirement** *(See 45 C.F.R. 96.126(b)).*

In FY 2008, the Department of State Health Service's Quality Management and Compliance Unit conducted site visits that reviewed administrative, organizational, and programmatic functions for 22 DSHS treatment providers. Elements reviewed included compliance with: priority population clients receiving priority admissions; the 14-120 days waitlist timeframe and the provision of interim services for clients on the waitlist. If non-compliance findings were identified, providers were required to submit a plan of improvement. If needed, technical assistance was provided. There were no findings related to waitlist requirements in FY 2008.

6. **42 U.S.C. 300x-23(b) of the PHS Act required any program receiving amounts from the grant to provide treatment for intravenous drug abuse carry out activities to encourage individuals in need of such treatment to undergo treatment. Describe how the State ensured that outreach activities directed toward IVDUs was accomplished** *(See 45 C.F.R. 96.126(e)).*

In FY 2008, DSHS used a mix of block grant funds and state funds for HIV community-based prevention and intervention services. As defined in DSHS contract terms for funded providers, one of the primary objectives was to educate drug users about harm associated with drug use. HIV risk reduction and community prevention and intervention staff were trained in Prochaska-DiClemente's Stages of Change and Motivational

Interviewing. Using these models as tools, prevention and intervention employees entered areas of the community where injection drug use and HIV were highest. During their outreach efforts, these staff developed rapport and worked with the potential clients in their communities, assessed readiness for treatment, and facilitated treatment admission when the clients were ready.

In FY 2008, 16 HIV outreach programs continued to perform activities associated with the CSAP core strategies, and utilized NIDA models for community outreach to IVDUs for training all staff. These activities included information dissemination, education and skill- building for target populations (including IVDUs and their families), substance abuse screening, and referral to treatment and other social services, HIV antibody pre-and post-test counseling, and health screenings for STD, Hepatitis B and C, and TB.

Program Compliance Monitoring (formerly Attachment D)

(See 45 C.F.R. §96.122(f)(3)(vii))

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

For the fiscal year two years prior (FY 2009) to the fiscal year for which the State is applying for funds:

In **up to three pages** provide the following:

• A description of the strategies developed by the State for monitoring compliance with each of the sections identified below; and

• A description of the problems identified and corrective actions taken:

1. **Notification of Reaching Capacity** 42 U.S.C. §300x-23(a)
(See 45 C.F.R. §96.126(f) and 45 C.F.R. §96.122(f)(3)(vii));
2. **Tuberculosis Services** 42 U.S.C. 300x-24(a)
(See 45 C.F.R. §96.127(b) and 45 C.F.R. §96.122(f)(3)(vii)); and
3. **Treatment Services for Pregnant Women** 42 U.S.C. §300x-27(b)
(See 45 C.F.R. §96.131(f) and 45 C.F.R. §96.122(f)(3)(vii)).

Program Compliance Monitoring

Notification of Reaching Capacity

Description of Strategies to Monitor Compliance:
DSHS used several strategies to monitor compliance with capacity reporting requirements in FY2008. Each substance abuse treatment contractor was required to enter daily census data in BHIPS, an electronic clinical management system owned and managed by DSHS, that has a web based capacity management reporting system. Program specialists monitored this data for compliance. If contractors did not meet the requirements they were given formal notification with an offer of technical assistance. If non-compliance with reporting capacity information continued, the contractor was referred to a Contract Oversight Team to develop corrective action plans and/or determine appropriate contract action.

There were thirteen Outreach, Screening, Assessment, and Referral contractors who authorized residential bed days for clients. They also maintained a statewide waitlist for all residential services. They used census data in BHIPS and the statewide waitlist to monitor residential services daily.

It was a requirement that priority populations be admitted before non-priority populations. Priority population clients were automatically moved to the top of waitlists in the BHIPS system. Clients could access residential care by going directly to a residential contractor or by going to an Outreach, Screening, Assessment and Referral contractor. Clients could be admitted prior to authorization at the residential setting but contractors were required to obtain an authorization no later than two business days following the admission.

Residential contractors were required by contract to notify the authorizing agents prior to discharging clients. In addition they were required to notify the authorizing agents when they were reaching capacity for state funded beds.

Program Services subject matter experts met quarterly with Outreach, Screening, Assessment and Referral contractors to discuss successes and failures with contract obligations and rule requirements. Often, the contractors would share problems they were having with residential contractors in the state. The Program Services employees would work with both sets of contractors to resolve issues that were raised during the year. Residential contractors would also contact the Program Services subject matter expert when they were having conflicts regarding authorizations. Again, the subject matter expert would work with the contractors to resolve the issues. When necessary the subject matter expert would enlist the assistance of the contract manager of the Medical Director. If patterns of non-compliance or conflict persisted then the subject matter expert and contract managers contacted Quality Management to request a more in depth review of business practices that were affecting capacity.

Quality Management desk and onsite reviews of the Outreach, Screening, Assessment and Referral and treatment contractors included a comparison of capacity data reported with client census records, review of client records, waitlist review, review of contractor's policies and procedures. Quality Management Specialists issued a findings report requiring corrective action

plans for each finding. The options made available to the contractors included but were not limited to: technical assistance, increased monitoring, contract sanctions; liquidation of damages, and manual pay.

Problems Identified and Corrective Actions Taken:

In FY 2008 improvements in the BHIPS capacity management system led to contractors consistently reporting their capacity for residential services. Review results indicated increased compliance with the requirements for reporting capacity. As a result there was no need for contractor corrective actions.

DSHS developed a new electronic clinical management system (CMBHS) that included all the successful elements of the BHIPS capacity management system plus additional improvements like the ability to make reservations at a residential setting. The system was available for contractors to begin using during FY 2010. Monitoring for compliance with capacity reporting will continue to occur in a variety of ways as mentioned above in Description of Strategies to Monitor Compliance.

Tuberculosis Services

Description of Strategies to Monitor Compliance:
DSHS required that all licensed treatment facilities offer tuberculosis training to staff and provide access to tuberculosis services for clients in treatment. DSHS contracted with the Workers Assistance Program to provide training to funded contractors on tuberculosis issues. DSHS monitored and reviewed the training contract for compliance. DSHS also assessed compliance with the tuberculosis screening requirements for employees and clients seeking treatment.

Desk and onsite reviews of treatment contractors were conducted to assess client reports to verify that contractors screened, assessed, and referred to tuberculosis services when appropriate. Reviewers also verified that tuberculosis test results were documented in personnel records prior to employee contact with clients.

DSHS promoted relationships between contractors and local health departments to ensure clients in need of tuberculosis services were identified and services were provided. DSHS created and provided the new TB Elimination Division Standards of Performance manual located on the DSHS website at the following link: http://www.dshs.state.tx.us/idcu/disease/tb/publications/. The manual is a comprehensive description of the process of identifying and screening people at risk of tuberculosis as they are being considered for employment or admission to treatment.

Problems Identified and Corrective Actions Taken:

No problems were identified requiring corrective action during reviews of Substance prevention, intervention, or treatment contractors during FY 2008. In FY 2010 DSHS will continues to monitor for compliance with the rules and contract requirements regarding tuberculosis.

Treatment Services for Pregnant Women

Description of Strategies to Monitor Compliance:
DSHS funded and licensed programs, specifically designed for pregnant women and women with dependent children. DSHS rules required that pregnant women may not be denied treatment simply on the basis of their pregnancy. Injecting drug users; pregnant substance abusers; parents with children in foster care; and veterans with honorable discharges receive priority admission over other populations. Availability of specialized female services was adequately publicized at the local level. Service requirements for specialized female services and treatment programs for women with children were described in the contract attachments. Rules and contract specifications required all treatment services hold current memorandums of agreement with at least local health departments and the Early Childhood Interventions programs to ensure appropriate services are available for the priority populations.

Desk and onsite review of treatment contractors included assessment of client record content to verify contractors screened, assessed and referred to appropriate support services for women that were pregnant or with children. DSHS reviewed clients identified on the waitlists to determine if interim services were documented. Other oversight activities included review of client records to determine compliance with priority population requirements, contract service delivery requirements, memorandum of agreement requirements with community services and referrals made to local agencies delivering support services for women and children.

Problems Identified and Corrective Actions Taken:
In FY 2008 DSHS reviewed memorandums of agreements during onsite visits with contractors. DSHS also reviewed client records to ensure appropriate treatment referral services were provided to pregnant women. The types of problems identified during the review of client records and memorandums of agreement varied. The following is a partial list of findings issued in reports created by Quality Management Specialists: memorandums of agreement were not current, referrals to Early Childhood Intervention programs were not consistently made for clients with children that met the age requirements for referrals, missing supporting documentation to verify financial eligibility criteria, staff were not all trained on childhood development prior to serving clients, etc. Corrective action plans were submitted for each finding issued by DSHS following desk reviews or onsite reviews. No corrective actions plans were rejected when reviewed by Quality Management Specialists.

Goal #5: TB Services

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

Note: In addressing this narrative the State may want to discuss activities or initiatives related to the provision of: *Compliance monitoring: Referrals; Screening; PPD or Mantoux Skin tests; Provider contracts; Site visits/reviews; Assessments; Counseling; Training/TA; Cooperative agreements; Case management; Wait lists; Promotional materials*

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

GOAL 5 – TB Services *FY 2011 (Intended Use):* The DSHS Prevention and Preparedness Division will continue to provide federal and state funding to prevent the transmission of tuberculosis. These funds will support public health interventions, such as targeted TB testing within at-risk populations such as substance users, the homeless, and inmates of jails and state correctional facilities. In addition, these funds will be used to support the management of TB outbreaks and contact investigations, and Directly Observed therapy (DOT). It will be critical that settings such as correctional facilities, residential substance abuse treatment centers, and homeless shelters screen residents for tuberculosis before admission. This intervention will reduce the opportunity for transmission. DSHS-funded HIV and treatment providers will continue to work closely with the DSHS HIV/TB/STD Unit staff of the Prevention and Preparedness (P & P) Division. DSHS will continue to build relationships between treatment providers, local health departments, and DSHS HIV programs to ensure that persons in need of substance abuse treatment and HIV, Hepatitis, and/or tuberculosis services are identified through the screening and assessment process and are provided access to those services.

It is expected that a new demonstration project through the DSHS Prevention and Preparedness Division will begin this year. It‘s focus is on moving to an Interferon Gamma Release Assay (IGRA) using the quantiFERON-Gold (QFT-G) and the T-Spot for TB tests. Implementation will take place at 2-3 sites. Discussions are underway to determine if the IGRA would be implemented routinely for all new intakes, or only for those patients reporting or testing HIV-positive. This project will be a collaborative effort between the DSHS HIV, TB, and MHSA units and will be implemented in several HIV Early Intervention programs.

Another joint project between the DSHS Preparedness and Prevention Division and the DSHS MHSA Division will begin at a minimum of 3 DSHS funded opiod treatment sites during this year. The project will utilize the newly developed infectious disease panel. It will include opt out routine HIV testing; Hepatitis B and C testing and immunizations; and TB testing on all new intakes at these treatment centers. The joint project involves funding through the DSHS P&P division with technical assistance and monitoring by both divisions. Data will be reported through the CMBHS system, and then analyzed by the P&P division to evaluate success and further develop the program and protocols.

State funding for TB services designated for persons who receive treatment for substance abuse is estimated to consist of 24% of funds designated for TB screening and services to the population at large. State funding for TB services are administered by the DSHS Prevention and Preparedness Services Division. The total funding is estimated to be $26,234,532, with $8,000,000 in Federal funding and $18,199,336 in general revenue funds from the State of Texas for FY2010.

DSHS will continue to sponsor and support training and technical assistance (TA). This will include how to establish and maintain linkages through Qualified Service Organization Agreements (QSOAs), and how to enhance availability and efficiency of service provision. DSHS Training for TB, HIV, hepatitis and other communicable diseases will continue to be coordinated through the HIV Training Services (HTS)

component of the Coordinated Training Service (CTS) contract. It is anticipated that the HTS contractor will train over 500 HIV providers in HIV and TB during the fiscal year. The contractor also addresses topics such as QSOAs and other administrative matters as appropriate within the framework of their numerous curricula. DSHS staff and subject matter experts will review each curriculum for accuracy, fidelity of materials, and quality of presentation. Each quarter, DSHS staff will review evaluations from each training event held by the HTS to ensure fidelity and accuracy of the material presented.

***FY2012* – Intended Use**

DSHS will continue to follow the Texas Administrative Code (TAC) and CDC recommendations related to TB and HIV Early Intervention protocols. Collaborative efforts with P&P division and MHSA will continue to build.

DSHS MHSA will use the HTS contractor to train HIV and SA staff statewide in TB, HIV, and other communicable diseases. DSHS anticipates an additional 400 people will be trained during the year through classroom trainings or through the use of scheduled webinars.

Additional efforts that will continue include:

- Expansion of the demonstration projects related to TB testing as indicated, based on evaluated success and available funding for more sophisticated and reliable TB tests with high risk populations. It is expected that at least two additional sites will be added during the year.

- Examination of feasibility and cost effectiveness of the use of Rapid Hepatitis testing through HIV Early Intervention programs. Piloting the use of this testing alongside Rapid HIV testing in the community will be considered during the year.

- Expansion of the use of infectious disease panel, opt out HIV testing, and Hepatitis immunizations into a minimum of eight additional opiod treatment sites throughout the state.

FY2013 – Intended Use

Major statewide training goals will continue as in 2012. Texas will utilize more rapid testing as it becomes available, cost-effective, and refined for TB, Hepatitis, and HIV

Texas will continue to build a continuum of services related to infectious disease and the needs of people with SA issues. This also will create an impetus to encourage non-DSHS SA providers to utilize standards related to the use of the infectious disease panels and immunizations for Hepatitis in their programs.

GOAL 5 – TB Services

FY 2008 (Compliance): In FY 2008, DSHS rules for facility licensure required that screening for tuberculosis be made available to all clients that received funded treatment services, and that testing be performed as needed. Additionally, as in previous years, DSHS MHSA's Quality Management Unit monitored for compliance with this rule through review of provider documentation regarding who had been screened. The DSHS substance abuse policy states that all persons admitted to treatment, or who are on waiting lists to enter treatment, are to be screened for Tuberculosis (TB) unless there is documentation that screening has occurred within the previous year. The vast majority of treatment admissions were provided TB screening services, since it is rare that someone presenting for admission can provide documentation of a previous screen that occurred within the specified time frame. DSHS funded treatment and HIV service providers were given information and training about TB and HIV. During the year, over 119 treatment and HIV contractor staff received specific training. This consisted of a three hour course entitled, "Tuberculosis: What Every Counselor Should Know." In addition, 652 additional treatment and HIV contractor staff received training in two other curricula on HIV/AIDS which contained specific TB content. These providers offered education about HIV and TB as an interim service for individuals on wait lists for treatment, to clients receiving treatment, and as a follow-up service to clients who had been discharged.

Programs were monitored based on a scale related to level of risk. The Quality Management unit verified documentation of TB screens using a sampling method for every program where site visits were performed during FY 2008. Those with larger amounts of funding were monitored more often than those with minimal funding. Those with non-compliance findings in program performance or fiscal accountability were more frequently monitored.

GOAL 5 – TB Services

FY 2010 (Progress): In the current year, through June, 2010, over 412 staff in SAMHSA funded SA treatment and HIV providers received specific training on TB and HIV/AIDS through the HIV Training Services (HTS) contractor. HIV/TB and communicable disease education is offered to all contract program staff at no charge. The *HIV Update* training is created annually and reviewed by DSHS. The TB curriculum is updated regularly with information that is timely, accurate, and appropriate for delivery to all prevention, intervention, and treatment populations. Quality Service Organization Agreements continue to be instrumental in promoting good relations with community and county health department efforts to locate and identify those who may have been exposed to TB while seeking shelter, or treatment among individuals at high risk for TB.

Current data from the agency HIV/STD Epidemiology and Surveillance Branch indicates that in the top 5 counties in Texas reporting the highest rates of HIV/AIDS approximately 72 out of 717 confirmed TB cases are reported to have HIV/ AIDS (1/1/09 – 12/31/09). They also report 1501 total (excluding TDCJ) TB cases from 1/1/09 – 12/31/09, with 317 of these clients self-reporting some form of substance abuse problems (injecting drugs, non-injecting drugs, or alcohol abuse). Texas has also seen a modest reduction in co-morbidity over time, which is most likely attributed to the introduction of antiretroviral drugs and follow-up services.

During this year a joint effort with DSHS Prevention and Preparedness Department was initiated. It included the development of an infectious disease panel (which includes testing TB, Hepatitis, syphilis and HIV) that is being recommended be done in all opiod treatment programs that are DSHS funded.

SAMHSA-funded HIV program providers are required to assist in the provision of interim TB services for all contracted treatment facilities in their catchment areas. Three Block Grant contractors have been trained by their local health departments and now provide TB testing when they provide HIV testing services. DSHS continues to require the provision of TB education, screening, and assessment services for individuals on wait lists and for those receiving funded treatment services as defined by Rule 447.701 (B), which states as follows: "Interim services shall include counseling and education about HIV and TB, including the risks of needle-sharing, the risks of transmission to sexual partners and infants, and steps that can be taken to prevent transmission. Referrals for HIV or tuberculosis treatment are provided, if necessary".

Documentation of client schedules, and participation for all activities performed while clients participate in treatment, is required by contract. This includes education and counseling activities associated with TB, HIV, and other communicable diseases. Interim services are also documented for clients on waiting lists for treatment. All such documentation (client schedules and interim services) continues to be monitored by the Quality Management unit during site visits to ensure program requirements are met.

Goal #6: HIV Services

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

Note: If the State is or was for the reporting periods listed a designated State, in addressing this narrative the State may want to discuss activities or initiatives related to the provision of: *HIV testing; Counseling; Provider contracts; Training/TA Education; Screening/assessment; Site visits/reviews; Rapid HIV testing; Referral; Case management; Risk reduction; and HIV-related data collection*

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

GOAL 6 – HIV Services

***FY 2011 (Intended* Use):** A total of 28 SAMHSA HIV early intervention programs will be serving Texans in FY11. HIV programs will continue to rely on the Rapid Test as the primary tool for counseling and testing high-risk populations. This year the minimum requirement on Rapid Based HIV testing for the HIV Early Intervention programs will increase from 40% to 60% of all testing. Programs will continue to focus on the appropriate use of behavior change counseling within the context of risk reduction and HIV testing. HEP C rapid testing may become available in FY2011, and both divisions of DSHS that work with HIV will collaborate to determine the feasibility of piloting this testing with HIV testing. DSHS will ensure that there are clear discussions, training, and shared research and information available for contractors to determine the best options for clients. In addition, staff will work closely with contractors to follow all CDC and SAMHSA recommendations and possible changes in protocols. Counseling and testing (not screening) will continue to be the strategy for performing HIV testing within SAMHSA/DSHS HIV programs.

This year, providers will receive additional information and training related to the state laws and requirements related to Disease Intervention Services (DIS). Supervisors will be required to provide more one on one supervision and training of the HIV Early Intervention program staff, and will receive special training through the mandatory annual conferences. More emphasis will be placed on the quality of motivational interviewing skills in an effort to produce increased client behavior change.

Training for contractors regarding the proper definitions of their key performance measures will be reviewed in a quarterly conference call with supervisors. Progress with performance measures will be monitored monthly through the DSHS electronic management system, and through quarterly reports from the contractors.

DSHS-sponsored Ryan White AIDS Drug Assistance Program (ADAP) program funding is expected to meet the demands of projected eligible cases. Since all HIV clients receiving case management meet the eligibility requirements for receiving those medications, there should be no gaps related to securing HIV antiretroviral treatment. There also will be increased emphasis for SAMHSA Block Grant providers to work more closely with Ryan White case managers and medical care systems, particular those Ryan White clients with identified substance abuse problems. Further examination of Ryan White funds around substance abuse treatment for HIV+ persons is needed. Together, the DSHS divisions working with HIV prevention, intervention, and treatment services will examine how to better leverage substance abuse treatment funds for persons with HIV. This will include further assessment of the value of the statewide residential HIV treatment program in Texas. This process will continue through 2013, when it may be possible to require changes in programming.

New joint collaboration planning meetings between the DSHS Preparedness and Prevention division and the DSHS HIV/MHSA division will continue in FY 11.

All DSHS HIV program services will continue to be monitored onsite using the program matrix developed by the Quality Management unit. In-house desk reviews will be performed by DSHS staff, using monthly and quarterly reviews as submitted quarterly in CMBHS. It is anticipated that all HEI case managers will begin to use the electronic case management system this year. This also will allow for better program monitoring. Annual meetings with all SAMHSA HIV providers will be held with the HIV Program Coordinator, and a minimum of three program site visits will be conducted.

DSHS also will monitor changes in drug use patterns across the state, especially in the Texas-Mexico Border regions. Working closely with SAMHSA and the Gulf Coast Addiction Technology Transfer Center, researchers will allow staff to monitor the use of injection and non injection drugs, which increasingly is impacting high risk sexual activity and risk for HIV/AIDS. Staff also will monitor changes in border cartel violence and how that impacts referrals to treatment, and the co-occurring disorders experienced by clients.

***FY 2012* Intended**

Texas will focus on maintaining a highly trained and productive statewide group of HIV Early Intervention providers through its HTS contractor. We will continue to focus on risk reduction methods, behavior change, and medical and substance abuse care and treatment for those at risk of HIV/AIDS, or those currently infected.

The need for collaboration with the HIV Early Intervention program staff will increase as more DSHS MHSA funded opiod treatment programs begin to conduct increased opt out Routine HIV testing. Expansion of these types of services during the intake process in opiod treatment facilities will require linking up with the HIV Early Intervention programs once a client tests positive for HIV. Connecting clients with substance abuse treatment and medical care services, and providing primary prevention services to members of the target population who are not infected with HIV will be a key area of focus.

DSHS will also study the feasibility of testing for Hepatitis and HIV \ in all treatment facilities/programs for all clients. This is a public health and substance abuse treatment issue which will require a strong integrated approach with clear protocols and clear communication with clients. DSHS will encourage increased collaboration at the local levels to assist with development of a higher level of case finding and client retention in care services throughout the state. This will assist with treatment of those who test late in their HIV disease, and encourage those who consider dropping out of care to remain in their treatment programs.

***FY2013* – Intended**

This year will mark the beginning of the new solicitation process for the SAMHSA Block Grant HIV Early Intervention services. There will be a thorough study of the latest epidemiological data on HIV transmission, Hepatitis B/C, TB, STDs and drug use trends in Texas and the US in order to redesign services and funding patterns around the state.

Texas will examine the training needs and requirements related to substance abuse services and HIV service provision. Requirements related to Protocol Based Counseling (PBC) and the impact of routine HIV testing will be assessed to provide a clear picture of the training needs of providers within the MH systems and throughout all levels of SA treatment. This also may impact the solicitation for services throughout the state.

There will be a continued focus on client retention in services related to HIV medical care, substance abuse treatment, and mental health care. Texas will continue to focus on the latest evidence based research for continuing and retooling its HIV Early Intervention programs throughout the state.

Quality will be monitored by the Quality Management unit of DSHS and the HIV Program Coordinator. Site visits, quarterly conference calls, and biannual meetings with programs at trainings and conferences will also continue.

GOAL 6 – HIV Services

FY 2008(Compliance): In FY 2008, a network of HIV early intervention services was maintained with block grant funds to ensure a service system that would target substance abusers at risk for and infected with HIV. These services promoted communicable disease education and training for those at risk, their families, and significant others. The HIV program network was comprised of 31 HIV prevention and intervention programs. These programs provided testing, risk reduction, and case management. There was also one training program--the HIV training services (HTS), which promoted communicable disease education, and training; and one HIV residential treatment program. The HIV residential program is not funded with set-aside funds. HIV programs funded with HIV set aside funds were in nine of the 11 regions of the state; these provided critical services in sub-state planning areas that were most in need of HIV early intervention services. This includes Regions 1, 3, 4, 5, 6, 7, 8, 10 and 11. Houston, Dallas, and Fort Worth receive the majority of these funds, as they are the areas with the greatest epidemiological statistics for HIV cases and higher drug use.

Proposals were reviewed during this fiscal year to determine the next cycle of funding for the HIV Early Intervention services. HIV intervention and risk reduction programs were responsible for targeting active users at highest risk of infection and performing the first line of intervention for promoting behavior change. These programs utilized the Motivational Interviewing techniques and the Transtheoretical Model, Prochaska-DiClemente Stages of Change as primary intervention tools. They also performed HIV counseling and testing , located and identified HIV-infected, chemically-dependent persons (as well as those identified at risk) and encouraged them to enroll in HIV early intervention case management, medical services, and substance abuse treatment services. In FY 2008, HIV community outreach programs contacted over 11,000 (adults and youth) at risk for HIV and other communicable diseases. HIV early intervention programs performed case management for an ongoing caseload of HIV-infected, chemically-dependent individuals. The program's purpose was to ensure that adequate resources were dedicated to services related to HIV disease management and to address substance abuse treatment and recovery simultaneously with clients, their partners, and family members.

HIV early intervention case management programs also reduced barriers to SA treatment access by serving as the gate for admission to Homeward Bound. Homeward Bound is the statewide HIV residential treatment program that provides treatment services to HIV-infected persons in need of and ready for substance abuse treatment. (NOTE: The treatment program portion of the network was funded separately and was not considered a part of the HIV set-aside). HIV intervention, risk reduction, and early intervention programs provided interim services for all treatment providers in their region. Block Grant funds also supported education, training, and quality improvement through the HTS contractor. HTS contactor services were set up to ensure that all HIV contract staff, and all funded treatment and prevention programs were kept current on the latest HIV clinical information. The HTS contractor also trained HIV contract staff on the National Institute on Drug Abuse's Community-based Outreach Model, Motivational

Interviewing, and the Transtheoretical Model of Change/Prochaska-DiClemente's Stages of Change.

All staff providing HIV testing through these grants were required to complete the Texas Protocol Based Counseling 40 hour training course. HIV programmatic and fiscal activities were monitored by comparing monthly and quarterly reports against performance measure projections submitted by providers, and by using matrices built by DSHS staff specific to each program type. These tools were used to monitor the contractor's ability to provide interim services to IVDU clients waiting for treatment, performance measure documentation, and service agreements that link provider resources.

GOAL 6 – HIV Services

FY 2010(Progress): This was the second year of the HIV Early Intervention contract cycle. These contracts continue to focus on HIV early intervention services in the regions of the state that have growing numbers of HIV/AIDS cases, increased risk factors, and drug use. Nine of eleven regions in the state are recipients of these five year (annual renewal) grants. Contractors continue to target: (1) Persons at risk of being infected with HIV as a result of practicing behaviors related to a substance abuse lifestyle, (2) Persons who are HIV infected and identified as having a problem with substance abuse, and (3) Significant others and/or family members of those described in (1) and (2).

Currently there are 28 SAMHSA HIV funded block grant programs, not including the HIV Training Services contract. Together these 28 HIV early intervention case management programs are serving an average of 1,900 HIV-infected, chemically-dependent individuals on their caseloads. HIV testing, intervention and risk reduction activities account for approximately 25,800 contacts for the year based on numbers reported during the first, second, and third quarters of FY 10.

This year, the DSHS Preparedness and Prevention Division with funds provided by CDC and HRSA, was able to assist in the purchase of additional HIV Rapid tests for the DSHS MHSA funded programs. This level of active collaboration allowed for more leveraging of resources and services to targeted populations.

Revised key performance measures were introduced this year in an attempt to make sure there was standardized collection of data by all contractors. These measures are monitored quarterly. DSHS provides technical assistance to all contractors in how best to report their accomplishments and the changing trends/needs of target populations across the state. In addition to completing electronic reporting, contractors who work most closely with targeted community testing, also voluntarily provide a narrative report on current drug use trends directly to the HIV Program Coordinator.

DSHS HIV programs continued to rely on the Rapid Test as the primary tool for counseling and testing high-risk populations. Counseling and testing (not screening) continued to be the strategy for performing HIV testing within SAMHSA/DSHS HIV programs. All HIV testing contractors were required to use Rapid Test methods for at least 40% of all HIV testing performed. Most used Rapid Tests 90% of the time, holding to blood draws only when requested or when working with less transient populations or when combining with testing for HEP C and Syphilis. Programs reported far fewer false positive tests for the Rapid HIV tests this year.

HIV early intervention program services continue to be monitored through a matrix developed by the Program Implementation and Quality Management units of MHSA. The HIV Program Coordinator met with all HIV contractors at least once during the year and provided program reviews and onsite visits to 4 contractors. In addition, this year the first planned training event for HIV Early Intervention Program supervisor's took place

in a 1 day meeting in Austin. The premise is that by increasing support and training for supervisor's there will be an increase in the quality of services in the field and the retention of skilled staff.

HIV early intervention programs continue to report quarterly through the DSHS clinical electronic management system on level of access to services associated with case management. The case management portion of the new CMBHS will have revised and updated screens which will better capture HIV case management activities and their effectiveness.

Tuberculosis (TB) and Early Intervention Services for HIV (formerly Attachment E)

(See 45 C.F.R. §96.122(f)(1)(x))

For the fiscal year three years prior (FY 2008; Annual Report/Compliance) to the fiscal year for which the State is applying for funds:

Provide a description of the State's procedures and activities and the total funds expended for tuberculosis services. If a "designated State," provide funds expended for early intervention services for HIV. Please refer to the FY 2008 Uniform Application, Section III.4, FY 2008 Intended Use Plan (Form 11), and Appendix A, List of HIV Designated States, to confirm applicable percentage and required amount of SAPT Block Grant funds expended for early intervention services for HIV.

Examples of **procedures** include, but are not limited to:

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

Examples of **activities** include, but are not limited to:

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

TB and Early Intervention Services for HIV

Procedures

FY 2008 saw an increase in collaboration between the two divisions responsible for public health and prevention of communicable diseases and mental health/substance abuse prevention, intervention, and treatment. There is more information flowing between the divisions and greater focus on providing a full array of public health services as part of early HIV intervention services, thus linking people who need assistance.

In FY 2008, DSHS's Prevention and Preparedness Services Division, which is responsible for preventing and addressing communicable diseases, continued to provide funding and support to the block grant funded substance abuse treatment programs. Their task was to work with local health departments and DSHS substance abuse HIV outreach programs to provide TB screening, medical examinations, and instruction for appropriate self-care medications for all clients in substance abuse treatment. DSHS rules for substance abuse contractors required service agreements to be initiated and maintained between local health departments and funded HIV and HEI program providers, with the goal to identify and treat persons exposed to, or infected with, TB.

All HIV early intervention programs continued to be under program requirement to initiate and maintain specific service agreements (QSOAs) between their individual organization and all public health services, social service agencies, substance abuse treatment organizations, and other community organizations with an interest in providing services or benefit to the target population in their service catchment areas. City and county health departments, Federally Qualified Health Clinics (FQHCs) and licensed and funded substance abuse treatment programs are included in this requirement. Compliance is monitored during Quality Management site visits. Quality Management personnel check to make sure these service agreements are updated annually and specifically describe services provided by that organization. That includes provision of interim services and facilitation of TB, HIV, and other screenings or tests for communicable disease for clients of funded treatment providers.

State funding for TB services that target persons receiving treatment for substance abuse are administered by DSHS' Prevention and Preparedness Services Division. The total funding spent in 2008 on persons receiving substance abuse treatment was estimated to be $3,576, 178.00 or 24% of the total funds designated for TB screening and services for the population at large.

Activities

In FY 2008, access to TB screening was and continued to be a licensure requirement for all substance abuse treatment program providers. Rules ensured that every client admitted to treatment was screened unless a recent previous test with a negative result could be verified within the prior year. TB education for contracted staff was part of an ongoing training curriculum offered at no cost to all funded providers

Specific TB information was provided in one curriculum entitled, "Tuberculosis: What Every Counselor Should Know," which is a three hour course. It also was infused into the, "HIV Update" curriculum, and the "Standard Precautions" trainings. These curricula are available from the HTS contractor. Training on TB is provided upon request and at no cost to all block grant funded treatment, intervention, and prevention program providers.

All HIV early intervention programs shared responsibility for providing interim services. This included education about TB, Hepatitis, HIV, and other communicable diseases for all persons on waiting lists for substance abuse treatment whenever it is requested by the treatment provider. FY2008 was the fifth year in the 5 year contract funding cycle of the DSHS MHSA HIV Early Intervention programs and all those receiving funding for subsequent years were notified of their award and new contract requirements for the FY2009 cycle.

In FY 2008, there were 22 organizations providing HIV risk reduction, intervention, and case management services under the SAMHSA funded HIV early intervention programming, in addition to providing required interim services. Those were on call and available to offer interim services to all IVDUs and other substance abusers on waiting lists for treatment providers in Regions 1, 3, 4, 5, 6, 7, 8, 10 and 11. The education presentations or counseling sessions included information about communicable diseases and risks associated with drug and alcohol use. They offered access to testing and screening for HIV, TB, and STDs in accordance with agreements established between the HIV service provider and the treatment program.

Early Intervention Services for HIV

In FY 2008, a network of HIV early intervention services was maintained through block grant funds to ensure a service system that would target substance abusers at risk for and infected with HIV. The HIV program network was comprised of 31 HIV risk reduction, community based interventions, and early intervention case management programs; one training program (HIV training services or HTS), which promotes communicable disease education and training; and one HIV residential treatment program. A total of $6,775,919 was expended in block grant funds on early intervention services for HIV, consistent with the 5% set-aside requirement established in the summer of 2002. An additional amount of $1,176,945 was expended in substance abuse general revenue funds. A combination of block grant set-aside funds and state general revenue supported all the programs within the HIV network with one exception. The HIV statewide residential SA treatment program continued to be funded with block grant treatment funds.

In FY 2008, early intervention programming comprised a number of strategies designed to intervene with persons actively involved in risk behaviors associated with HIV and other communicable diseases. HIV early intervention programs were located in nine of the 11 Health and Human Service regions of Texas. Multiple programs were funded in major metropolitan areas with high rates of HIV/AIDS (Houston, Dallas, and Ft. Worth). High risk areas Texas Mexico Border areas, such as South Texas (Laredo, McAllen, Brownsville, and Harlingen), and other risk areas such as Galveston, El Paso, and

Beaumont also received funds. One training program, HTS, continued as the primary training and capacity building agent in the network. The program offered over 12 different curricula to contractors in order to build motivational interviewing skills, improve counseling skills, and support behavior change efforts. HTS also provided training in the outreach model established by the National Institute on Drug Abuse (NIDA) which was designed to ensure that all HIV community based programs operate in a safe and effective manner. In FY 2008, the HTS facilitated education about HIV, TB, hepatitis, and other communicable diseases for all block grant funded treatment, intervention and prevention programs. Over 641 participants were trained through their HIV/AIDS Update and TB courses.

The HIV prevention and intervention programs continued to provide HIV testing that targeted injection drug users and substance users at high risk. All HIV Early Intervention contractors used the Rapid Testing methods, citing this as the most effective tool for testing in a non-medical type setting and for testing the primary target population. All persons who were identified and had preliminary positive tests and those confirmed as positive were offered immediate intervention services that included risk reduction, case management, access to an HIV-knowledgeable primary care physician, and opportunities to enter substance abuse treatment and recovery.

Goal #7: Development of Group Homes

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

Note: If this goal is no longer applicable because the project was discontinued, please indicate.

If the loan fund is continuing to be used, please indicate and discuss distribution of loan applications; training/TA to group homes; loan payment collections; Opening of new properties; Loans paid off in full; and loans identified as in default.

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

GOAL 7: Development of Group Homes

FY2011 – FY2013 (Intended Use):

FY2011: Texas will enter into a contract with Oxford House for the development of six residences in one of five metropolitan areas of the state. A revolving loan fund of $ 24,000 will be established. This renewed emphasis on housing for persons exiting treatment is consistent with DSHS' guiding principles and interest in reducing homelessness. It unites Texas with SAMHSA's Strategic Initiative regarding housing assistance and homelessness. While six residences may appear to be insignificant for such a large state, it must be noted that almost 60 Oxford Houses currently operate throughout Texas.

A primary goal of the Oxford House contract is to locate housing for persons who successfully complete DSHS-funded treatment programs, who may or may not have a job, and who risk return to a former environment where the newly won sobriety/drug-free status may be compromised. DSHS' objective is to assist an individual to move into drug free, self supporting housing for a period of time until he/she gains employment. Once the group home and revolving loan fund are established, all necessary reporting measures will be provided in accordance with 42 U.S.C. 300x-25.

Additionally, other housing programs will be assessed. This is a topic of consideration by the Texas Recovery Initiative (TRI), a project designed to gather information and develop recommendations regarding addiction treatment protocols that are both evidence based and recovery oriented. Other discussions will be initiated with the mental health units in the agency who already have housing programs in place and can provide technical assistance and direction about developing more housing opportunities.

FY2012: Contract will be continued through the year if all Contract requirements and performance measures have been met, and if sufficient funds exist to continue.

FY2013: Contract continues if funds are available and contract requirements have been met. Consideration may be given to operating the fund maintenance in-house if there is sufficient knowledge around the state regarding the Oxford concept, so that referrals for new houses continue to be received. This would be appropriate only if people and programs are aware of this service and know how to access it.

Texas / SAPT FY2011 /

N/A

GOAL 7: Development of Group Homes

FY2010 (Progress): N/A

The Texas Department of State Health Services (DSHS) was approached by SAMHSA to reconsider their position on supporting the Oxford House concept in Texas. Approximately ten years ago, the state had a revolving fund for the purpose of developing Oxford Houses. However, a decision was made to discontinue state level funding involvement. In 2009, the State attended the Oxford House National Conference after receiving an invitation from SAMHSA. Texas and several other states met with Oxford House representatives who provided a presentation on the benefits of Oxford Houses to their target populations and a proposed cost analysis. After discussions with executive management, DSHS agreed to enter into a contract with Oxford House.

After numerous delays and negotiations due to the State's projected General Revenue budget cuts, a contract start date was agreed upon with Oxford House for one year, beginning in FY 2011, with one extension.

Group Home Entities and Programs (formerly Attachment F)

(See 42 U.S.C. §300x-25)

If the State has chosen in FY 2008 to participate and support the development of group homes for recovering substance abusers through the operation of a revolving loan fund, the following information must be provided.

Provide a list of all entities that have received loans from the revolving fund during FY 2008 to establish group homes for recovering substance abusers. In a narrative of **up to two pages**, describe the following:

• the number and amount of loans made available during the applicable fiscal years;

• the amount available in the fund throughout the fiscal year;

• the source of funds used to establish and maintain the revolving fund;

• the loan requirements, application procedures, the number of loans made, the number of repayments, and any repayment problems encountered;

• the private, nonprofit entity selected to manage the fund;

• any written agreement that may exist between the State and the managing entity;

• how the State monitors fund and loan operations; and

• any changes from previous years' operations.

Group Home Entities and Programs

N/A – See Goal 7 Intended Use/Plan

Goal #8: Tobacco Products

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

• Is the State's FY 2011 Annual Synar Report included with the FY 2011 uniform application? (Yes/No)

• If No, please indicate when the State plans to submit the report: (mm/dd/2010)

Note: The statutory due date is December 31, 2010.

The State's FY2011 Annual Synar Report is included with the FY2011 uniform application.

Goal #9: Pregnant Women Preferences

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

Note: In addressing this narrative the State may want to discuss activities or initiatives related to the provision of: *Priority admissions; Referral to Interim services; Prenatal care; Provider contracts; Routine reporting; Waiting lists; Screening/assessment; Residential treatment; Counseling; Training/TA Educational materials; HIV/AIDS/TB Testing*

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

GOAL 9 – Admission Preference for Pregnant Women and Interim Services – Intended Use

FY 2011 (Intended Use): In FY 2011, the new electronic clinical management system will be fully in place for treatment providers and will provide an improved ability to monitor available slots in DSHS funded treatment programs that serve pregnant women and women with dependent children. DSHS staff will continue to monitor the data to ensure that capacity information is accurate and timely, and that appropriate services are available to pregnant women. The new system will provide improved detailed data on priority population females including clinical profiles, needs and service use trends. Through ongoing review of utilization and capacity data, DSHS will continue to provide leadership for interagency efforts to ensure that treatment services for pregnant women are provided in a timely, effective and efficient manner. DSHS staff and Outreach, Screening, Assessment and Referral (OSAR) programs will use the capacity management system to access available bed space for priority admissions.

In FY 2011, DSHS will continue funding for 13 Pregnant and Postpartum Intervention (PPI) programs. The PPI programs provide outreach, intervention, screening and referral for perinatal women at risk for substance abuse. Staff members are located in Women, Infant and Children (WIC) sites, perinatal clinics, Department of Family and Protective Services (DFPS) offices and similar sites. Staff facilitates early identification and access to substance abuse services. The goals are to improve birth outcomes, improve parenting skills and support mother-child bonding. Improved contracts and performance measures will ensure greater consistency between providers and begin to allow DSHS to collect and analysis important provider and client data.

Beginning in FY 2011, contractors will have detailed Statements of Work where requirements related to services for pregnant women (including priority admission and interim services) are clearly described in one document. This will make monitoring and technical assistance efforts more streamlined. DSHS will continue to provide technical assistance to develop a seamless continuum of care and ensure priority access to services for pregnant women. This will be accomplished through monthly conference calls and individual provider consultation. DSHS will continue to monitor compliance with licensure requirements and rules specific to priority admission for pregnant women and women with dependent children.

DSHS will continue to collaborate and cross-train with internal and external entities that serve pregnant women to ensure that contracted substance abuse providers are knowledgeable about services available to clients and that the other entities are aware of treatment service availability and the prioritization of pregnant women.

The Regional Outreach, Screening, Assessment and Referral (OSAR) providers in each region will continue to provide interim services in conjunction with substance abuse treatment providers. Ultimately, the treatment provider will remain responsible for these services if the client presents directly to that treatment provider.

As the substance abuse Medicaid benefit is implemented, it is expected that capacity for this population will be expanded and there should be fewer instances where a pregnant woman cannot be admitted immediately. Block Grant funds will also be used to provide supplemental wrap-around services for women who are admitted to treatment with their children under Medicaid funding, as the Medicaid benefit does not cover many of the services provided in this level of care.

Texas will need to prepare for Health Care Reform related to this population as when so many new Texas will be covered for treatment services under Medicaid, there could be renewed capacity problems as a result. Texas will need to engage, plan with and prepare providers (those funded by DSHS as well as those that are currently not funded by DSHS) as changes are made to the block grant requirements as a result of Health Care Reform to ensure that (regardless of a block grant requirement) pregnant women have immediately access to services they need.

GOAL 9 – Admission Preference for Pregnant Women and Interim Services – Intended Use

FY 2012 (Intended Use): In FY 2012, DSHS staff will continue to monitor data to ensure appropriate services are available to pregnant women. DSHS staff will also be working with contractors to ensure that any clients who are waiting for treatment are prioritized according to federal regulations. Regular data reports will be monitored to ensure that any pregnant clients who have not been immediately admitted are receiving appropriate interim services.

DSHS will continue to provide technical assistance to develop a seamless continuum of care and ensure priority access to services for pregnant women. This will be accomplished through monthly conference calls and individual provider consultation. DSHS will continue to monitor compliance with licensure requirements and rules specific to priority admission for pregnant women and women with dependent children.

DSHS will continue to collaborate and cross-train with internal and external entities that serve pregnant women to ensure that contracted substance abuse providers are knowledgeable about services available to clients and that the other entities are aware of treatment service availability and the prioritization of pregnant women.

In FY 2012, DSHS will continue funding for 13 Pregnant and Postpartum Intervention (PPI) programs. The PPI programs provide outreach, intervention, screening and referral for perinatal women at risk for substance abuse. During 2012, DSHS will be actively collaborating with current PPI providers to make positive program design changes as preparations are made to release a Request for Proposals for prevention and intervention services across the state for the next five-year funding cycle for these serviecs.

FY 2012 will be a busy time as Texas will need to prepare for Health Care Reform related to this population as when so many new Texas will be covered for treatment services under Medicaid, there could be renewed capacity problems as a result. Texas will need to engage, plan with and prepare providers (those funded by DSHS as well as those that are currently not funded by DSHS) as changes are made to the block grant requirements as a result of Health Care Reform to ensure that (regardless of a block grant requirement) pregnant women have immediately access to services they need.

FY 2013 (Intended Use): For the purpose of this Block Grant Application, the following assumes that the Block Grant will have similar requirements in 2013 as are in place currently. Healthcare Reform is anticipated to greatly affect the Block Grant uses and requirements. The Medicaid expansion will be implemented in 2013 and, in Texas; Medicaid is administered by another state agency. For this reason, it is difficult to say for certain what the roles and activities of DSHS will be.

Assuming similar Block Grant uses and requirements in FY 2013, DSHS staff will continue to monitor data to ensure appropriate services are available to pregnant women. DSHS staff will also be working with contractors to ensure that any clients who are waiting for treatment are prioritized according to federal regulations. Regular data reports will be monitored to ensure that any pregnant clients who have not been immediately admitted are receiving appropriate interim services.

DSHS will continue to provide technical assistance to develop a seamless continuum of care and ensure priority access to services for pregnant women. This will be accomplished through monthly conference calls and individual provider consultation. DSHS will continue to monitor compliance with licensure requirements and rules specific to priority admission for pregnant women and women with dependent

GOAL 9 – Admission Preference for Pregnant Women and Interim Services – Intended Use

children.

DSHS will continue to collaborate and cross-train with internal and external entities that serve pregnant women to ensure that contracted substance abuse providers are knowledgeable about services available to clients and that the other entities are aware of treatment service availability and the prioritization of pregnant women.

In 2013, a report will be due to the Texas Legislature on the cost neutrality of the Substance Abuse Medicaid Benefit. This benefit may be continued in Texas at that time, or may be dismantled if shown not to be cost neutral. It is anticipated that pregnant women receiving Medicaid-funded treatment, who deliver drug-free and health babies, will substantially impact this outcome.

In FY 2013, DSHS will implement a new funding cycle for the Pregnant and Postpartum Intervention (PPI) programs. The PPI programs will likely continue to provide outreach, intervention, screening and referral for perinatal women at risk for substance abuse, along with a few additional services that will benefit the pregnant woman seeking treatment.

GOAL 9 – Admission Preference for Pregnant Women and Interim Services – Compliance

FY 2008 (Compliance): In FY 2008, to facilitate priority treatment access and referrals for pregnant women, Department of State Health Services (DSHS)-funded service providers were required to report daily capacity for treatment through the Behavioral Health Integrated Provider System (BHIPS) Capacity Management System, an automated statewide reporting system. The system provided information on all available treatment slots including those designated for Specialized Female Services (SFS). The Program Implementation Unit of the DSHS-Community Mental Health and Substance Abuse (MHSA) Services Division managed and closely monitored the system for compliance, accuracy and timeliness of reporting. The capacity management system provided better access to treatment and data on availability of treatment slots. For pregnant women, the contracts continued to require:

- DSHS treatment providers submit updated daily capacity information by 11 a.m. The information provided included number of available residential, outpatient and methadone slots and waitlist information.
- If a program was unable to admit a pregnant woman due to insufficient capacity, providers were required to call the capacity management system's toll-free number for statewide capacity information.

All substance abuse treatment programs receiving SAPT Block Grant funds were required to provide treatment on demand for pregnant substance abusing females who presented for treatment. If the program did not have capacity, DSHS required the facility to access the capacity management system to identify other treatment resources.

In the event that no DSHS provider had the capacity to admit a pregnant female into treatment, the provider that screened the woman was required to make interim services available within 48 hours from the time she sought treatment. These services included, but were not limited to, information on the effects of alcohol, tobacco and other drugs on the fetus, communicable disease information, education, intervention and perinatal service access. Pregnant opiate drug users were referred to methadone treatment programs where they were given priority admission status.

DSHS SFS residential and women and children residential treatment programs were required to publicize the availability of services for pregnant substance abusing women and to inform relevant entities in their communities that such treatment was available. Relevant entities included health clinics providing prenatal care, emergency treatment facilities, hospital obstetrical units, local Department of Family and Protective Services (DFPS) offices and street outreach programs.

GOAL 9 – Admission Preference for Pregnant Women and Interim Services – Progress

FY 2010 (Progress): In FY 2010, DSHS continues to analyze service utilization and demand to identify gaps in service and to refine a statewide delivery system based on regional and sub-regional referral and access trends.

To facilitate priority treatment access and referrals for pregnant women, Department of State Health Services (DSHS)-funded service providers are required to report daily capacity for treatment through the Behavioral Health Integrated Provider System (BHIPS) Capacity Management System, an automated statewide reporting system. The system provided information on all available treatment slots including those designated for Specialized Female Services (SFS).

For pregnant women, provider contracts continue to require:

- DSHS treatment providers submit updated daily capacity information by 11 a.m. The information provided includes number of available residential, outpatient and methadone slots and waitlist information.
- If a program is unable to admit a pregnant woman due to insufficient capacity, providers are required to call the capacity management system's toll-free number for statewide capacity information.

All substance abuse treatment programs receiving SAPT Block Grant funds are required to provide treatment on demand for pregnant substance abusing females who presented for treatment. If the program does not have capacity, DSHS requires the facility to access the capacity management system to identify other treatment resources.

In the event that no DSHS provider has the capacity to admit a pregnant female into treatment, the provider that screened the woman is required to make interim services available within 48 hours from the time she seeks treatment. These services include, but are not limited to, information on the effects of alcohol, tobacco and other drugs on the fetus, communicable disease information, education, intervention and perinatal service access. Pregnant opiate drug users are referred to methadone treatment programs where they are given priority admission status.

DSHS also continues to implement a new electronic clinical management system to replace BHIPS, and the new system will enhance how capacity is managed with contractors with real-time information available on contractors' available capacity.

Through monthly conference calls, processes are discussed and providers communicate with each other about capacity and referrals between each other. Also, DSHS staff including the Women's Coordinator and Clinical Director are available to assist with difficulties with the population. Often contractors seek guidance when coordinating care for pregnant clients, particularly when there are barriers to treatment.

The Request for Proposals released in FY 2010 strengthens the written protocols and procedures for future contractors to manage this population and work continues this fiscal year towards finalizing this process.

GOAL 9 – Admission Preference for Pregnant Women and Interim Services – Progress

Capacity Management and Waiting List Systems (formerly Attachment G)

See 45 C.F.R. §96.122(f)(3)(vi))

For the fiscal year two years prior (FY 2009) to the fiscal year for which the State is applying for funds:

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

• development of procedures (and any subsequent amendments) to reasonably implement a capacity management and waiting list system;

• the role of the Single State Agency (SSA) for substance abuse prevention and treatment;

• the role of intermediaries (county or regional entity), if applicable, and substance abuse treatment providers; and

• the use of technology, e.g., toll-free telephone numbers, automated reporting systems, etc.

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

• how interim services are made available to individuals awaiting admission to treatment ;

• the mechanism(s) utilized by programs for maintaining contact with individuals awaiting admission to treatment; and

• technical assistance.

Capacity Management and Waiting List Systems

In FY 2009, a total of $16,031.00 was expended to comply with the requirement to maintain capacity management and waiting list systems for intravenous drug users and pregnant women. This was consistent with 45 C.F.R. 96.126 (c) and 45 C.F.R. 96.131 (c) respectively.

In FY 2009, the data entry screen in the Behavioral Health Integrated Provider System (BHIPS) provided access to the Available Capacity System, which allowed DSHS MHSA to monitor beds available in state-funded treatment programs, including methadone programs.

DSHS staff monitored the Capacity Management System daily to ensure that providers were in compliance with capacity management reporting requirements in BHIPS, and appropriate service levels were accessed by priority population clients. Using information from the BHIPS entry screens and internal reports, DSHS staff identified providers who did not use BHIPS and provided technical assistance by phone to providers that did not report. Staff also provided assistance to providers who requested assistance in finding available treatment capacity for priority populations (pregnant females and IV drug users).

Substance Abuse treatment providers had a contractual requirement to report Daily Available Capacity information by 11 a.m., Monday thru Friday. Providers that adequately explained days of non-compliant reporting were excused for those days. When there was a pattern or trend toward late reporting or non-reporting in a given month, the provider received a "non-compliant" rating for that month. A non-compliant month of available capacity reporting was treated as a late fiscal report when consideration was given to historical performance for future funding. The reporting system provided data to help DSHS analyze utilization of resources. A weekly synopsis of the daily reports entered in BHIPS was generated by the DSHS Capacity Management Coordinator to ensure that capacity information was submitted in a timely manner. The Capacity Management Coordinator also notified providers weekly by e-mail when a pattern of late reporting or non-reporting was identified.

Substance Abuse treatment providers used the on-line function in BHIPS to search for available capacity by county or by provider name. The system allowed providers with priority population clients on their waiting list to search for treatment programs that had available beds. Online instructions directed providers to contact DSHS staff for assistance in placing clients into treatment or interim services. The wait list information in the BHIPS system gave step-by-step instructions on how to maintain the wait list. Providers who were at maximum capacity placed clients who needed treatment services on the wait list for the specific service type that addressed the highest severity problem for the client.

Interim services were provided until needed services became available, and clients in the priority population who had been on the wait list the longest were admitted first. Weekly reports were run to monitor wait lists, real-time data relating to the average number of days a client remained on a wait list by region and the statewide average for both adults and youths. The report also reflected the type of interim services a client received upon being placed on a wait list. Additionally, a weekly wait list summary report by provider was also available for review.

The use of the BHIPS Capacity Management System for monitoring capacity was verified through DSHS performance reviews and on-site monitoring visits. The DSHS Quality Management Unit conducted a review of documentation related to the provision of interim services for pregnant females and IV drug users. They also verified if providers encouraged substance abusers in need of treatment to receive treatment, and assisted them in accessing services in a timely and efficient manner. The DSHS Quality Management Unit also reviewed the provider's current waiting list to determine the program's mechanism used in maintaining contact with the individual awaiting admission to treatment. Quality Management Unit visits resulted in a range of recommendations, which included technical assistance support, and/or sanctions.

In late 2010, the conversion began from BHIPS to the Clinical Management for Behavioral Health Services (CMBHS). The capacity management function within the new system allows providers to separately report actual adult and youth availability in all level of services. The Outreach, Screening, Assessment, and Referral Services (OSAR) agencies continue to maintain the centralized residential waitlist in each region. An outpatient waitlist continue to be maintained by the individual provider. Conversion to CMBHS was phased in one region at a time which required the capacity management function to be simultaneously monitored within the two systems.

In FY 2011 once all regions are completely trained in the use of CMBHS, weekly and monthly synopsis reports and all functions in BHIPS will be available in order to monitor capacity in the new system.

Goal #10: Process for Referring

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

Note: In addressing this narrative the State may want to discuss activities or initiatives related to the provision of: *Training/TA; Implementation of ASAM criteria; Use of Standardized assessments; Patient placement using levels of care; Purchased/contracted services; Monitoring visits/inspections; Work groups/task forces; Information systems; Reporting mechanisms; Implementation protocols; Provider certifications.*

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

GOAL 10 – Process for Referring

FY 2011-2013
FY 2011 (Intended Use): In SFY 2011, DSHS substance abuse treatment and OSAR contractors will continue to use an electronic clinical records system to ensure appropriate client referral and placement. With training completed in 2010, providers will complete transition from BHIPS to CMBHS in SFY 2011.. Components of the new system include algorithms that provide for calculation of clinically-appropriate service packages for individuals accessing mental health services, and clinically-appropriate service level placements for individuals accessing substance use/abuse services. This enhanced functionality of CMBHS will enable DSHS to track and monitor the treatment levels of care received more effectively. This will assist with continued efforts to improve the matching of clients with the most appropriate level of care.

In 2011, the OSARS will continue to develop and expand referral relationships with the local mental health centers as part of the *Crisis Services Redesign* initiative.

***FY 2012-2013 (Intended Use*)**: In SFY 2012, DSHS substance abuse treatment and OSAR contractors will use the electronic clinical records system to ensure appropriate client referral and placement. DSHS is in the process of reviewing the delivery of services that will include Local Public Health agencies and other health agencies appropriate to the referral processes.

GOAL 10 – Process for Referring

FY 2008 (Compliance): Texas residents who met financial guidelines and diagnosed as having a substance use disorder (DSM IV-TR) were eligible for DSHS services. DSHS clients remained in treatment as long as there was a documented clinical need for continued services.

OSAR providers served as the front door to local treatment services for specific geographic areas. Every HHSC region had at least one OSAR, and two of the more populated regions were served by two OSARs. In seven counties around the Dallas metroplex, NorthSTAR provided oversight and referral functions.

OSARs were responsible for providing information, screening and outreach to their identified service areas and maintaining close working relationships with local treatment providers. Individuals and organizations inquiring about services by phone or via the internet were directed to the appropriate OSAR location for screening, assessment, and referral.

OSARs matched clients to appropriate services using the assessment tool found in BHIPS. They identified appropriate services using the capacity and waiting list data found in BHIPS, and gave clients a choice of appropriate providers and their contact information. When necessary, OSARs also communicated with each other across regions to facilitate referrals and allow priority population patients to access services more quickly. When possible, the OSAR would schedule an appointment for the client with the chosen provider to promote successful follow-through. After obtaining client consent, the OSAR would share assessment results with the provider through BHIPS.

In FY 2008, effective use of the continuum of care was achieved by strengthening the process for client referral and capacity management. Routine follow-up determined if clients were matched to and/or received the type and level of services most appropriate to their individual needs. OSARs gave providers regular feedback on client placement and service utilization based on placement criteria and length of stay guidelines that were developed and implemented in FY 2004.

The state maintained its “no wrong door” policy, allowing treatment providers to perform assessments and, when necessary, provide referrals for individuals who applied directly to them. The role of OSARs includes performing gatekeeper functions for residential treatment slots. OSARs were required to authorize each residential admission after verifying that the BHIPS assessment documented a clinical need for that level of service. This OSAR gate keeping function was limited to residential services; other funded services such as outpatient, detox, and opiod replacement therapy did not require OSAR approval for admission.

In FY 2008, the referral process continued to benefit from the comprehensive functionality of BHIPS, which was fully implemented in FY 2004. Data from BHIPS enabled providers to identify need, demand and gaps in service. The capacity management function helped providers to locate appropriate services for clients more quickly and allowed them to access client records electronically concurrent with the physical referral of the client. Through the BHIPS system the state was able to maximize limited resources by providing information to the general public, referral sources, potential clients, and treatment providers so that clients could be more effectively and efficiently matched with services that best met their needs.

GOAL 10 – Process for Referring

FY 2010 (Progress): DSHS contracts with Outreach, Screening, Assessment, and Referral providers to serve all but the seven counties that participate in the NorthSTAR Medicaid Waiver program. With the exception of the NorthSTAR catchment area, OSARs are located in all regions of the state. OSARS serve as the front door, but DSHS maintains its "no wrong door" policy for clients entering services. Clients access DSHS Substance Use Disorder treatment services via self referral and through referral from a variety of sources that include courts, criminal justice and juvenile justice agencies, physicians and hospitals, families, employers, the Department of Family and Protective services and other state agencies, community-based mutual support organizations (AA, NA, etc.), and treatment providers. Eligible clients residing in areas served by NorthSTAR are initially enrolled in services, and then assessed and referred for treatment to NorthSTAR-contracted providers.

Referral data from FY 2010 was reviewed for appropriateness of placement and provider compliance with the new placement criteria. Review of the data shows higher utilization of outpatient services while continuing to maintain residential capacity. The regional OSARs facilitated quarterly regional face-to-face meetings with, treatment providers, and referring agencies to present data on placement decisions and outcomes, and to solicit input on revisions to the placement and approval process. To better reach youth in need of treatment, each OSAR developed a plan to improve the communication with youth prevention services within their regions of responsibility, with special focus upon the Youth Prevention Indicated programs.

DSHS continued a major Motivational Enhancement Training initiative to improve referral and treatment. All OSAR and treatment staff are required to have training in motivational interviewing, and DSHS has provided training sessions throughout the state. The initiative was developed as a partnership with the Health Behavior Research and Training Institute of the University of Texas, and includes intensive workshops paired with individualized coaching for participants to help them apply and improve their motivational interviewing skills.

OSARs initiated quarterly regional meetings that included substance abuse providers, referral agencies, and Local Mental Health Authorities' (LMHA) crisis response units to improve referral and better access to appropriate services.

Since approximately fifty per cent of individuals experiencing a mental health crisis also have substance use issues, access to substance abuse services is an essential part of crisis redesign. In SFY 2010 DSHS instituted a new process for handling crisis calls. The regional OSARs are partners in the local crisis response teams and provide referrals for substance abuse prevention and treatment services, including detoxification. To support implementation of the crisis redesign initiative, DSHS is providing training for crisis hotline staff and crisis mobile outreach teams. The OSARs forward their phones to the LMHA crisis hotlines for after hours crisis response.

Goal #11: Continuing Education

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

Note: In addressing this narrative the State may want to discuss activities or initiatives related to the provision of: *Counselor certification; Co-occurring training; ATTCs training; Motivational interviewing training; HIV/AIDS/TB training; Ethics training; Confidentiality and privacy training; Special populations training; Case management training; Train-the-trainer model; Domestic violence training; Faith-based training; Suicide prevention training; Crisis intervention training.*

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

GOAL 11 – Continuing Education

FY 2011- 2013 (Intended Use): It is DSHS's intent for FY 2011-2013 to offer evidenced based strategies in prevention, treatment and prevention of Human Immunodeficiency Virus (HIV) and other communicable diseases to prevent and treat substance use and mental health problems.
DSHS plans to continue to offer opportunities for substance abuse and mental health professionals to improve skills and competencies, and strengthen the integrated service delivery system through regional trainings and conferences that offer continuing education hours.

In FY 2011-2013, DSHS plans to implement a Recovery Oriented Systems of Care (ROSC). Training of Peer Specialists will be just one aspect of the implementation of the ROSC project. Peer Specialists work from the perspective of "having been there."

Training and Technical Assistance: In FY 2011-2013, Regional trainings will continue for Motivational Enhancement Therapy (MET), Cannabis Youth Treatment (CYT), Trauma Informed Services/*Seeking Safety* manual and Co-occurring Psychiatric and Substance Abuse Disorders (COPSD) to all substance abuse and mental health professionals to improve skills and competencies, and strengthen the integrated service delivery system. DSHS substance abuse and mental health professionals who had received prior training in Motivational Interviewing (MI) will continue to receive follow up/booster training to assess progress and continued advancement in using MI techniques. It is DSHS's intent that these professionals will be able to work with their agency staff to ensure the fidelity of MI is maintained within their agencies.

Annual Institute: It is DSHS's intent for FY 2011-2013 to continue to host the Annual Institute.

Coordinated Training Services (CTS): In FY 2011-2013, CTS will continue to provide statewide prevention training services and technical assistance. CTS will schedule evidence based curriculum training as requested by the providers based on need. The CTS will schedule newly designed prevention training to meet the specific Substance Abuse Prevention Specialist Certification domains, other alcohol, tobacco and other drugs (ATOD) prevention training, as well as workforce development training to enhance the skills of the prevention specialists providing direct services and training on communicable diseases.

CTS will continue to work with the Prevention Resource Centers (PRCs) and the Education Service Centers in each of the 11 HHSC regions to ensure the delivery of prevention training services in each region that will help maintain and strengthen the prevention infrastructure throughout Texas.

CTS will continue to provide DSHS with assistance and support in the coordination of the DSHS Annual Prevention Provider Meeting, the Annual Fall Meeting, and the Spring

Meeting for the Prevention Resource Centers (PRC) and Community Coalition Partnerships (CCPs), the Texas Collaborative Prevention Committee webinars.

CTS will continue to maintain the 800 phone number and the websites for CTS and Texas Coalitions. This website will contain current training and conference and resource information to make training accessible to DSHS prevention providers.

Prevention/Intervention : In FY2011-2013, DSHS along with the HIV Training Services (HTS) contractor will continue to improve skills and expertise of HIV Early Intervention (HEI) and HIV program supervisors and clinicians through training, technical assistance and skill building conferences, while also supporting the delivery of quality services through the frontline staff. The HTS contractor will continue building upon the webinar courses offered and providing onsite regional trainings. The unique approach DSHS, in partnership with the training contractor, is taking will provide experiential exercises, practice and training in small groups with the case managers and then with their supervisors. An expert MI clinician experienced with the target populations will be providing direct feedback and skill building opportunities to improve MI skills and behavior change to use with their clients. The annual HIV Street Outreach Worker Conference is planned to continue in FY 2011-2013.

FY 2011-2013, Protocol Based Counseling required by the State of Texas will be required of all HIV and HEI contractors. This training will continue at no cost throughout the state through the DSHS HIV/STD contractor.

FY 2011-2013, DSHS will utilize the 2010 version of the "Border Violence and Disaster Prevention" curricula, specifically designed for the Texas Mexico border population, for Promtoras/Community Health Workers (CHWs) to continue to train CHWs in the border areas of the state.

Tobacco: It is DSHS's intent for FY 2011-2013 to continue to co-host *The Texas Teen Summit and Comprehensive Tobacco Prevention Conferenc*e.

Clinical Management for Behavioral Health Services (CMBHS): In FY 2011-2013 CMBHS trainings will continue especially as new screens and functionality are developed. CMBHS trainings will be conducted monthly for both new hires and former employees. Training topics consist of prevention, intervention, and non-treatment provider staff functions such as administrative and billing. CMHBS will continue training all providers in FY2011-2013 as BHIPS is phased out and CMHBS replaces BHIPS.

GOAL 11 – Continuing Education

FY 2008 (Compliance): During FY 2008, DSHS continued to develop its' training program by providing workshops and conferences whose primary focus was to present evidenced-based practices and strategies for preventing and treating substance use/abuse and mental health problems. Workshops and conferences provided opportunities for substance abuse and mental health professionals to improve skills and competencies, and to strengthen the integrated service delivery system. Evidenced-based workshops on prevention and treatment methods and strategies were offered regionally and provided continuing education hours. Workshops and conferences included prevention of Human Immunodeficiency Virus (HIV) and other communicable diseases, and the care and treatment of people with substance abuse and HIV/AIDS.

DSHS Training and Technical Assistance Unit (TTA): FY 2008 was the second year of the TTA unit. Trainings were conducted by contracted vendors/developers from around the country and by DSHS's training and technical assistance staff who possess subject matter expertise. Trainings continued through the Coordinated Services Training (CTS) contract, the Annual Institute and the Behavioral Health Integrated System (BHIPS). Trainings were open to both mental health and substance abuse providers statewide when applicable. Trainings were held in state-owned facilities and contracted hotels in urban regions. Training locations were determined by accessibility to the largest concentration of funded providers.

FY 2008, the TTA unit provided statewide trainings on the Cannabis Youth Treatment (CYT) manual to all DSHS youth treatment providers. TTA staff provided technical assistance to providers for the implementation of the CYT manual into their programs.

Trauma Informed Services training was provided to all Administrators of DSHS-funded Specialized Female treatment facilities, Outreach, Screening, Assessment and Referral (OSAR) providers and Pregnant Postpartum Intervention Program (PPI) providers. Administrators were asked to develop a plan to implement trauma informed services into their programs. The implementation plans were reviewed by experts in the field on trauma and Administrators were provided detailed analysis and feedback on their implementation plans. Clinicians of these same programs attended training on the *Seeking Safety* manual to learn how to implement the manual into their program. Technical assistance was provided to clinicians for help in implementing the Seeking Safety manual.

DSHS provided a series of Motivational Interviewing (MI) trainings for Supervisors and Clinicians for Mental Health and Substance Abuse (MHSA) Treatment Providers statewide. The training series began in April 2008 and ended in August 2009. The series of MI trainings included an initial 1.5 day MI training, three monthly taped session reviews, expert coaching feedback provided via a webbased coaching application and a one-day follow up training to assess progress and provide advanced MI training. Seven MI trainings were conducted regionally.

Other trainings and conferences provided in 2008 were: Suicide Prevention, Texas Recommended Assessment Guidelines, Mobile Crisis Outreach, Barkley Defiant Child and Cognitive Behavioral Therapy, Co-Occurring Psychiatric Substance Disorders, BHIPS, the Preparedness Training Project, CTS contract, and the Annual Institute.

The 51st Annual Institute: The 51st Annual Institute was held in Dallas, August 25-29, 2008. The theme was "Knowledge in the Neighborhood: Partnerships to Healthy Communities". There were 1,338 paid attendees and 200 unpaid attendees. The conferences offered 'Prevention Specialist Training' and a 'Coalition Summit'. The tracks were: Counseling Essentials, Treatment, Prevention, Youth and Family, Mental Health, Improving the Workforce, Community Issues and Recovery and Criminal Justice.

Coordinated Training Services (CTS): In FY 2008, DSHS continued to fund the Workers Assistance Program of Texas to implement the statewide Coordinated Training Services (CTS) for the final year of the FY2005 funding cycle. The CTS contractor provided statewide prevention training and technical assistance services to all DSHS funded prevention providers. The trainings included evidence-based curriculum, sixteen hours of Substance Abuse Prevention Specialist Certification domains, prevention of alcohol, tobacco and other drugs (ATOD), communicable diseases, and workforce development.

In FY 2008, CTS was awarded the statewide Coordinated Training Services contract though the DSHS Behavioral Health Coordinated Training Services Request for Proposals issued on November 14, 2007, RFP#SA-PTS/HTS-241.1. Services under this RFP were scheduled to begin in FY2009.

Prevention/Intervention: This was the first year of the five year renewable HIV intervention contracts; the HIV Statewide Training Systems contractor focused training efforts on key contract required trainings for providers. These included HIV/AIDS Update, HIV/AIDS Outreach in the Community, and Hepatitis B/C.

The annual HIV Street Outreach Worker Conference (SOWC) was held in Austin in June 2008. The HIV Early Intervention Conference was held on October 24-25, 2007. As in the past, these conferences focused on updating all SAMHSA block grant funded DSHS HIV staff on HIV clinical information and to ensure consistency of related prevention, intervention, treatment and harm/risk reduction messages delivered to the target population throughout the state. In FY08 the Workers Assistance Program conducted 92 HIV related trainings throughout the state

Tobacco: The Texas Teen Summit and Comprehensive Tobacco Prevention Conference were held in July, 2008.

Behavioral Health Integrated Provider System (BHIPS): DSHS conducted 24 BHIPS trainings for a total of 265 participants trained.

Clinical Management for Behavioral Health Services (CMBHS): Work groups met continuously in preparation for a 2009 pilot and 2010 launch.

GOAL 11 – Continuing Education

FY 2010 (Progress): In FY 2010, DSHS continued to develop its training system by offering workshops and conferences that provide evidence-based practices and strategies for preventing and treating substance use/abuse and mental health problems. DSHS offered opportunities for substance abuse and mental health professionals to improve their skills and competencies and strengthen the integrated service delivery system through regional trainings and conferences that offer continuing education hours. Training was open to both mental health and substance abuse providers statewide when applicable.

DSHS Training and Technical Assistance Unit: FY 2010 the TTA unit was reorganized. TTA will now be provided through the division's program services section. Trainings under the program services section will be presented through the divisions' subject matter experts or by a contracted vendor. Trainings that were scheduled prior to the disbanding of the TTA unit continued through December 2009.

The TTA unit developed and implemented the second phase of the Motivational Interviewing training that was initiated in FY2008 and began Statewide Regional Training of Trainers (TOT) for Motivational Enhancement Therapies (MET). This training was based on Treatment Improvement Protocol 35: *Enhancing Motivation for Change in Substance Abuse Treatment* TIP 35. As a means of sustaining the fidelity of Motivational Interviewing, DSHS trained 25 clinicians to be state certified MET trainers allowing providers to have access to more regional and onsite trainers. Trainers were also created for the Cannabis Youth Treatment (CYT) manual. DSHS trained 18 youth treatment clinicians to be state certified CYT trainers; trainers will conduct two trainings per year in their regions.

Monthly conference calls with treatment providers (specialized female, adults and youth) started in FY 2009 and continued in FY 10. Through the treatment provider conference calls, information was disseminated to providers and stakeholders. Subject matter experts established working relationships with providers in order to maintain a standard of care, encourage collaboration to problem solve and to ensure a consistency in delivery of services.

The 53rd Texas Behavioral Health Institute*:* The Annual Institute was held in Austin July 19-23, 2010. The theme was "Roads to Recovery". There were approximately 1,150 attendees. The Institute offered prevention, treatment, and work force development sessions for alcohol and other drug abuse professionals, mental health professionals, and community volunteers.

Coordinated Training Services (CTS): In FY2010, CTS continued to provide statewide prevention training services including statewide prevention training and technical assistance services to all DSHS funded providers. CTS offered an array of prevention training which included evidence based curriculum training, 15 hours of Substance Abuse Prevention Specialist Certification domains, workforce development, alcohol tobacco and

other drug (ATOD) training, Strategic Prevention Framework (SPF) training, coalition training, tobacco prevention training, as well as training on communicable diseases.

The CTS contractor continued to work with DSHS to coordinate and provide technical support and meeting logistics to DSHS for the Annual Provider Meeting and the Annual Fall and Spring Prevention Resource Center (PRC) and Community Coalition Partnership (CCP) Meetings. CTS also provided technical assistance and support for the quarterly Texas Collaborative Prevention Committee webinars.

Prevention/Intervention: In 2010 the Human Immunodeficiency Virus (HIV) Statewide Training Systems contract focused its training efforts on enhancing the skills of intervention and prevention providers in the area of Motivational Interviewing (MI), Case Management and Outreach trainings. Case Management and Outreach 201 were two new curricula unveiled during this year. Four case management trainings and two Outreach 201 trainings were conducted.

The annual DSHS sponsored HIV Outreach conference (SOWC) took place on June, 2010 in Austin with 187 in attendance. This was lower than anticipated due to the fact that the biannual DSHS statewide HIV/STD conference in Austin was held in May 2010. This year's SOWC focused on skill building around HIV disease and how to encourage testing and behavior change with Injecting Drug User's (IDUs). The annual HIV Early Intervention (HEI) conference took place in September 2009 with a special track for HEI case managers focusing on building MI and case management skills. DSHS partnered with the HIV Training Services (HTS) contractor and the Coastal Bend AIDS Foundation in Corpus Christi to sponsor the conference.

Tobacco: the *Texas Teen Summit and Comprehensive Tobacco Prevention Conference* was held in July 2010 to provide tobacco prevention and control education to youth and adults who represented local law enforcement, local school districts and community-based organizations.

Behavioral Health Integrated System (BHIPS): Training was offered as needed; DSHS moved to transition to CMHBS.

Clinical Management for Behavioral Health Services (CMBHS): CMBHS trainings were rolled out regionally throughout 2010. During 2010, the CMBHS Training and Technical Assistance Team provided 55 CMBHS Training sessions for 602 participants.

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Goal #12: Coordinate Services

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

Note: In addressing this narrative the State may want to discuss activities or initiatives related to the provision of: *Convened work groups/task force/councils; Conduct training/TA; Partnering with association(s)/other agencies; Coordination of prevention and treatment activities; Convening routine meetings; Development of polices for coordination; Convening town hall meetings to raise public awareness; Implementation of evidence-based services.*

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

GOAL 12 – Coordinate Services

FY 2011 (Intended Use): DSHS will continue to require funded providers to coordinate prevention and treatment with other appropriate services. This will ensure a holistic approach and more effective services. Collaboration and coordination will be monitored through the electronic record system, desk reviews, and onsite compliance visits.

Through OSARs, DSHS continues to enhance coordination of services across the continuum of care. Key strategies in this effort include close collaboration with local prevention and treatment service providers, maintenance of a waiting list, contact with clients, and providing or facilitating interim services. Although each OSAR works primarily within a specific region, OSARS also establish arrangements with providers in other regions to promote timely access to limited services, particularly for priority populations.

The Drug Demand Reduction Advisory Committee will continue its efforts to coordinate prevention, treatment, and enforcement strategies to reduce drug demand reduction. In FY 2011, the DDRAC will focus on workforce development and training, data sharing, and communications/media strategies. The committee plans to expand the scope of the current DDRAC website. The DDRAC will also continue to plan and execute educational events, such as the successful FY2010 DDRAC Border Symposium.

Recovery management will be a key focus of efforts to develop a more comprehensive and flexible treatment system. The goal is to provide increased service options and broader availability of recovery support resources to more effectively address clients' needs at the time they present for services. DSHS also will explore ways to expand the continuum of substance abuse services to include screening and brief intervention, enhance continuity of care and client retention in treatment, and increase coordination among substance use, mental health, and physical health service systems. The Texas Recovery Initiative will continue with its objective to facilitate statewide implementation of recovery oriented systems of care (ROSC). ROSC includes early identification of substance abuse and dependence with appropriate intervention, expansion of evidence-based approaches to treatment, and a broad array of post-treatment or alternative to treatment support mechanisms, which have in common a focus on enhancing recovery capital to reduce recidivism and relapse. DSHS, in collaboration with subject matter experts, providers, and other stakeholders, is developing an agenda for said implementation. This process is ongoing with the purpose of continually expanding availability and access to recovery support services.

Several grant activities will continue to assist with addressing coordinated services in FY 2011.

- For 2011, DSHS has applied for a new round of ATR funding from the Substance Abuse and Mental Health Services Administration (SAMHSA). If approved, the new funding will continue to provide services to eligible clients in the current ATR II program counties, and an additional seven new counties. The new

funding also will focus on the provision of treatment and recovery support services to targeted counties along the Texas-Mexico border, and in the Rio Grande Valley area.

- DSHS has applied for a grant designed to enhance the recovery orientation of the current system of treatment for women with substance use disorders in Houston, Texas. The project is designed to improve long term recovery outcomes for women through the addition of recovery support services, and assignment of peer recovery coaches to work with clients prior to treatment, during treatment, and following discharge from treatment.
- Funding for school health specialists in each of the 11 Education Service Centers continued. These specialists provide education and training in local schools with the goal aimed of improving student health including their behavioral health.
- The federally funded Money Follows the Person Behavioral Health Pilot (MFP BH) services continued. These services include adult substance abuse treatment and Cognitive Adaptation Training (CAT), a rehabilitative service designed to help the individual establish daily routines, organize their environment, and build social skills.

In FY 2011, a primary initiative of DSHS will be the full implementation of the Clinical Management for Behavioral Health Services (CMBHS) system for substance abuse. The development of the mental health component of CMBHS also is targeted to begin in FY 2011. This electronic health record initiative will provide new opportunities for coordination between mental health and substance abuse prevention and treatment services, and between substance abuse treatment, substance abuse prevention, and other appropriate services. This will be accomplished through enhancements in functionality that will enable easier exchange of information across service systems and providers. The system is expected to facilitate improved access and outcomes, and to ensure uniform service delivery regardless of where clients enter the service system. Implementation will require extensive training and technical assistance, and DSHS will promote and require participation by all providers. DSHS will continue to try and secure a federal grant through Synectics so that progress on this system can continue.

Changing trends in admissions to treatment of persons with a substance abuse diagnoses, individual client outcomes, and program performance measures will be monitored. Monitoring for prevention services will include participant pre- and post-tests, fidelity to curriculum, and performance measures. Technical assistance will be offered as data is analyzed, and trainings on recovery-oriented service provision and evidence-based practices will be provided.

FY 2012-13 (Intended Use): DSHS will require funded providers to coordinate prevention and treatment with other appropriate services to ensure a holistic approach and more effective services. Collaboration and coordination will be monitored through the electronic record system, desk reviews, and onsite compliance visits for substance abuse and mental health.

DSHS continues to enhance coordination of services across the continuum of care. Key strategies in this effort include close collaboration with local health centers, local mental health and substance abuse treatment providers, and health risk information providers.

The Drug Demand Reduction Advisory (DDRAC) Committee will continue with its efforts to coordinate prevention, treatment, and enforcement strategies to reduce drug demand. The DDRAC will focus on workforce development and training, data sharing, and communications/media strategies. The committee continues to expand the scope of the current DDRAC website. The DDRAC also will plan and execute educational events, such as the successful FY 2010 DDRAC Border Symposium.

The Texas Recovery Initiative will continue with its objective to facilitate statewide implementation of Recovery Oriented Systems of Care (ROSC). ROSC includes early identification of substance abuse and dependence with appropriate intervention, expansion of evidence-based approaches to treatment, and a broad array of post-treatment or alternative to treatment support mechanisms. These have in common a focus on enhancing recovery capital to reduce recidivism and relapse.

GOAL 12 – Coordinate Services

FY 2008 (Compliance):

In FY 2008, DSHS's direct service prevention programs were delivered primarily in the schools using curricula identified as effective by the CSAP/NREP process. These prevention programs were required to coordinate with other community resources and treatment providers to facilitate referrals for family members identified as having a substance abuse or dependence problem.

Outreach, Screening, Assessment, and Referral (OSAR) providers were responsible for referrals and service coordination for treatment, prevention, and other community services through a variety of strategies. In addition to making referrals to prevention and early intervention programs, they managed admissions and lengths of stay in residential treatment. The OSARs maintained residential treatment waiting lists for all regions and referred clients to appropriate levels of care as soon as bed slots became available. The OSARs delivered or arranged for interim services for individuals on the wait list. As needed, they also linked individuals with services outside of the treatment or prevention continuum during the waiting period, or to augment treatment.

Treatment programs were required to establish formal agreements with available substance abuse and other mental health, health care, and social service providers to address the multi-dimensional needs of individual clients and to facilitate referrals for family members needing services. Treatment programs provided case management and referred clients to ancillary services to help clients meet treatment goals. They also conducted follow-up with clients leaving treatment or on waiting lists to ensure that the clients and referral sources successfully made contact, and that clients accessed needed services and supports.

The Drug Demand Reduction Advisory Committee (DDRAC) continued in SFY 08. The DDRAC is a state mandated committee that consists of 16 state agency participants and five at-large members from different geographical areas within the state. DDRAC conducted numerous initiatives to build on the legislatively-mandated statewide strategy to reduce drug demand in Texas. Member agencies reached a consensus on the mission, principles, philosophy, goals, and actions to meet the strategic objectives. This was a demonstration of the effectiveness of a multi-faceted statewide strategy.

Specialized treatment and intervention programs for persons at risk for HIV, and priority female populations received ancillary services that addressed their needs in coordination with substance use services. These typically included transportation, childcare, and parenting education for pregnant women; and rapid testing, screening, and motivational interviewing strategies for individuals at risk for HIV and/or TB.

Treatment and prevention services were coordinated with other services through several other grant activities.

- The Access to Recovery (ATR) grant used a voucher program to provide treatment and recovery support services for individuals referred through drug courts, child protective services, and local probation departments. Recovery

support services included individual recovery coaching, employment training and spiritual support. These were intended to contribute to successful treatment outcomes and sustainable recovery gains.

- The Co-Occurring State Incentive Grant (COSIG) provided incentives for completion of treatment and ensured coordination with other necessary services for individuals with co-occurring disorders. These services included child care, medical services, medications, consultations, education, and job training.
- The Screening, Brief Intervention, and Referral to Treatment Initiative (SBIRT) demonstrated a successful framework for integration and coordination of physical and behavioral healthcare services. Patients presenting for primary, inpatient, or emergency medical care were routinely screened for substance use problems by health care staff. Individuals identified as being at risk or impacted by substance use problems received brief intervention and/or treatment from a trained specialist, with referral to specialized substance abuse in the community as needed. This project was a collaborative effort involving the Harris County Hospital District, Houston Council on Alcohol and Drug Abuse, the Steven Sessions Group, the University of Texas Addiction Research Institute, University of Houston Health Sciences Center, and Baylor College of Medicine.
- In FY 2008, the Robert Wood Johnson Foundation continued its partnership with DSHS and treatment providers in Dallas to target young teens abusing heroin, called "Cheese." The partnership consisted of DSHS, Homeward Bound, Inc., NEXUS, Phoenix House, Dallas County Juvenile Probation, and Dr. Tirado with Southwestern Medical University. The AR Practice Improvement Enhancer (PIE) model and other process improvement considerations led to: 1) increased recognition of key analytics and resulting planning required to achieve whole systems changes and 2) continued awareness regarding the role that key leadership individuals play in the success of associated activities.
- A set amount of funds from the Substance Abuse Block Grant and Mental Health Block grant were combined with funds from the DSHS division of Prevention and Preparedness to fund school health specialists in each of the 11 Education Service Centers. These specialists provide education and training in local schools with the goal aimed of improving student health including their behavioral health.
- Money Follows the Person Behavioral Health Pilot (MFP BH) is a federally funded demonstration project in Bexar County that provides specialized behavioral health services to help individuals with severe mental illness and / or substance use disorders transition from nursing facilities and live in the community. These services include adult substance abuse treatment and Cognitive Adaptation Training (CAT), a rehabilitative service designed to help the individual establish daily routines, organize their environment, and build social skills. Services are provided up to six months before discharge and for one year post-discharge.
- The federal grant entitled the "Strategic Prevention Framework State Incentive Grant (SPF-SIG)" demonstrated a collaborative effort in the state to provide community planned evidence-based environmental prevention strategies in seven high-risk counties in Texas. DSHS was able to fund culturally appropriate substance abuse prevention community-based coalitions. Services included an in-

depth needs assessment regarding binge drinking and alcohol-related car crashes among 12-25 year olds, building capacity to address this need, and planning, implementing, and evaluating evidence-based programs, policies and practices designed to address the intervening variables related to binge drinking and alcohol-related car crashes among youth and young adults.

The continued development of BHIPS, facilitated service coordination and information exchange between treatment and prevention providers. This system served to identify the need for, and to facilitate referrals to, other appropriate services. BHIPS supports a more holistic approach to service delivery for individuals with substance use problems. A federal grant through Synectics was used to assist with upgrades on BHIPS which created data used for our quality management system.

GOAL 12 – Coordinate Services

***FY 2010 (Progress)**:* In FY 2010, DSHS continues to promote coordination of prevention, treatment, and other appropriate services through its policies and programs, grants and contracts, MOUs, BHIPS to CMBHS functionality, special initiatives, and ongoing communication and collaboration with service providers and other service systems and agencies.

Direct service prevention programs continue to coordinate with other community resources and treatment providers to facilitate referrals for participants and family members, while PRCs and Community Coalitions work on coordinating community efforts and resources to address substance use issues. The prevention programs continued to promote prevention activities and information focused on Mental Health and Substance abuse issues.

Through OSARs, DSHS continues to enhance coordination of services across the continuum of care. Key strategies in this effort included close collaboration with local prevention and treatment service providers, maintenance of a waiting list, contact with clients, and providing or facilitating interim services. Although each OSAR works primarily within a specific region, OSARS also establish arrangements with providers in other regions to promote timely access to limited services, particularly for priority populations. BHIPS/CMBHS supports effective coordination across levels of care, service providers, and service types by facilitating sharing and exchange of assessments and other client information. The OSARs continue to hold regional quarterly interagency meetings designed to improve access to recovery services.

Treatment programs remain responsible for identifying and coordinating resources needed to support each client's treatment and recovery needs through written agreements and other efforts. In preparation for the FY 2011 Treatment RFP, DSHS renewed its commitment to the Texas Recovery Initiative. The objective of the initiative is to facilitate statewide implementation of recovery oriented systems of care (ROSC). ROSC includes early identification of substance abuse and dependence with appropriate intervention, expansion of evidence-based approaches to treatment, and a broad array of post-treatment or alternative to treatment support mechanisms which have in common a focus on enhancing recovery capital to reduce recidivism and relapse. DSHS, in collaboration with subject matter experts, providers, and other stakeholders, is developing an agenda for said implementation. This process is ongoing with the purpose to continually expand availability and access to recovery support services.

A Local Recovery-Oriented Systems of Care (ROSC) pilot program was initiated in FY10, in the Houston area. A grant proposal was written to help fund this program. DSHS is still awaiting award notification. ROSC services include enhancing personal strengths, improving social functioning, building recovery self-management skills, and receiving continuing support during the recovery process.

Texas had been meeting with the Oxford House to develop plans to enter into a contract with Oxford House for the development of 6 residences in one of five metropolitan areas of the state. A revolving loan fund of $ 24,000 will be established to assist with initial housing expenses. This renewed emphasis on housing for persons coming out of treatment is consistent with our guiding principles and our interest in reducing homelessness. It also brings Texas in line with SAMHSA Strategic Initiative number 5 regarding housing assistance and homelessness.

The Drug Demand Reduction Advisory Committee (DDRAC) is a legislatively established committee with a mandate to develop a comprehensive statewide strategy and make legislative recommendations to reduce drug demand in Texas. The state directed 16 state agencies and five at-large members from different geographical areas within the state to participate in this effort. The DDRAC continues to conduct numerous initiatives to build on the legislative-mandated statewide strategy to reduce drug demand in Texas. In January 2009, the DDRAC issued its report to state leadership, making several legislative recommendations including: removal of the exclusion clause for medical expenses from the Uniform Individual Accident and Sickness Policy Provision Law (UPPL), passage of a statewide public smoking ban, and increasing funds for wage support adjustments to recruit and retain quality service professionals in the field of substance abuse prevention and treatment. The DDRAC also held a Border Symposium in August, with presentations by experts on border drug demand issues. The symposium focused on the current challenges, as well as ongoing and proposed efforts to reduce drug demand through prevention, treatment, and enforcement: http://www.dshs.state.tx.us/sa/ddrac/symposium.shtm/

The Rural Border Intervention (RBI) Projects (5) continue to be a link between prevention, intervention, and treatment services. Community Health Workers/*Promotores*, skilled volunteers, and contractor staff provide prevention, screening, and intervention services. These range from curriculum based prevention programs for youth, to motivational interviewing and behavior change interventions for people who are not able to access substance abuse treatment. These contractors engage residents in rural, frontier, and border areas of the Texas-Mexico border that are at higher risk for and have less access to substance use/abuse prevention, intervention, and treatment services. These programs work closely with the OSARS and all community providers to better leverage services to remote and disenfranchised communities on the Texas-Mexico Border.

In FY 2010, a variety of grant activities continued to provide opportunities for collaboration and coordination between DSHS and other service systems, including the criminal justice and the child protective services systems.

- The Robert Wood Johnson Foundation continued a partnership with DSHS and treatment providers in Dallas that targeted young teens abusing heroin, called "Cheese". The partnership consisted of DSHS, Homeward Bound, Inc., NEXUS, Phoenix House, Dallas County Juvenile Probation, and Dr. Tirado with Southwestern Medical University. This ended 6/2010.
- Access to Recovery (2) grant continued in FY 10.

- Funding for school health specialists in each of the 11 Education Service Centers continued. These specialists provide education and training in local schools with the goal aimed of improving student health including their behavioral health.
- The federally funded Money Follows the Person Behavioral Health Pilot (MFP BH) services continued. These services include adult substance abuse treatment and Cognitive Adaptation Training (CAT), a rehabilitative service designed to help the individual establish daily routines, organize their environment, and build social skills.
- The federal grant entitled the "Strategic Prevention Framework State Incentive Grant (SPF-SIG)" continued through the year but was slated to end September 30, 2010.
- DSHS was able to secure additional funding related to Hurricane Ike and Dolly. A Social Services Block Grant (SSBG) was awarded to Texas and it provided additional funds to one of the RBI programs in South Texas. Some of these funds were used to assist in the creation of two conferences on Border Violence and Disaster Prevention (the first of their kind in Texas and the US).

The Texas Family Recovery Initiative is establishing an integrated system of care for pregnant women, and women with dependent children who have substance problems. This is a new partnership between DSHS, judicial systems, and the mental health and substance abuse service systems. The program provides and coordinates mental health and substance abuse services with other gender-specific and support services, such as counseling for trauma and abuse issues, transportation, childcare, and prenatal care.

Because approximately half of the individuals experiencing a mental health crisis also have substance use issues, access to substance abuse services is an essential part of crisis redesign. The regional OSARs are partners in the local crisis response teams and provide referrals for substance abuse prevention and treatment services, including detoxification. To support implementation of the crisis redesign initiative, DSHS is providing training for crisis hotline staff and crisis mobile outreach teams, and has made arrangements for the transfer of crisis phones during non-office hours the LMHA's.

A new electronic health record for substance abuse and mental health, known as the Clinical Management for Behavioral Health Services (CMBHS) Initiative has been initiated for substance abuse providers. This online health record will promote improved coordination of mental health and substance abuse prevention, early intervention, and treatment services, as well as coordination with other appropriate services. A federal grant through Synectics was used to assist in the creation of CMBHS.

Goal #13: Assessment of Need

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

Note: In addressing this narrative the State may want to discuss activities or initiatives related to the provision of: *Data-based planning; Statewide surveys; Youth survey(s); Archival/social indicator data; Data work groups; Risk and protective factors Household survey data utilization; Prioritization of services; Provider surveys; Online surveys/Web-based reporting systems; Site visits.*

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

GOAL 13 – Assessment of Need

Goal 13- Assessment of Need

***FY 2011-2013 (Intended Use*):** In FFY 2011, FFY 2012, and FFY 2013, DSHS will continue to collect substance-related consumption and consequence indicators through various data sources, and will survey data produced in past years. The 2010 statewide Texas School Survey of Substance Use (TSS) among elementary and secondary students, used to assess youth prevention and treatment needs, will be completed and reported in 2011. The 2012 statewide TSS will continue to be conducted by DSHS Mental Health and Substance Abuse Division in 2012, and will be completed and reported in 2013. The prevalence estimates from the National Survey on Drug Use and Health for Texas, used to assess adult treatment needs, will be requested and obtained from the Substance Abuse and Mental Health Services Administration every year in 2011-2013.

The annual report of Substance Abuse Trends in Texas, received through an MOU with the University of Texas Gulf Coast Addiction Technology Transfer Center, will be updated and posted on the agency website in 2011-2013. This report includes drug trafficking, poison cases of drug abuse, and other related information.

Data collected since 2009 through the newly developed Clinical Management for Behavioral Health Services (CMBHS) system, will be used to perform treatment and prevention reviews, and to assess how well providers are meeting the needs in 2011-2013. The CMBHS will be deployed to prevention and intervention providers in the first quarter of FY2011. The CMBHS system will combine the electronic health recordkeeping requirements for both mental health and substance abuse treatment providers into a single system. In addition to the web-based system, DSHS will implement a data-exchange process to minimize the impact to mental health providers who have their own electronic health records. The timeframe to implement this functionality is estimated to be in excess of eighteen months. A transitional step, will be to provide mental health information that currently is reported to the Client Assignment and Registration System (CARE), directly into CMBHS. This will facilitate access to a single repository for behavioral health information for mental health and substance abuse treatment providers. This is an important step in shifting information exchange from CARE to CMBHS, and is targeted to be available by the end of 2010.

The state epidemiology profile, survey data, and other social indicators will be updated periodically in 2011-2013 to support each step of the strategic prevention framework and enable evidence-based prevention programming to better target particular populations in Texas. The community needs assessment will continue to be performed by prevention coalitions. In addition, the annual Texas Behavioral Risk Factors Surveillance System that is conducted by DSHS' Center for Health Statistics will be used to provide information of adult current smoking for the regions, and to assist state and local assessment efforts.

GOAL 13 – Assessment of Need

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FY 2008 (Compliance): In FFY2008, DSHS utilized several processes to assess the need for both treatment and prevention services in the state. DSHS collected substance-related consequence data such as treatment clients, arrests, overdose deaths, and motor vehicle fatalities on a county-by-county basis. These data, along with other information such as school and household survey data and demographic statistics, assisted with determination of need. Some survey and indicator data was posted on DSHS' website on a state and sub-state basis.

Both statewide and regional Texas School Survey of Substance Use (4-6 and 7-12 grades) were completed in 2008, with final reports published and made available online. The school survey provided information to help estimate the need for youth prevention and treatment services at the state and regional level. Prevalence rates determined by the 2004-2008 National Survey on Drug Use and Health for Texas were also applied to estimate the need for adult treatment services at the state and regional level in 2008. The need estimates from the surveys and other indicator data such as population and poverty were factored into the funding formula that guided funding allocation decisions and policy development.

The annual report of Substance Abuse Trends in Texas with drug trafficking, poison cases of drug abuse, and other data was also posted on the agency website and used to inform the needs assessment and drug trends. Client and provider data collected through the Behavioral Health Integrated Provider System (BHIPS) data base, which was used by all DSHS-funded providers, was used to assist in assessing the need for treatment services in the state. All functions of BHIPS were required to be used by December 2002, thus increasing the amount of total client data collected since then and the capability to conduct in-depth analyses of treatment processes and outcomes on a periodic basis. Outcome measures for effective, promising, or model prevention curricula had been developed and incorporated into BHIPS and reported by prevention providers since September 2004. A new electronic client health record system, the Clinical Management for Behavioral Health Services (CMBHS), was under development in 2008. CMBHS combines the electronic health recordkeeping requirements for mental health and substance abuse treatment providers in a single system.

The Texas Epidemiological Workgroup (TEW), established in November 2004, served as part of the state prevention framework funded through the State Prevention Framework State Incentive Grant (SPF SIG). TEW in 2008 continued to assist the state in its capacity to collect, analyze, and report substance-related consumption and consequence data to support data-driven decision-making in each step of the strategic prevention framework. TEW also provided necessary information and support to the community coalitions on their local needs assessment as well as input on changes in selected prevention indicators. The SPF-funded 2007-2008 Adult Survey of Substance Use and Risk Behaviors in Seven Major Counties in Texas had been conducted since 2007, and the survey data was collected and completed in 2008. This adult phone survey was designed to help assess community changes and needs, inform prevention efforts, and have an impact on future epidemiological study. In addition, a binge-drinking module was included in the 2008 Texas Behavioral Risk Factors Surveillance System, a federally funded telephone survey, to provide more adult binge drinking data for the regions and assist state and local assessment efforts.

GOAL 13 – Assessment of Need

FY 2010 (Progress): In FY 2010, substance-related consequence data along with other indicators continue to be updated and inform the needs assessment process. The school and household survey data continue to assist the agency with assessment of need and planning for prevention and treatment. The Texas School Survey of Substance Use conducted in a representative sample of elementary and secondary schools throughout the state has been administered and analyzed in 2010. Prevalence rates from the National Survey on Drug Use and Health for Texas continue to be applied for the state and sub-state adult needs estimates. Collaboration with the University of Texas Gulf Coast Addiction Technology Transfer Center continues to produce the annual report of Substance Abuse Trends in Texas through a MOU with DSHS, which includes drug trafficking, poison cases of drug abuse, and other related data.

The Clinical Management for Behavioral Health Services (CMBHS), a replacement to BHIPS, was rolled out across the state, by region, to substance abuse treatment service providers contracted with DSHS. By September 2010, the deployment to substance abuse treatment services regions was completed. CMBHS data are collected and reported at screening, admission, during treatment, discharge, and 60-days post-discharge. CMBHS data continues to be used to assist in assessing the need for treatment services in the state.

Prevention providers continue to report curriculum outcome measures through BHIPS to implement the evaluation plan in 2010. Survey data, social indicator data, as well as other related consumption and consequence statistics are collected and analyzed to continue to support data-driven decision-making in each step of the strategic prevention framework. The information is also provided to support the community coalitions on their local needs assessment as well as input on sustainability performance.

In addition, the state epidemiology profile with respect to substance abuse prevalence is performed and reported in the 2010 Texas Health Status Report to present the current status of smoking, alcohol use, and illicit drug use among Texans by demographic characteristic.

Goal #14: Hypodermic Needle Program

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

Note: In addressing this narrative the State may want to discuss activities or initiatives related to the provision of: *Prohibitions written into provider contracts; Compliance site visits; Peer reviews; Training/TA.*

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

GOAL 14 – Hypodermic Needle Program

FY 2011-13 (Intended Use): In FY 2011-13, while federal laws and regulations to support needle exchange programs have been lifted , the block grant requirements and the State of Texas still prohibit the activity and all funded programs will be expected to comply. DSHS will continue to conduct annual contract and program reviews in which the applicable regulations are monitored. Contracts with all providers will continue to include this prohibition.

GOAL 14 – Hypodermic Needle Program

FY 2008 (Compliance): In FY 2008, DSHS adhered to all federal regulations. The SAPT Grant Requirements were placed in the General Provisions - Section 19.07(f) of every contract, . The provisions stipulate that no funds may be used to provide needles or syringes to anyone. This requirement was monitored through annual contract budget reviews. No providers were found to be out of compliance with this regulation.

GOAL 14 – Hypodermic Needle Program

FY 2010 (Progress): In FY 2010, all DSHS providers continued to adhere to all federal regulations, including those prohibiting use of federal block grant funds for the purpose of providing individuals with needles or syringes to prevent communicable diseases. FY 2010 contracts include this restriction. Compliance with this regulation/requirement are monitored through contract budget reviews, which are conducted annually during each contract period. As of this date, no providers have been found to be out of compliance with this regulation since it was first monitored in 1994.

Goal #15: Independent Peer Review

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

Note: In addressing this narrative the State may want to discuss activities or initiatives related to the provision of: *Peer review process and/or protocols; Quality control/quality improvement activities; Review of treatment planning reviews; Review of assessment process; Review of admission process; Review of discharge process; achieving CARF/JCAHO/(etc) accreditation.*

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

GOAL 15 – Independent Peer Review

FY 2011-2013 (Intended Use): In FY 2011, an annual independent peer review process will be conducted as described in the compliance report. The review will be in accordance with the federal requirement to use an Independent Peer Review process to assess and improve the quality and appropriateness of treatment services delivered by funded providers. The Independent Peer Review Process for SFY 2011 will be initiated in the fall of FY 2011. Five reviewers will be selected with input from the 2010 reviewers and the Association of Substance Abuse Providers (ASAP). With input from the clinical specialist, reviewers will develop the process, questions, and criteria for review. In October, 2010, the reviewers will assess activities pertaining to 15 randomly selected clients who were treated during the previous year. This selection of clients will come from a randomly chosen 6% of treatment providers. This volume of providers exceeds the requirement to review 5% of the treatment providers.

Peer reviewers will continue to use the electronic data (CMBHS) record keeping system to review automated client records and determine the consistency, continuity, and the quality of care that the clients receive. The Division's clinical Coordinator and a designated member of the Substance Abuse Treatment Unit will continue to oversee the Peer Review Quality Improvement Process (PRQIP), and assist the peer reviewers in this effort. The peer reviewers will assess the process and the efficacy of the new electronic data system CMBHS, and recommend modifications to the clinical specialist, as needed.

The independent peer review process will be conducted through the web-based internet capability of the newly developed CMBHS. Peer reviewers will be given instructions, and oversight and technical assistance (TA) will be provided during the review process at the BHIPS training facility in Austin. At the end of the review process, the reviewers will summarize their findings and write a report. The report will be reviewed by the clinical specialist and an internal clinical policy group. Any appropriate recommendations for system improvements will be provided to the DSHS-MHSA staff for training and technical assistance purposes.

GOAL 15 – Independent Peer Review

FY 2008 (Compliance): In FY 2008, DSHS conducted an Independent Peer Review Process called the Peer Review Quality Improvement Process (PRQIP). The purpose of the PRQIP was to perform quality assessment through peer review of client records. The annual report, prepared by the Peer Review Team and submitted to DSHS, contained recommendations for system improvements.

A team composed of five reviewers was selected by the DSHS's clinical director, with input from the Association of Substance Abuse Providers (ASAP), past reviewers, and volunteers. The review team consisted of new members as well as some prior members. The reviewers met in Austin for three days on October 14, 15, and 16, 2009 to review SFY 2008 activities. The review team performed the following:

- Planned the focus of the reviews
- Designed the instruments for the assessment
- Ensured that the selection of providers to be reviewed was a representative and random sample
- Planned the BHIPS reviews
- Trained committee members
- Reviewed the selected records in BHIPS
- Summarized the overall findings
- Developed and submitted a report to the clinical director of the DSHS's Program Implementation Section to inform system changes, if indicated.

The MHSA clinical director, representing the single state authority for substance abuse, provided guidance to the review team. The independent peer review process was conducted using the web-based internet capability of BHIPS. The review team convened in October to review treatment records of 15 clients from 6% of treatment providers' FY 2008 activities. The clinical director and a staff member from the Program Implementation Unit provided technical assistance to the PRQIP review team.

The PRQIP reviewers compiled and analyzed the data and developed and submitted a report to the clinical director. The report included system issues and recommendations.

GOAL 15 – Independent Peer Review

FY 2010 (Progress): In FY 2010, the independent peer review process (PRQIP) was conducted October 26-27 of 2010 to assess and improve the quality and appropriateness of treatment services. The review process was for activities performed by funded providers in SFY 2009. Records for the previous fiscal year were not closed out until September 30, 2010 which is why the review is conducted in October falling into the next State Fiscal Year.

For this process, reviewers selected the criteria, developed the instrument, and reviewed data in the electronic data systems (BHIPS and CMBHS). The data from the independent peer review process was collected and analyzed. By contract, funded providers are required to participate in the PRQIP, if selected and also are required to utilize the electronic data system. The peer reviewers used this system to review client records and conduct the peer review process. Programs/providers reviewed were randomly selected and notified. The sample collected represented 6% of the treatment providers.

Five reviewers made up the Independent Peer Review Panel. To ensure continuity from the previous year's processes, four members of the committee were maintained from the prior year. The previous year's panel also recruited and selected the fifth member of the panel. The substance abuse clinical coordinator, with assistance from a substance abuse program specialist staff member, facilitated the process during the October review in Austin. The random sampling process and selection of providers was completed by the DSHS Decision Support Unit in the Mental Health and Substance Abuse Division.

The reviewers met and developed a process to review documentation of records for continuity of care including the screening of the client to the discharge summary. The independent peer review was conducted through the web-based internet capability of an electronic data system. The reviewers analyzed the data and completed a report that was provided to the clinical director for review and then presented to the Substance Abuse Policy Committee for review and recommendations. The recommendations were used to design and provide technical assistance to providers concerning documentation in the medical records electronic system and to provide information for the newly developing electronic medical records system. (CMBHS).

Independent Peer Review (formerly Attachment H)

(See 45 C.F.R. §96.122(f)(3)(v))

In **up to three pages** provide a description of the State's procedures and activities undertaken to comply with the requirement to conduct independent peer review during FY 2009 (See 42 U.S.C. §300x-53(a)(1) and 45 C.F.R. §96.136).

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

• the role of the Single State Agency (SSA) for substance abuse prevention activities and treatment services in the development of operational procedures implementing independent peer review;

• the role of the State Medical Director for Substance Abuse Services in the development of such procedures;

• the role of the independent peer reviewers; and

• the role of the entity(ies) reviewed.

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

• the number of entities reviewed during the applicable fiscal year ;

• technical assistance made available to the entity(ies) reviewed; and

• technical assistance made available to the reviewers, if applicable.

Independent Peer Review

As the Single State Authority for substance abuse prevention and treatment services, the DSHS MHSA Division continued to monitor, refine, and implement the policies and procedures under which the PRQIP is performed.

I. PROCEDURES INCLUDING ROLES AND RESPONSIBILITIES

The DSHS- Mental Health and Substance Abuse Division serves as the Single State Authority for substance abuse prevention and treatment services.

A. **Clinical Coordinator -** oversaw the design, implementation, evaluation, and monitoring of the PRQIP process. The clinical coordinator performed the following functions:

- Facilitated and approved the on-going refinement of policies and procedures for independent peer review process;
- Acted as the project consultant on clinical matters related to peer record reviews; and
- Attended PRQIP reviewer meetings and provided training/TA on treatment issues relevant to record reviews by peers.

B. **Program Services Staff -** developed parameters and procedures for the peer review process including assisting with sampling plan for selection of programs being reviewed, development of review instrument, and provision of technical assistance to peer reviewers. Program Services staff performs the following functions:

- Coordinated recruitment, selection and training of peer reviewers;
- Assisted with development of sampling plan, review instrument and training materials;
- Mobilized and coordinated the flow of resources between review committee and the field;
- Provided ongoing technical assistance to peer reviewers and programs being reviewed; and
- Responded to conflict of interest or confidentiality issues and maintained documentation.

C. **Decision Support/Unit** – developed and implemented a sampling plan for selection of providers for review and notified providers that they had been selected to be reviewed under the PQIP.

Decision Support staff developed a plan for selecting treatment programs for review (the sampling plan) based on a random selection of between four percent and six percent of treatment programs, and Decision Support staff also

maintained documentation of methodology for selecting the programs. The data from the review also aided in the overall training processes.

D. PRQIP Peer Reviewers – reviewed selected providers and records, developed a Report, and made system recommendations to the clinical director. Peer reviewers also decided on the parameters and items reviewed in the records to determine quality.

The selected PRQIP peer reviewers have expertise in the field of alcohol and drug abuse treatment. Members of the committee were knowledgeable about the modality being reviewed and the underlying theoretical approach to addictions treatment. They were also sensitive to the cultural and environmental issues that may have influenced the quality of the services provided. Technical assistance was provided to the reviewers by the Program Implementation Unit and the clinical director.

E. Provider Entities Reviewed – treatment programs selected were informed by mail that they would be part of the peer review process. No additional provider preparation was required since reviews were conducted through BHIPS.

II. ACTIVITIES

A. Planning

During the planning stage, the clinical director, DSHS staff, and peer reviewers developed the review plan. The PRQIP study focused on the consistency processes for screening, conducting assessments, and developing treatment plans. The peer reviewers utilized BHIPS to review client records, representing a change from the previous procedure of on-site visits to providers. BHIPS is a web-based clinical, administrative, and fiscal data collection and billing system. All funded providers were required to utilize BHIPS. Programs to be reviewed were selected by the Decision Support staff using a random sampling methodology, and were notified by mail.

DSHS also developed new policy and procedures for PRQIP that indicated that the reviews would be looking at screening, assessment, and treatment plans of the randomly-selected programs.

B. Program Reviews

Seven (six percent of total) treatment programs were selected for review. Ten client records were selected at random from each of the treatment programs. Treatment record reviews were performed to determine the consistency of the process of conducting screenings, performing assessments, and developing treatment plans. A set of 10 questions that cross-checked data elements in the

screening, assessment, and treatment plans was utilized by each reviewer. In addition, the records were checked to determine whether the clinical record as a whole justified the type and intensity of services delivered.

C. Consensus Meeting

DSHS staff and the reviewers met and analyzed the information collected. Trends and issues related to quality, effectiveness, and appropriateness of treatment services purchased through the block grant were identified. The peer reviewers evaluated the records (screening, assessment, and treatment plans) as the means to assess the quality of the services, based on their experience as treatment providers.

DSHS and the peer reviewers utilized the information from the PRQIP to aid in the technical assistance training offered to providers, and the introduction of a review process for admissions to residential treatment.

Goal #16: Disclosure of Patient Records

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

Note: In addressing this narrative the State may want to discuss activities or initiatives related to the provision of: *Confidentiality training/TA; Compliance visits/inspections; Licensure requirements/reviews; Corrective action plans; Peer reviews.*

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

Texas / SAPT FY2011 /

FY 2011-FY 2013 (Intended Use/Plan): All contracted prevention, intervention, and treatment providers will be required by state administrative rules and performance contracts to protect client/participant records and client/participant-identifying information from unauthorized disclosure in accordance with 42 U.S.C. §300x-53(b), 45 C.F.R.§96.132(e), and 42 C.F.R. Part 2, and Health Insurance Portability and Accountability Act (HIPAA). DSHS staff will continue to monitor contractors' maintenance of client record confidentiality through desk reviews, onsite reviews, or complaint investigations. Remedies may include technical assistance, plans for improvement, corrective action plans, or increased monitoring. Confidentiality also will be monitored during annual peer reviews. FY 2011 will be the first full year that all SA contractors use the Clinical Management for Behavioral Health System (CMBHS), which is the new electronic clinical management system. Quality management and program services will monitor contractor compliance with the new system, which will include monitoring use of the confidentiality requirements. CMBHS data analysis results in 2012 and 2013 will provide useful information to the DSHS' program services and quality management staff to determine which contractors will need additional support. Support may include technical assistance, additional monitoring, quality management reviews, and remedies for non-compliance.

Texas / SAPT FY2011 /

FY 2008 (Annual Report/Compliance): In FY 2008, all contracted prevention, intervention, and treatment providers were required by rule and performance contract to protect client/participant paper and electronic records and client/participant-identifying information from unauthorized disclosure in accordance with 42 C.F.R., Part 2, and Health Insurance Portability and Accountability Act (HIPAA). Contracts required treatment and intervention contractors to maintain treatment and intervention client information in Behavioral Health Integrated Provider System (BHIPS), the electronic clinical management system owned and managed by DSHS. DSHS ensured BHIPS was compliant with HIPAA security and privacy requirements. Record retention requirements remained with the contractor, not DSHS.
Intervention contractors' documentation of services in BHIPS did not generate claims. Treatment contractors' documentation of client services in BHIPS resulted in HIPAA-compliant claims. BHIPS business rules prohibited release of patient record information without appropriate consent documented in the system. Prevention contractors entered performance measures with no client identifiable information.

The DSHS MHSA Quality Management and Program Compliance Unit provided oversight of client identifying information when performing onsite or desk reviews of contractors. The review tools included rule and contract references to assess compliance with disclosure and retention of client record information. All treatment and client record reviews assessed compliance with the state and federal requirements.

Contract language and Texas Administrative Code required contractors to have appropriate policies and procedures for disclosure and retention of patient record information. Provider compliance with these regulations was monitored through quality

FY 2010 (Progress): DSHS replaced BHIPS with a new electronic clinical management system, CMBHS. DSHS implemented CMBHS for contractors incrementally throughout the year; one or two regions of contractors at a time beginning in January and ending inSeptember. CMBHS contains all of the required HIPAA security measures for electronic clinical management systems. DSHS contracted treatment and intervention service providers are required to document the client activities in the DSHS owned and managed electronic clinical management system. Prevention contractors enter performance measures with no client identifiable information.

CMBHS has a function that allows for importing documents into the client's record so all the wet signature documents can be maintained with the client's electronic file. This feature will be released in September 2010. Client documents requiring wet signatures must be maintained at the contractors' facility. The contractor is required to follow all state and federal client record retention and client confidentiality requirements.

The contractors continue to demonstrate compliance with the state and federal rules regarding client confidentiality of records. There are no incidents of confidentiality violations or problems with record retention discovered during FY 2010 reviews conducted by the DSHS Quality Management and Compliance Unit.

Goal #17: Charitable Choice

An agreement to ensure that the State has in effect a system to comply with services provided by non-governmental organizations (See 42 U.S.C. §300x-65 and 42 C.F.R. part 54 (See 42 C.F.R. §54.8(b) and §54.8(c)(4), Charitable Choice Provisions; Final Rule (68 FR 189, pp. 56430-56449, September 30, 2003).

Note: In addressing this narrative *please specify if this provision was not applicable because State did not fund religious providers. If* the State did fund religious providers, it may want to discuss activities or initiatives related to the provision of: *Training/TA on regulations; Regulation reviews; Referral system/process; Task force/work groups; Provider surveys; Request for proposals; Administered vouchers to ensure patient choice.*

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

FY 2011-13 (Intended Use):Although the state does not intend to fund any programs utilizing or recognized as Charitable Choice with block grant funds, in FY 2011-13, the state plans to continue to include Charitable Choice requirements in the performance contracts for all block grant recipients. DSHS will continue to have complaint processes in place for all participants and clients receiving services.

The contract provisions require faith-based providers to inform clients of their choice options for treatment and offer alternatives prior to admission. These requirements are described further as follows:

A faith-based provider must ensure that recipients are advised of the following:

- Provider's religious character
- Recipient's freedom not to engage in religious activities, and
- Recipient's right to receive services from an alternate provider.

Alternatives: If the client objects to the religious nature of the program, the provider must be prepared to offer an accessible, high-quality alternative service with another provider in the same location. The faith-based provider must have made advance arrangements with the alternate provider, which includes access and transportation to the nearby provider.

FY 2008 (Compliance): The state did not fund any programs utilizing or recognized as Charitable Choice with block grant funds. However, in FY 2008, the state had a system in effect to comply with Charitable Choice regulations. The following provision, applicable to all block grant funded contractors, was included in the general provisions of the DSHS FY 08 Substance Abuse Services Performance Contracts.
Section 15.01. Charitable Choice. As applicable, Contractor will comply with 42 U.S.C. 300x-65 and 42 C.F.R. part 54 (42 C.F.R. 54.8(c)(4) and 54.8(b), Charitable Choice Provisions and Regulations. The Contractor will use the model notice provided in the regulations.
This contract provision required faith-based providers to inform clients of their choice options for treatment and offer alternatives prior to admission. These requirements were described further as follows:
A faith-based provider must ensure that recipients are advised of the following:

- Provider's religious character
- Recipient's freedom not to engage in religious activities, and
- Recipient's right to receive services from an alternate provider.

Alternatives: If the client objects to the religious nature of the program, the provider must be prepared to offer an accessible, high-quality alternative service with another provider in the same location. The faith-based provider must have made advance arrangements with the alternate provider, which includes access and transportation to the nearby provider.

FY 2010 (Progress): The state is not currently funding any programs utilizing or recognized as Charitable Choice with federal block grant funds. However,in FY 2010, the state currently has a system in effect to comply with Charitable Choice regulations. The following provision, applicable to all block grant funded contractors, is in the general provisions of the DSHS FY 2010 Substance Abuse Services Performance Contracts.
Section 19.05 Charitable Choice (Faith-Based Organizations). As applicable, Contractor shall comply with 42 USC § 300x-65 and 42 CFR part 54 (42 CFR §§ 54.8(c) (4) and 54.8(b), Charitable Choice provisions and regulations. If Contractor identifies itself as a faith-based or religious organization, Contractor shall post a notice to advise all clients and potential clients (collectively, “clients”) that if the client objects to the religious character of the Contractor’s organization, the client has the right to be referred to another DSHS-funded contractor that is not faith-based or that has a different religious orientation. Within a reasonable period of time after a client’s request for referral, Contractor shall make the referral to another DSHS-funded contractor, and shall ensure that the client receives the alternative services within a reasonable period of time. Contractor shall further ensure that the alternative DSHS-funded contractor is accessible to the client and has the capability to provide appropriate services, and that the services are of a value not less than the value of the services the client would have received from the Contractor. The Contractor shall use the model notice provided in Appendix A of 42 CFR Part 54.

There have been no complaints pertaining to this issue lodged.

Charitable Choice (formerly Attachment I)

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

The purpose of Charitable Choice is to document how your State is complying with these provisions.

For the fiscal year prior (FY 2010) to the fiscal year for which the State is applying for funds check the appropriate box(es) that describe the State's procedures and activities undertaken to comply with the provisions.

Notice to Program Beneficiaries -Check all that Apply

- ☑ Used model notice provided in final regulations
- ☐ Used notice developed by State (Please attach a copy in Appendix A)
- ☐ State has disseminated notice to religious organizations that are providers
- ☑ State requires these religious organizations to give notice to all potential beneficiaries

Referrals to Alternative Services -Check all that Apply

- ☐ State has developed specific referral system for this requirement
- ☑ State has incorporated this requirement into existing referral system(s)
- ☐ SAMHSA's Treatment Facility Locator is used to help identify providers
- ☐ Other networks and information systems are used to help identify providers
- ☐ State maintains record of referrals made by religious organizations that are providers
- ☑ 0 Enter total number of referrals necessitated by religious objection to other substance abuse providers ("alternative providers"), as 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.

Charitable Choice provisions are incorporated in DSHS rules, requests for proposals, open enrollment applications and performance contracts for all recipients of block grant funds. Texas Administrative Code and contractual client rights protocols require all contractors to notify participants and clients about grievance and complaint procedures that include filing complaints with DSHS against the contractor. The DSHS website included links to the charitable choice rules, client rights rules, and complaint processes. In FY 2008, following two years of no requests for training and no complaints, the Quality Management and Program Compliance Unit decided to use the complaint protocols to address any client complaints about charitable choice. There were no complaints made in FY 2009 or FY 2010. In FY 2009 DSHS presented a Request for Proposals (RFP), Substance Abuse, Outreach, Screening, Assessment and Referral Services and Treatment Services, RFP#: SA-OSR.TRT-0371.1 to stakeholders throughout Texas. The RFP contained charitable choice requirements for all applicants that would receive the contractual award. No stakeholders had any questions about the Charitable Choice requirements for contractors. DSHS provides training to new contractors on all aspects of the contract. Technical assistance is provided upon request.

Waivers (formerly Attachment J)

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

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

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

Waivers

Waivers

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

This narrative response not included because it does not exist or has not yet been submitted.

Form 8 (formerly Form 4)

SUBSTANCE ABUSE STATE AGENCY SPENDING REPORT

Dates of State Expenditure Period: From: 9/1/2007 To: 8/31/2008

	Source of Funds					
Activity	**A.SAPT Block Grant FY 2008 Award (Spent)**	**B.Medicaid (Federal, State and Local)**	**C.Other Federal Funds (e.g., Medicare, other public welfare)**	**D.State Funds**	**E.Local Funds (excluding local Medicaid)**	**F.Other**
Substance Abuse Prevention* and Treatment	$ 90,456,885	$ 1,216	$ 10,289,591	$ 16,233,219	$ 0	$ 424,120
Primary Prevention	$ 34,589,118		$ 2,462,958	$ 5,303,580	$ 0	$ 0
Tuberculosis Services	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0
HIV Early Intervention Services	$ 6,775,919	$ 0	$ 0	$ 1,176,945	$ 0	$ 0
Administration: Excluding Program/Provider	$ 3,696,459		$ 393,582	$ 1,750,678	$ 0	$ 15,322
Column Total	**$135,518,381**	**$1,216**	**$13,146,131**	**$24,464,422**	**$0**	**$439,442**

***Prevention other than Primary Prevention**

Form 8ab (formerly Form 4ab)

Form 8a. Primary Prevention Expenditures Checklist

Activity	SAPT Block Grant FY 2008	Other Federal	State Funds	Local Funds	Other
Information Dissemination	$ 0	$ 0	$ 0	$ 0	$ 0
Education	$ 0	$ 0	$ 0	$ 0	$ 0
Alternatives	$ 0	$ 0	$ 0	$ 0	$ 0
Problem Identification & Referral	$ 0	$ 0	$ 0	$ 0	$ 0
Community Based Process	$ 0	$ 0	$ 0	$ 0	$ 0
Environmental	$ 0	$ 0	$ 0	$ 0	$ 0
Other	$ 0	$ 0	$ 0	$ 0	$ 0
Section 1926 - Tobacco	$ 0	$ 0	$ 203,219	$ 0	$ 0
Column Total	**$0**	**$0**	**$203,219**	**$0**	**$0**

Form 8b. Primary Prevention Expenditures Checklist

Activity	SAPT Block Grant FY 2008	Other Federal	State Funds	Local Funds	Other
Universal Direct	$ 11,558,597	$ 0	$ 1,596,654	$ 0	$ 0
Universal Indirect	$ 4,886,627	$ 2,462,958	$ 715,325	$ 0	$ 0
Selective	$ 8,347,201	$ 0	$ 1,235,775	$ 0	$ 0
Indicated	$ 9,796,693	$ 0	$ 1,552,607	$ 0	$ 0
Column Total	**$34,589,118**	**$2,462,958**	**$5,100,361**	**$0**	**$0**

Form 8c (formerly Form 4c)

Resource Development Expenditure Checklist

Did your State fund resource development activities from the FY 2008 SAPT Block Grant?
◉ Yes ○ No

Expenditures on Resource Development Activities are:
○ Actual ◉ Estimated

Activity	Column 1 Treatment	Column 2 Prevention	Column 3 Additional Combined	Total
Planning, Coordination and Needs Assessment	$ 0	$ 0	$ 0	$ 0
Quality Assurance	$ 2,078,418	$ 739,366	$ 0	$ 2,817,784
Training (post-employment)	$ 326,287	$ 116,072	$ 0	$ 442,359
Education (pre-employment)	$ 0	$ 0	$ 0	$ 0
Program Development	$ 1,073,096	$ 381,738	$ 0	$ 1,454,834
Research and Evaluation	$ 0	$ 0	$ 0	$ 0
Information Systems	$ 781,239	$ 277,914	$ 0	$ 1,059,153
Column Total	**$4,259,040**	**$1,515,090**	**$0**	**$5,774,130**

Form 9 (formerly Form 6)

SUBSTANCE ABUSE ENTITY INVENTORY

				FISCAL YEAR 2008			
1. Entity Number	**2. I-SATS ID** [X] if no I-SATS ID	**3. Area Served**	**4. State Funds** (Spent during State expenditure period)	**5. SAPT Block Grant Funds for Substance Abuse Prevention and Treatment Services(other than primary prevention)**	**5a. SAPT Block Grant Funds for Services for Pregnant Women and Women with Dependent Children**	**6. SAPT Block Grant Funds for Primary Prevention**	**7. SAPT Block Grant Funds for Early Intervention Services for HIV** (if applicable)
2	TX903074	Central	$73,070			$247,946	
2	TX903074	Statewide (optional)	$201,639	$0	$0	$659,550	$443,312
4	TX110506	High Plains	$92,324	$401,049	$37,656	$0	$175,791
5	TX301808	Central	$141,832	$1,894,811	$954,815	$0	$0
6	TX902811	Northwest Texas	$195,181	$1,536,536	$589,245	$249,461	$0
6	TX902811	Upper South Texas	$62,782	$198,251	$0	$0	$0
9	TX909675	Metroplex	$741,347	$3,432,112	$955,019	$0	$845,130
10	TX902647	Metroplex	$30,609	$744,357	$601,928	$0	$0
12	TX902563	Upper East Texas	$345,756	$2,781,090	$887,858	$0	$0
17	TX102867	Central	$159,595	$1,859,507	$1,037,590	$0	$0
18	TX100028	Central	$357,120	$1,025,709	$11,519	$0	$576,928
25	TX905012	Gulf Coast	$242,135	$38,387	$0	$0	$1,000,272
26	TX908602	High Plains	$62,911	$366,249	$0	$124,681	$0
33	TX100374	Upper South Texas	$157,272	$1,052,107	$0	$0	$204,693
39	TX302954	High Plains	$134,902	$513,278	$14,227	$0	$112,429

43	X	Metroplex	$57,203	$0	$0	$615,328	$0
44	TX750616	Metroplex	$350,203	$378,694	$0	$693,331	$0
47	TX111504	Northwest Texas	$27,409	$37,154	$36,276	$207,116	$0
47	TX111504	Metroplex	$143,452	$685,879	$300,988	$561,852	$0
48	TX120281	Metroplex	$244,415	$0	$0	$457,716	$755,192
53	X	Upper East Texas	$0	$8,970	$0	$0	$0
56	TX752075	Upper East Texas	$342,515	$275,460	$0	$717,247	$0
59	TX121636	Upper Rio Grande	$25,649	$12,739	$0	$226,723	$0
65	TX302962	West Texas	$130,839	$1,180,393	$244,473	$85,761	$0
68	TX904007	West Texas	$56,526	$358,607	$221,897	$114,411	$0
70	X	Central	$126,151	$164,201	$0	$313,831	$0
77	TX901821	Central	$37,277	$0	$0	$283,319	$0
83	X	Central	$13,089	$0	$0	$130,567	$0
90	TX303044	Central	$14,329	$60,738	$0	$0	$0
95	TX104574	Southeast Texas	$968,967	$4,746,088	$1,008,965	$1,301,892	$198,856
99	TX906200	Gulf Coast	$504,959	$1,280,543	$758,047	$1,288,823	$0
106	TX903421	Gulf Coast	$433,395	$317,344	$0	$1,469,250	$0
117	X	Upper South Texas	$97,402	$0	$0	$915,873	$0
131	TX908685	Metroplex	$40,911	$0	$0	$318,566	$0
133	TX902431	Central	$110,066	$297,251	$49,875	$250,211	$0
213	TX904999	Gulf Coast	$113,209	$441,350	$0	$0	$0
215	TX751242	Upper South Texas	$148,594	$727,558	$0	$0	$0
216	TX751259	Upper South Texas	$30,778	$1,104,977	$950,813	$0	$0
217	TX750350	Lower South Texas	$292,400	$1,753,621	$393,000	$0	$0
221	TX905103	High Plains	$15,590	$237,016	$144,691	$0	$0
		Upper	$0	$306,901	$306,901	$0	$0

222	TX902928	South Texas					
222	TX902928	Metroplex	$129,245	$893,922	$549,813	$283,575	$0
222	TX902928	Gulf Coast	$85,085	$1,224,860	$981,191	$202,049	$0
228	X	Northwest Texas	$198,302	$234,030	$0	$413,723	$0
231	TX752265	Lower South Texas	$308,776	$734,919	$206,986	$751,645	$0
242	TX904775	Gulf Coast	$160,475	$281,169	$0	$693,653	$0
255	TX303937	Upper East Texas	$13,889	$0	$0	$192,306	$0
256	TX303929	Central	$88,213	$63,553	$0	$555,081	$0
260	TX103105	Central	$81,649	$384,379	$192,324	$446,724	$0
261	TX109169	Lower South Texas	$128,764	$817,192	$433,429	$745,801	$108,113
340	TX300016	Upper Rio Grande	$371,426	$3,384,103	$1,776,981	$935,951	$181,225
342	TX303093	Lower South Texas	$123,526	$651,975	$230,139	$102,287	$0
342	TX303093	Upper South Texas	$103,978	$526,424	$0	$0	$0
342	TX303093	Metroplex	$0	$42,150	$0	$0	$0
342	TX303093	Gulf Coast	$295,470	$640,583	$0	$246,094	$443,999
344	TX903322	Gulf Coast	$261,437	$0	$0	$870,127	$0
345	TX100622	Lower South Texas	$171,302	$704,444	$0	$447	$0
354	TX303366	Upper South Texas	$324,108	$2,615,644	$991,516	$0	$171,842
358	TX303051	Gulf Coast	$69,387	$471,739	$0	$0	$0
359	TX303101	Metroplex	$77,220	$0	$0	$390,875	$0
373	TX750343	Gulf Coast	$0	$0	$0	$14,264	$0
484	TX100671	Gulf Coast	$308,126	$1,737,643	$304,527	$86,177	$219,447
493	TX100614	Gulf	$473,796	$3,381,199	$743,664	$0	$0

495	TX100014	Coast					
543	TX900997	Gulf Coast	$80,966	$0	$0	$897,648	$0
593	TX101471	Lower South Texas	$30,470	$217,684	$112,839	$0	$0
696	TX112676	Upper South Texas	$73,440	$118,998	$0	$165,848	$0
858	TX302947	Metroplex	$135,866	$626,328	$0	$0	$0
881	X	Metroplex	$52,809	$0	$0	$680,744	$0
901	TX104608	Upper Rio Grande	$59,852	$0	$0	$240,472	$0
1030	TX906408	Lower South Texas	$57,955	$0	$0	$379,587	$0
1077	X	Lower South Texas	$16,308	$0	$0	$150,492	$0
1193	X	Upper Rio Grande	$0	$0	$0	$183,014	$0
1193	X	Statewide (optional)	$0	$232,375	$0	$0	$0
1316	X	Upper South Texas	$32,927	$0	$0	$337,998	$0
1341	TX103378	Statewide (optional)	$68,247	$409,330	$0	$0	$0
1341	TX103378	Upper Rio Grande	$57,093	$338,229	$0	$0	$0
1341	TX103378	Metroplex	$102,083	$667,600	$0	$0	$0
1371	X	High Plains	$0	$9,640	$0	$0	$0
1567	TX104582	Metroplex	$34,981	$0	$0	$313,115	$0
1576	TX101257	Gulf Coast	$81,256	$522,781	$0	$0	$0
1579	TX104285	Metroplex	$17,781	$132,485	$0	$0	$0
1636	TX112692	Northwest Texas	$18,425	$63,576	$0	$48,219	$0
1769	X	Gulf Coast	$0	$13,940	$0	$0	$0
1775	X	Northwest Texas	$0	$9,552	$0	$0	$0
1810	X	Upper South Texas	$48,023	$0	$0	$575,697	$0
1842	X	Metroplex	$26,175	$0	$0	$240,419	$0

2508	X	Statewide (optional)	$203,219	$0	$0	$0	$0
2576	X	Statewide (optional)	$49,450	$116,492	$0	$0	$0
2624	X	West Texas	$96,161	$162,199	$0	$152,202	$0
2645	TX101661	Statewide (optional)	$672,936	$0	$0	$0	$0
2686	TX109136	Gulf Coast	$91,013	$0	$0	$760,924	$71,152
2698	X	Metroplex	$0	$407,262	$407,261	$0	$0
2726	X	Upper East Texas	$44,554	$0	$0	$163,677	$0
2791	X	Metroplex	$0	$12,981	$0	$0	$0
2835	X	Metroplex	$0	$10,998	$0	$0	$0
2836	X	Lower South Texas	$0	$12,500	$0	$0	$0
2866	X	Metroplex	$31,912	$0	$0	$219,793	$0
2974	X	Metroplex	$122,957	$0	$0	$607,563	$0
2978	TX118228	Upper South Texas	$283,152	$395,711	$0	$836,529	$0
2981	TX109862	Upper South Texas	$45,572	$57,824	$0	$115,096	$0
2987	TX000507	Upper South Texas	$17,264	$82,340	$0	$0	$0
3040	X	Metroplex	$35,225	$0	$0	$581,527	$0
3178	TX109177	Lower South Texas	$176,714	$897,327	$102,391	$544,246	$0
3184	X	Upper South Texas	$13,151	$0	$0	$73,232	$0
3207	TX112007	Lower South Texas	$356,562	$642,916	$38,189	$505,286	$0
3268	TX109060	Metroplex	$69,240	$410,850	$0	$0	$0
3285	TX106736	Gulf Coast	$92,924	$4,161,829	$3,760,988	$17,506	$0
3315	TX101846	Gulf Coast	$106,574	$591,431	$0	$0	$0
3352	TX105407	Metroplex	$122,797	$608,433	$0	$0	$0
3352	TX105407	Gulf	$46,172	$258,780	$0	$0	$0

3352	TX105407	Coast					
3387	TX104897	Metroplex	$64,310	$0	$0	$88,928	$428,151
3397	X	Lower South Texas	$32,879	$0	$0	$50,737	$255,130
3455	X	Lower South Texas	$14,747	$0	$0	$121,111	$0
3496	TX110241	High Plains	$379,822	$2,123,855	$749,313	$1,111,722	$87,151
3512	X	High Plains	$4,269	$0	$0	$40,094	$0
3544	X	Upper South Texas	$72,303	$69,061	$0	$23,668	$0
3577	TX110043	Central	$61,452	$357,349	$0	$0	$0
3605	TX112189	Upper East Texas	$77,239	$238,074	$0	$0	$181,267
3660	X	Metroplex	$13,689	$0	$0	$45,565	$0
3663	X	Metroplex	$49,132	$0	$0	$621,351	$0
3679	X	Lower South Texas	$53,564	$0	$0	$412,479	$261,140
3700	TX121362	Metroplex	$108,993	$220,211	$0	$353,932	$0
3700	TX121362	Gulf Coast	$59,489	$0	$0	$547,393	$0
3700	TX121362	Central	$364,114	$1,144,690	$0	$447,157	$0
3705	TX112205	Upper East Texas	$51,891	$261,175	$0	$0	$0
3735	TX121123	Metroplex	$0	$0	$0	$26,803	$0
3759	TX116230	Upper East Texas	$74,360	$350,051	$0	$0	$0
3778	X	Central	$240,434	$422,792	$0	$0	$0
3793	TX113658	Gulf Coast	$70,042	$674,952	$82,803	$30,436	$0
3795	TX116289	Gulf Coast	$208,568	$1,140,015	$0	$0	$0
3810	TX116248	Metroplex	$206,387	$0	$0	$1,100,123	$0
3823	TX106702	Gulf Coast	$258,147	$1,393,472	$0	$0	$0
3890	X	Central	$10,893	$0	$0	$174,163	$0
3909	TX120950	Northwest Texas	$22,356	$168,613	$0	$21,297	$0
		Upper	$44,790	$362,472	$0	$0	$0

3917	TX101688	South Texas					
3928	X	Upper South Texas	$51,014	$0	$0	$495,851	$0
3934	X	Upper South Texas	$17,045	$0	$0	$115,090	$0
3948	X	Central	$45,816	$0	$0	$229,622	$0
4258	TX000509	Gulf Coast	$17,941	$134,850	$0	$0	$0
4449	TX001224	Upper South Texas	$82,527	$349,442	$0	$0	$0
4642	X	Upper East Texas	$60,496	$172,070	$172,070	$277,173	$0
4645	X	Upper East Texas	$17,710	$0	$0	$101,913	$0
4693	TX000504	Gulf Coast	$75,554	$415,760	$0	$0	$0
5498	TX000505	Central	$11,830	$70,768	$0	$0	$0
5727	TX122097	Gulf Coast	$96,959	$524,350	$0	$0	$0
6212	X	West Texas	$38,775	$0	$0	$222,916	$0
6511	TX001343	Lower South Texas	$97,833	$449,978	$0	$0	$0
8258	TX118138	Gulf Coast	$44,859	$304,934	$0	$0	$0
9456	X	Statewide (optional)	$3,250,000	$0	$0	$0	$0
9817	X	West Texas	$18,667	$0	$0	$102,563	$0
9862	X	Metroplex	$0	$9,989,096	$872,630	$0	$0
10272	TX000510	Northwest Texas	$30,476	$193,884	$0	$0	$0
10355	X	Statewide (optional)	$331,723	$0	$0	$277,705	$0
10431	X	Upper Rio Grande	$17,784	$0	$0	$71,683	$0
10495	X	Metroplex	$0	$509,930	$509,930	$41,197	$0
10497	X	Central	$26,721	$0	$0	$170,227	$0
11436	X	Metroplex	$26,249	$207,830	$0	$0	$0
11451	TX000501	Gulf	$38,580	$156,666	$0	$0	$0

11451	TX000501	Coast					
11451	TX000501	Lower South Texas	$38,718	$121,506	$0	$0	$0
11451	TX000501	Upper East Texas	$89,232	$371,264	$0	$0	$0
11500	X	Metroplex	$9,130	$0	$0	$0	$54,699
12097	X	Upper Rio Grande	$122,987	$187,282	$0	$78,987	$0
12456	X	Upper South Texas	$0	$0	$0	$23,220	$0
12940	X	Upper South Texas	$0	$9,028	$0	$0	$0
12941	X	Upper Rio Grande	$0	$15,438	$0	$0	$0
13039	X	Central	$0	$14,803	$0	$0	$0
13040	X	Central	$0	$17,681	$0	$0	$0
13041	X	Upper South Texas	$0	$10,162	$0	$0	$0
14045	X	Upper Rio Grande	$0	$7,502	$0	$0	$0
14983	X	Upper East Texas	$0	$13,249	$0	$0	$0
15745	X	Lower South Texas	$0	$14,679	$0	$0	$0
15746	X	West Texas	$0	$10,811	$0	$0	$0
15747	X	High Plains	$0	$10,320	$0	$0	$0
15909	X	Northwest Texas	$0	$13,747	$0	$0	$0
22463	X	Statewide (optional)	$0	$216,943	$0	$0	$0
22761	X	Gulf Coast	$0	$11,064	$0	$0	$0
22865	X	Southeast Texas	$0	$18,331	$0	$0	$0
23545	X	Statewide (optional)	$12,090	$0	$0	$0	$0
23684	X	Statewide (optional)	$7,350	$0	$0	$0	$0

24550	X	Statewide (optional)	$0	$7,895	$0	$0	$0
25635	X	Central	$0	$0	$0	$52,793	$0
25635	X	Lower South Texas	$0	$0	$0	$8,928	$0
25635	X	Upper South Texas	$0	$0	$0	$97,431	$0
25636	X	Gulf Coast	$0	$0	$0	$24,429	$0
26102	X	Metroplex	$0	$0	$0	$25,363	$0
Totals:			**$21,992,119**	**$84,679,291**	**$22,724,767**	**$34,589,118**	**$6,775,919**

FY2008 Form 9 --Column 5 includes SAPT paid to providers (excluding Primary Prevention & HIV Early Intervention) but not direct program support in the amount of $5,777,594. The discrepancies between Form 9 column 5, and Form 8 row 1, are the direct program support included in Form 8c Resource Development Checklist.

Please Note:

A provider would not have an I-SATS ID if they only provide prevention and intervention activities. Providers without an I-SATS ID are listed on the Provider Address report.

PROVIDER ADDRESS TABLE

Provider ID	Description	Provider Address
43	Rainbow Days, Inc.	8150 N. Central Expressway, Ste. 1600 Dallas, TX 75206-1883 214-887-0726
53	REGION VIII EDUCATION SERVICE CENTER	PO BOX 1894 Mount Pleasant, TX 75456-1894 903-572-8551
70	Heart of Texas Council on Alcohol and Drug Abuse	900 Austin Avenue #803 Waco, TX 76701 254-753-7332
83	YWCA of Greater Austin	2015 South IH35 Suite 110 Austin, TX 78741 512-326-1222
117	San Antonio Council on Alcohol and Drug Abuse	AT and T Bldg., 7500 Hwy 90 W Suite 100 San Antonio, TX 78227 210-233-5860
228	Abilene Regional Council on Alcohol and Drug Abuse, Inc.	104 Pine Street Suite 210 Abilene, TX 79601 325-673-2242
543	Family Services of Greater Houston	3815 Montrose Blvd. Suite 200 Houston, TX 77006 713-802-7855
881	Dallas Challenge, Inc.	7777 Forest Lane B-410 Dallas, TX 75230 972-566-4680
1077	Communities In Schools - Corpus Christi	3502-1/2 Greenwood P. O. Box 331203 Corpus Christi, TX 78416
1193	Texas A & M University	College of Architecture, Rm 109C Langford Bldg MS 3137 College Station, TX 77843 979-862-2374
1316	Family Violence Prevention Services, Inc.	7911 Broadway San Antonio, TX 78209 210-930-3669

1371	REGION XVII EDUCATION SERVICE CENTER	1111 W. Loop 289 Lubbock, TX 79416 806-281-5852
1769	REGION IV EDUCATION SERVICE CENTER	7145 W TIDWELL RD Houston, TX 77092-2096 713-744-6534
1775	REGION XIV EDUCATION SERVICE CENTER	1850 HWY 351 Abilene, TX 79601-4750 325-675-8609
1810	Family Service Association of San Antonio, Inc.	702 San Pedro San Antonio, TX 78212 210-299-2400
1842	Promise House Inc	224 W. Page Street Dallas, TX 75208
2508	Texas State University	601 University Dr Grants Accounting JCK Bldg 440 San Marcos, TX 78666-4685 877-304-2727
2576	The University of Texas at Austin	PO Box 7159 Office of Accounting Austin, TX 78713-7159 512-471-6424
2624	Permian Basin Regional Council on Alcohol and Drug Abuse	120 E 2nd Street Odessa, TX 79761-5405 432-580-5100
2698	Tarrant County Hospital District	1500 S. Main Street Cost Center 794 Fort Worth, TX 76104 817-927-1230
2726	Henderson County Help Center	309 Royall Street Athens, TX 75751
2791	EDUCATION SERVICE CENTER REGION 10	PO BOX 831300 Richardson, TX 75083 972-348-1000
2835	REGION XI EDUCATION SERVICE CENTER	3001 North Freeway Fort Worth, TX 76106 817-740-3689
2836	REGION II EDUCATION SERVICE CENTER	209 N. WATER Corpus Christi, TX 78401 361-561-8484
2866	Child and Family Guidance Center	8915 Harry Hines Blvd. Dallas, TX 75235 214-351-3490
2974	Drug Prevention Resources, Inc.	1200 Walnut Hill Lane Suite 2100 Irving, TX 75038 972-812-6336
	Boys and Girls Clubs of	3218 E. Belknap

3040	Boys and Girls Clubs of Greater Fort Worth Inc.	Fort Worth, TX 76111 817-834-4711
3184	Comal County Family Violence Shelter Inc	P. O. Box 310344 New Braunfels, TX 78131
3387	Mosaic Family Services, Inc.	4144 North Central Expressway Suite 530 Dallas, TX 75204 214-821-5393
3397	Valley AIDS Council	418 E. Tyler Suite B Harlingen, TX 78550 956-428-9322
3455	Cameron Co Task Force on Redu Teen Preg	806 Morgan Blvd. Suite B Harlingen, TX 78550
3512	Family Support Services of Amarillo	1001 S. Polk Amarillo, TX 79101 806-342-2525
3544	Quad Counties Council on Alcohol and Drug Abuse	902 S. Main Street Suite C Del Rio, TX 78840 830-774-7411
3660	Girls Inc of Tarrant County	2820 Matlock Rd. Arlington, TX 76015
3663	Viable Options in Community Endeavors	P. O. Box 687 Corsicana, TX 75151 903-872-0180
3679	Coastal Bend AIDS Foundation Inc	400 Mann Street Suite 800 Corpus Christi, TX 78401-2046 361-814-2001
3778	Bluebonnet Trails Community MHMR Center	1009 North Georgetown Street Round Rock, TX 78664 512-244-8305
3890	PAXUnited	2155 Chenault Drive Suite 410 Carrollton, TX 75006 972-671-9550
3928	Joven Juvenile Outreach and Vocational Educational	102 W. White Street San Antonio, TX 78214 210-924-0330
3934	Karnes Wilson Juvenile Board	101 N. Panna Maria Avenue Suite 3 Karnes City, TX 78118 830-780-2228
3948	Youth and Family Alliance	3700 South 1st Austin, TX 78704 512-735-2453

4642	Longview Wellness Center, Inc. dba Wellness Pointe	1107 East Marshall Avenue Longview, TX 75601 903-758-2610
4645	City of Longview Drug Task Force	P O Box 1952 Longview, TX 75606 903-237-1017
6212	RY Team-N-Texas	P.O. Box 14765 Odessa, TX 79768 432-552-7445
9452	University of Texas - Austin	P O Box 7159 Austin, TX 78713-7159 512-232-9388
9456	Texas Department of Criminal Justice	P. O. Box 99 Huntsville, TX 77342 (936) 437-2101
9817	Palmer Drug Abuse Program-Midland	1201 West Texas Avenue Midland, TX 79701-6173 432-685-3645
9862	Value Behavioral Health of Texas Inc. dba Value Options	1199 South Belt Line Suite 100 Coppell, TX 75019-4667 972-906-2563
10355	Sherry Matthews	200 S Congress Ave Ste. # 30 Austin, TX 78704-8921 (512)478-4397
10431	Housing Authority of the City of El Paso	5300 E. Paisano Drive El Paso, TX 79905-2931 (915) 849-3700
10495	University of Texas at Arlington	P O Box 19145 Arlington, TX 76019-0145 214-645-0914
10497	Leon County Community Coalition (formerly) The Lord's Pantry of Leon County	P. O. Box 1591 Buffalo, TX 75831-1591 903-322-4377
11436	Lakes Regional Mental Health and Mental Retardation Center	P O Box 747 Terrell, TX 75160-0012 972-524-4159
11500	Your Health Clinic-AIDS Resource Center of Texoma	303 Sunset Blvd Sherman, TX 75092-5581 903-813-1272
12097	El Paso County Hospital District (former) El Paso Co Hospital District/R.E.Thomason General Hospital	4815 Alameda Avenue 8th Floor - Suite A El Paso, TX 79905 915-521-7396
	PREFERRED FAMILY	306 S. Flores

12456	PREFERRED FAMILY HEALTHCARE, INC.	San Antonio, TX 78204 660-665-1962
12940	REGION III EDUCATION SERVICE CENTER	1905 LEARY LN Victoria, TX 77901-2899 361-573-0731
12941	REGION XVIII EDUCATION SERVICE CENTER	PO BOX 60580 Midland, TX 79711-0580 432-567-3210
13039	REGION XII EDUCATION SERVICE CENTER	2101 West Loop 340 Waco, TX 76702 254-297-1113
13040	REGION XIII EDUCATION SERVICE CENTER	5701 SPRINGDALE RD Austin, TX 78723-3675 512-919-5499
13041	REGION XX EDUCATION SERVICE CENTER	1314 HINES AVENUE San Antonio, TX 78208 210-370-5200
14045	REGION XIX EDUCATION SERVICE CENTER	PO BOX 971127 El Paso, TX 79997-1127 915-780-6571
14983	REGION VII EDUCATION SERVICE CENTER	1909 N LONGVIEW ST Kilgore, TX 75662 903-988-6711
15745	REGION I EDUCATION SERVICE CENTER	1900 W SCHUNIOR ST Edinburg, TX 78539-2234 956-984-6001
15746	REGION XV EDUCATION SERVICE CENTER	PO BOX 5199 San Angelo, TX 76902-5199 325-658-6571
15747	REGION XVI EDUCATION SERVICE CENTER	5800 BELL ST Amarillo, TX 79109-6230 806-677-5010
15909	REGION IX EDUCATION SERVICE CENTER	301 LOOP 11 Wichita Falls, TX 76306 940-322-6928
22463	Department of Assistive and Rehab	4900 N Lamar Austin, TX 78756-0000
22761	REGION VI EDUCATION SERVICE CENTER	3332 Montgomery Road Huntsville, TX 77340 936-435-8200
22865	REGION V EDUCATION SERVICE CENTER	2295 Delaware Street Beaumont, TX 77703-4299 409-951-1855
23545	Treatment Innovations	12 COLBOURNE CRES Brookline, MA 02445-4522 617-731-1501
23684	Community Connections	801 Pennsylvania Ave SE Ste 201

23684	Community Connections	Washington, DC 20003-2152 202-608-4735
24550	Beck Institute	1 BELMONT AVE STE 700 Bala Cynwyd, PA 19004-1610
25635	Connections Individual and Family Services Inc	P.O. Box 311268 New Braunfels, TX 78131-1268 (830)629-6571 x-202
25636	Depelchin Children's Center	4950 Memorial Dr Attn: Accounting Houston, TX 77007-7440 713-802-7638
26102	Proverb 31 NFP	718 Bagley Hill Dallas, TX 75211 (214)403-1597

Form 9a (formerly Form 6a)

Prevention Strategy Report

Column A (Risks)	Column B(Strategies)	Column C (Providers)
Children of Substance Abusers [1]	Clearinghouse/information resources centers [1]	0
	Resources directories [2]	0
	Brochures [4]	0
	Radio and TV public service announcements [5]	0
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	0
	Information lines/Hot lines [8]	0
	Parenting and family management [11]	0
	Ongoing classroom and/or small group sessions [12]	0
	Peer leader/helper programs [13]	0
	Education programs for youth groups [14]	0
	Mentors [15]	0
	Preschool ATOD prevention programs [16]	0
	Drug free dances and parties [21]	0
	Youth/adult leadership activities [22]	0
	Community service activities [24]	0
	Recreation activities [26]	0
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	0
	Systematic planning [42]	0
	Multi-agency coordination and collaboration/coalition [43]	0
	Accessing services and funding [45]	0

	Promoting the establishment of review of alcohol, tobacco, and drug use policies in schools [51]	0
	Modifying alcohol and tobacco advertising pratices [53]	0
Pregnant Women/Teens [2]	Clearinghouse/information resources centers [1]	0
	Resources directories [2]	0
	Media campaigns [3]	0
	Brochures [4]	0
	Radio and TV public service announcements [5]	0
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	0
	Information lines/Hot lines [8]	0
	Parenting and family management [11]	0
	Ongoing classroom and/or small group sessions [12]	0
	Education programs for youth groups [14]	0
	Mentors [15]	0
	Preschool ATOD prevention programs [16]	0
	Drug free dances and parties [21]	0
	Community service activities [24]	0
	Recreation activities [26]	0
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	0
	Systematic planning [42]	0
	Multi-agency coordination and collaboration/coalition [43]	0
	Accessing services and funding [45]	0
	Modifying alcohol and tobacco advertising pratices [53]	0
Drop-Outs [3]	Clearinghouse/information resources centers [1]	0

	Resources directories [2]	0
	Media campaigns [3]	0
	Brochures [4]	0
	Radio and TV public service announcements [5]	0
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	0
	Information lines/Hot lines [8]	0
	Ongoing classroom and/or small group sessions [12]	0
	Education programs for youth groups [14]	0
	Mentors [15]	0
	Drug free dances and parties [21]	0
	Community drop-in centers [23]	0
	Recreation activities [26]	0
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	0
	Systematic planning [42]	0
	Multi-agency coordination and collaboration/coalition [43]	0
	Accessing services and funding [45]	0
	Modifying alcohol and tobacco advertising pratices [53]	0
Violent and Delinquent Behavior [4]	Clearinghouse/information resources centers [1]	0
	Resources directories [2]	0
	Media campaigns [3]	0
	Brochures [4]	0
	Radio and TV public service announcements [5]	0
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	0
	Information lines/Hot lines [8]	0
	Parenting and family management [11]	0

	Ongoing classroom and/or small group sessions [12]	0
	Education programs for youth groups [14]	0
	Mentors [15]	0
	Drug free dances and parties [21]	0
	Youth/adult leadership activities [22]	0
	Community service activities [24]	0
	Recreation activities [26]	0
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	0
	Systematic planning [42]	0
	Multi-agency coordination and collaboration/coalition [43]	0
	Accessing services and funding [45]	0
	Promoting the establishment of review of alcohol, tobacco, and drug use policies in schools [51]	0
	Modifying alcohol and tobacco advertising pratices [53]	0
Mental Health Problems [5]	Clearinghouse/information resources centers [1]	0
	Resources directories [2]	0
	Brochures [4]	0
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	0
Economically Disadvantaged [6]	Clearinghouse/information resources centers [1]	0
	Resources directories [2]	0
	Media campaigns [3]	0
	Brochures [4]	0
	Radio and TV public service announcements [5]	0
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	0

	Information lines/Hot lines [8]	0
	Parenting and family management [11]	0
	Ongoing classroom and/or small group sessions [12]	0
	Peer leader/helper programs [13]	0
	Education programs for youth groups [14]	0
	Mentors [15]	0
	Preschool ATOD prevention programs [16]	0
	Drug free dances and parties [21]	0
	Youth/adult leadership activities [22]	0
	Community drop-in centers [23]	0
	Community service activities [24]	0
	Recreation activities [26]	0
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	0
	Systematic planning [42]	0
	Multi-agency coordination and collaboration/coalition [43]	0
	Accessing services and funding [45]	0
	Promoting the establishment of review of alcohol, tobacco, and drug use policies in schools [51]	0
	Modifying alcohol and tobacco advertising pratices [53]	0
Already Using Substances [9]	Clearinghouse/information resources centers [1]	0
	Resources directories [2]	0
	Media campaigns [3]	0
	Brochures [4]	0
	Radio and TV public service announcements [5]	0
	Speaking engagements [6]	0
	Health fairs and other health	

	promotion, e.g., conferences, meetings, seminars [7]	0
	Information lines/Hot lines [8]	0
	Parenting and family management [11]	0
	Ongoing classroom and/or small group sessions [12]	0
	Peer leader/helper programs [13]	0
	Education programs for youth groups [14]	0
	Mentors [15]	0
	Drug free dances and parties [21]	0
	Youth/adult leadership activities [22]	0
	Community drop-in centers [23]	0
	Community service activities [24]	0
	Recreation activities [26]	0
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	0
	Systematic planning [42]	0
	Multi-agency coordination and collaboration/coalition [43]	0
	Accessing services and funding [45]	0
	Promoting the establishment of review of alcohol, tobacco, and drug use policies in schools [51]	0
	Modifying alcohol and tobacco advertising pratices [53]	0
Homeless and/or Run away Youth [10]	Clearinghouse/information resources centers [1]	0
	Resources directories [2]	0
	Media campaigns [3]	0
	Brochures [4]	0
	Radio and TV public service announcements [5]	0
	Health fairs and other health promotion, e.g., conferences,	0

	meetings, seminars [7]	
	Information lines/Hot lines [8]	0
	Parenting and family management [11]	0
	Ongoing classroom and/or small group sessions [12]	0
	Education programs for youth groups [14]	0
	Mentors [15]	0
	Drug free dances and parties [21]	0
	Youth/adult leadership activities [22]	0
	Community drop-in centers [23]	0
	Community service activities [24]	0
	Recreation activities [26]	0
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	0
	Systematic planning [42]	0
	Multi-agency coordination and collaboration/coalition [43]	0
	Accessing services and funding [45]	0
	Promoting the establishment of review of alcohol, tobacco, and drug use policies in schools [51]	0
	Modifying alcohol and tobacco advertising pratices [53]	0

Form 10a (formerly Form 7a)

TREATMENT UTILIZATION MATRIX

Dates of State Expenditure Period: From: 9/1/2007 To: 8/31/2008

	Number of Admissions ≥ Number of Persons		Costs per Person		
Level of Care	**A. Number of Admissions**	**B. Number of Persons**	**C. Mean Cost of Services**	**D. Median Cost of Services**	**E. Standard Deviation of Cost**
Detoxification (24-Hour Care)					
Hospital Inpatient	1030	979	$ 787.20	$ 750	$ 280.75
Free-standing Residential	6986	6101	$ 783.95	$ 750	$ 343.65
Rehabilitation / Residential					
Hospital Inpatient	30	30	$ 3854.67	$ 2102.50	$ 4809.99
Short-term (up to 30 days)	11471	10269	$ 1564.47	$ 1628	$ 896.71
Long-term (over 30 days)	3831	3526	$ 5936.89	$ 4070	$ 4916.66
Ambulatory (Outpatient)					
Outpatient	20152	19089	$ 710.19	$ 540	$ 675.24
Intensive Outpatient	7066	6789	$ 1175.40	$ 978	$ 1045.69
Detoxification	2421	2214	$ 581.77	$ 510	$ 512.42
Opioid Replacement Therapy (ORT)					
Opioid Replacement Therapy	1717	1694	$ 5475.67	$ 4554	$ 4732.87

Form 10b (formerly Form 7b)

Number of Persons Served (Unduplicated Count) for alcohol and other drug use in state-funded services by age, sex, and race/ethnicity

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	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
1. 17 and under	5,309	774	353	653	176	2		11	9	6	3	11	6	2,513	792	1,512	562	2,458	777
2. 18-24	8,479	1,881	1,825	704	531	8	5	30	14	17	18	14	14	2,066	1,352	2,828	2,521	1,892	1,238
3. 25-44	23,827	5,836	5,528	2,323	1,814	12	10	42	19	65	77	43	21	4,550	3,487	9,030	8,224	3,841	2,732
4. 45-64	8,842	2,586	1,639	1,600	734	2	3	12	4	29	22	14	8	1,519	670	4,654	2,758	1,108	322
5. 65 and over	136	37	15	34	4									39	7	73	21	37	5
6. Total	46,593	11,114	9,360	5,314	3,259	24	18	95	46	117	120	82	49	10,687	6,308	18,097	14,086	9,336	5,074
7. Pregnant Women	765		334		148		0		1		3		1		278		493		272

Did the values reported by your State on Forms 7a and 7b come from a client-based system(s) with unique client identifiers? ◉ Yes ○ No

Numbers of Persons Served who were admitted in a period prior to the 12 month reporting period. 11,238

Numbers of Persons Served outside of the levels of care described in Form 10a. 0

Description of Calculations

Description of Calculations

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

Table II: Tuberculosis Services

The MOE for tuberculosis services was calculated based upon expenditures for TB services to substance abusers funded by the former Texas Department of Health (TDH), now a part of the Texas Department of State Health Services (DSHS). TB hospital expenses are not included in the expenditure calculations. The tuberculosis base was established by using the 1991-1992 state expenditures. The expenditures for TB services to substance abusers in SFY 1991 were $868,499 and expenditures for SFY 1992 were $868,499 creating a base figure of $868,499.

To calculate the amount of state funds spent on TB patients with substance abuse, the number of TB patients with a substance abuse disorder is divided by the number of reported TB patients less the number of TB patients reported at death. The result is the percentage of living TB patients with substance abuse. This percentage is applied to the total state funds expended on TB services for all persons. For SFY 2010, DSHS used the reported state expenditures of $15,304,127 and applied the percentage of reported substance abuse clients (27.0345%) to determine the amount of state funds spent on clients who were substance abusers in treatment, totaling $4,137,392.

Table III: HIV Early Intervention Services
The maintenance of effort (MOE) for HIV consists of all non-Federal funds spent on early intervention services for HIV provided to substance abusers in treatment at the site at which they received substance abuse treatment during the state fiscal year.

The MOE for HIV early intervention services was calculated based upon expenditures for outreach services funded by the former Texas Department of Health (TDH), now a part of the Texas Department of State Health Services (DSHS), compared to the TB base established by state expenditures by TDH for HIV early intervention services in 1991-1992. The MOE base was calculated by using the 1991-1992 state expenditures for HIV services provided to substance abusers in treatment as the average of TDH (now part of DSHS) expenditures in SFY 1991 and SFY 1992, $54,000 and $67,000 respectively, creating a base figure of $60,500.

By using the most recent AIDS case data of June 30, 2010 only adult AIDS cases (more than 12 years old) are selected for analysis. A frequency of mode (method) of exposure results in the number of cases and percent of the selected cases each mode represents. The percentages for Injecting Drug Use and Male-Male Sex-Injecting Drug Use are added together to provide the total percent of eligible cases in which injecting drug use is a risk. This percentage (21.7%) was applied to the expenditures from the HIV Early Intervention Programs, HIV State Services Programs, and Ryan White Programs to calculate the total of all state funds spent on early intervention services for HIV. Based on annualized expenditures, it is projected that total state funds in the amount of $8,575,181 will be spent on HEI in SFY 2010.

Table IV: Pregnant Women and Women with Dependent Children

On June 29, 1995, the Texas Commission on Alcohol and Drug Abuse (TCADA), now part of the Department of State Health Services (DSHS) issued an official interpretation of the Women's base requirement to CSAT. As a result of such action, the Women's base was established utilizing the 1992 requirement of $6,720,580. For 1993,

the Women's base requirement was equal to the 1992 requirement plus 5 percent of the 1993 Block Grant ($6,720,580 + $3,508,233) for a total of $10,228,813. For 1994, the Women's base requirement was equal to the 1993 base plus 5 percent of the 1994 Block Grant ($10,228,813 + $3,759,080), yielding a total of $13,987,893.

The FY 2010 total amount of projected expenditures for direct services to pregnant women and women with dependent children is $22,692,214 which includes $22,403,678 in Federal Block Grant funds and $288,536 in state funds paid to contracted entities throughout the State. This exceeds the federal set aside requirement of $13,987,893, and excludes administrative and/or program support costs. The expenditures include all FFY 2010 block grant spent and FY2010 state funds spent for direct services to pregnant women and women with dependent children. The finalized expenditures will be provided in the FFY 2012 SAPT Block Grant Application.

In order to correctly identify expenditures related to direct services for Pregnant Women and Women with Dependent Children; unique codes were created when TCADA was consolidated with DSHS beginning in September 2005. Three specific program codes are utilized: Treatment-Adult Female, Treatment-Youth Female; and Pregnant Intervention. These program codes are set up in both the DSHS accounting system and DSHS contracting system. When a substance abuse contractor invoices electronically; the contracting system is able to identify and separate out services for Pregnant Women and Women with Dependent Children based on information provided by the contractor. This information is summarized by contractor and interfaced over to the accounting systems for payment processing.

In addition, Pregnant Women and Women with Dependent Children activities that occur in through the NorthSTAR 7 county area are provided separately utilizing client data analyzed by DSHS NorthSTAR staff.

SSA (MOE TABLE I)

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

PERIOD (A)	EXPENDITURES (B)	B1(2007) + B2(2008) ---------- 2 (C)
SFY 2008 (1)	$24,464,422	$24,464,761
SFY 2009 (2)	$24,465,099	
SFY 2010 (3)	$ 25,164,815	

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

FY 2008 ◉ Yes ○ No
FY 2009 ○ Yes ◉ No
FY 2010 ○ Yes ◉ No

If estimated expenditures are provided, please indicate when "actual" expenditure data will be submitted to SAMHSA (mm/dd/yyyy): 9/30/2011

The MOE for State fiscal year(SFY) 2010 is met if the amount in Box B3 is greater than or equal to the amount in Box C2 assuming the State complied with MOE Requirements in these previous years.

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

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

○ Yes ◉ No If yes, specify the amount and the State fiscal year: $, (SFY)

Did the State 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? (Date)

Revised SFY 2008 = $24,464,422 -- Final
Revised SFY 2009 = $24,465,099 -- Projected

TB (MOE TABLE II)

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

(BASE TABLE)

Period	Total of All State Funds Spent on TB Services (A)	% of TB Expenditures Spent on Clients who were Substance Abusers in Treatment (B)	Total State Funds Spent on Clients who were Substance Abusers in Treatment AX B (C)	Average of Columns C1 and C2 C1 + C2 -------- 2 (D)
SFY 1991 (1)	$ 8,862,234	9.80 %	$ 868,499	$ 868,499
SFY 1992 (2)	$ 8,862,234	9.80 %	$ 868,499	

(MAINTENANCE TABLE)

Period	Total of All State Funds Spent on TB Services (A)	% of TB Expenditures Spent on Clients who were Substance Abusers in Treatment (B)	Total State Funds Spent on Clients who were Substance Abusers in Treatment AX B (C)
SFY 2010 (3)	$ 15,304,127	27.034483 %	$ 4,137,392

HIV (MOE TABLE III)

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

(BASE TABLE)

Period	Total of All State Funds Spent on Early Intervention Services for HIV (A)	Average of Columns A1 and A2 A1 + A2 -------- 2 (B)
SFY 1991 (1)	$ 54,000	$ 60,500
SFY 1992 (2)	$ 67,000	

(MAINTENANCE TABLE)

Period	Total of All State Funds Spent on Early Intervention Services for HIV* (A)
SFY 2010 (3)	$ 8,575,181

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

Womens (MOE TABLE IV)

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

(MAINTENANCE TABLE)

Period	Total Women's Base (A)	Total Expenditures (B)
1994	**$13,987,893**	
2008		**$22,724,767**
2009		**$18,860,122**
2010		$ 22,692,214

Enter the amount the State plans to expend in FY 2011 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}): $ 16,374,742

Form T1

Most recent year for which data are available	From: 9/1/2008 To: 8/31/2009

Aggregates		
Employment\Education Status – Clients employed or student (full-time and part-time) (prior 30 days) at admission vs. discharge	Admission Clients (T_1)	Discharge Clients (T_2)
Number of clients employed or student (full-time and part-time) [numerator]	7066	7765
Total number of clients with non-missing values on employment\student status [denominator]	9340	9340
Percent of clients employed (full-time and part-time)	75.65%	83.14%

State Description of Employment\Education Status Data Collection (Form T1)

STATE CONFORMANCE TO INTERIM STANDARD

States should detail exactly how this information is collected. Where data and methods vary from interim standard, variance should be described

Admission and Discharge records are collected at that time from all clients. A unique client id number is used to match clients across all admission and discharage episodes. The first admission during the year and the last discharge during the year are used to identify clients for the NOMS.

DATA SOURCE

What is the source of data for table T1? (Select all that apply)

- [x] Client Self Report
- Client self-report confirmed by another source:
  - [ ] Collateral source
  - [ ] Administrative data source
- [ ] Other: Specify

EPISODE OF CARE

How is the admission/discharge basis defined for table T1? (Select one)

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

Matched records for clients first admission and last discharge during the year were identified

DISCHARGE DATA COLLECTION

How was discharge data collected for table T1? (Select all that apply)

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

	☐ Discharge records are not collected for approximately [ ] % of clients who were admitted for treatment
RECORD LINKING	**Was the admission and discharge data linked for table T1? (Select all that apply)** ☑ Yes, all clients at admission were linked with discharge data using an Unique Client Identifier (UCID) Select type of UCID: ◉ Master Client Index or Master Patient Index, centrally assigned ○ Social Security Number (SSN) ○ Unique client ID based on fixed client characteristics (such as date of birth, gender, partial SSN, etc.) ○ Some other Statewide unique ID ○ Provider-entity-specific unique ID ☐ No, State Management Information System does not utilize UCID that allows comparison of admission and discharge data on a client specific basis (data developed on a cohorts basis) or State relied on other data sources for post admission data ☐ No, admission and discharge records were matched using probabilistic record matching
IF DATA IS UNAVAILABLE	**If data is not reported, why is State unable to report? (Select all that apply)** ☐ Information is not collected at admission ☐ Information is not collected at discharge ☐ Information is not collected by the categories requested ☐ State collects information on the indicator area but utilizes a different measure.
DATA PLANS IF DATA IS NOT AVAILABLE	**State must provide time-framed plans for capturing employment\student status data on all clients, if data is not currently available. Plans should also discuss barriers, resource needs and estimates of cost.**

Form T2

Most recent year for which data are available	From: 9/1/2008 To: 9/1/2009

Aggregates

Stability of Housing – Clients reporting being in a stable living condition (prior 30 days) at admission vs. discharge	Admission Clients (T_1)	Discharge Clients (T_2)
Number of clients in a stable living situation [numerator]	24908	26249
Total number of clients with non-missing values on living arrangements [denominator]	27087	27087
Percent of clients in stable living situation	91.96%	96.91%

State Description of Stability of Housing (Living Status) Data Collection (Form T2)

STATE CONFORMANCE TO INTERIM STANDARD

States should detail exactly how this information is collected. Where data and methods vary from interim standard, variance should be described

DATA SOURCE

What is the source of data for table T2? (Select all that apply)

- [x] Client Self Report
  - Client self-report confirmed by another source:
    - [ ] Collateral source
    - [ ] Administrative data source
- [ ] Other: Specify

EPISODE OF CARE

How is the admission/discharge basis defined for table T2? (Select one)

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

Admission is the first service during the year and Discharge is the last service during the year.

DISCHARGE DATA COLLECTION

How was discharge data collected for table T2? (Select all that apply)

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

RECORD LINKING

Was the admission and discharge data linked for table T2? (Select all that apply)

- [x] Yes, all clients at admission were linked with discharge data using an Unique Client Identifier (UCID)

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

IF DATA IS UNAVAILABLE	**If data is not reported, why is State unable to report? (Select all that apply)** ☐ Information is not collected at admission ☐ Information is not collected at discharge ☐ Information is not collected by the categories requested ☐ State collects information on the indicator area but utilizes a different measure.

DATA PLANS IF DATA IS NOT AVAILABLE	**State must provide time-framed plans for capturing living status data on all clients, if data is not currently available. Plans should also discuss barriers, resource needs and estimates of cost.**

Form T3

Most recent year for which data are available	From: 9/1/2008 To: 8/31/2009

Aggregates

Clients without arrests (any charge) (prior 30 days) at admission vs. discharge	Admission Clients (T_1)	Discharge Clients (T_2)
Number of Clients without arrests [numerator]	25703	27023
Total number of clients with non-missing values on arrests [denominator]	28424	28424
Percent of clients without arrests	90.43%	95.07%

State Description of Criminal Involvement Data Collection (Form T3)

STATE CONFORMANCE TO INTERIM STANDARD

States should detail exactly how this information is collected. Where data and methods vary from interim standard, variance should be described

Admission and Discharge records are collected at that time from all clients. A unique client id number is used to match clients across all admission and discharage episodes. The first admission during the year and the last discharge during the year are used to identify clients for the NOMS.

DATA SOURCE

What is the source of data for table T3? (Select all that apply)

- [x] Client Self Report
- Client self-report confirmed by another source:
  - [ ] Collateral source
  - [ ] Administrative data source
- [ ] Other: Specify

EPISODE OF CARE

How is the admission/discharge basis defined for table T3? (Select one)

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

Matched records for clients first admission and last discharge during the year were identified

DISCHARGE DATA COLLECTION

How was discharge data collected for table T3? (Select all that apply)

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

RECORD LINKING

Was the admission and discharge data linked for table T3? (Select all that apply)

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

IF DATA IS UNAVAILABLE	**If data is not reported, why is State unable to report? (Select all that apply)** ☐ Information is not collected at admission ☐ Information is not collected at discharge ☐ Information is not collected by the categories requested ☐ State collects information on the indicator area but utilizes a different measure.

DATA PLANS IF DATA IS NOT AVAILABLE	**State must provide time-framed plans for capturing arrest data on all clients, if data is not currently available. Plans should also discuss barriers, resource needs and estimates of cost.**

Form T4

Most recent year for which data are available	From: 9/1/2008 To: 8/31/2009

Aggregates		
Alcohol Abstinence – Clients with no alcohol use (all clients regardless of primary problem) (use Alcohol Use in last 30 days field) at admission vs. discharge.	Admission Clients (T_1)	Discharge Clients (T_2)
Number of clients abstinent from alcohol [numerator]	4702	10283
Total number of clients with non-missing values on "used any alcohol" variable [denominator]	14127	14127
Percent of clients abstinent from alcohol	33.28%	72.79%

(1) If State does not have a "used any alcohol" variable, calculate instead using frequency of use variables for all primary, secondary, or tertiary problem codes in which the coded problem is Alcohol (e.g. ,TEDS Code 02)

State Description of Alcohol Use Data Collection (Form T4)

STATE CONFORMANCE TO INTERIM STANDARD

States should detail exactly how this information is collected. Where data and methods vary from interim standard, variance should be described

Admission and Discharge records are collected at that time from all clients. A unique client id number is used to match clients across all admission and discharage episodes. The first admission during the year and the last discharge during the year are used to identify clients for the NOMS.

DATA SOURCE

What is the source of data for table T4? (Select all that apply)

- [x] Client Self Report
- Client self-report confirmed by another source:
  - [ ] urinalysis,blood test or other biological assay
  - [ ] Collateral source
  - [ ] Administrative data source
- [ ] Other: Specify

EPISODE OF CARE

How is the admission/discharge basis defined for table T4? (Select one)

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

Matched records for clients first admission and last discharge during the year were identified

DISCHARGE DATA COLLECTION

How was discharge data collected for table T4? (Select all that apply)

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

	☐ Discharge records are not collected for approximately [ ] % of clients who were admitted for treatment

RECORD LINKING	**Was the admission and discharge data linked for table T4? (Select all that apply)** ☑ Yes, all clients at admission were linked with discharge data using an Unique Client Identifier (UCID) Select type of UCID: ◉ Master Client Index or Master Patient Index, centrally assigned ○ Social Security Number (SSN) ○ Unique client ID based on fixed client characteristics (such as date of birth, gender, partial SSN, etc.) ○ Some other Statewide unique ID ○ Provider-entity-specific unique ID ☐ No, State Management Information System does not utilize UCID that allows comparison of admission and discharge data on a client specific basis (data developed on a cohorts basis) or State relied on other data sources for post admission data ☐ No, admission and discharge records were matched using probabilistic record matching

IF DATA IS UNAVAILABLE	**If data is not reported, why is State unable to report? (Select all that apply)** ☐ Information is not collected at admission ☐ Information is not collected at discharge ☐ Information is not collected by the categories requested ☐ State collects information on the indicator area but utilizes a different measure.

DATA PLANS IF DATA IS NOT AVAILABLE	**State must provide time-framed plans for capturing alcohol abstinence data on all clients, if data is not currently available. Plans should also discuss barriers, resource needs and estimates of cost.** [ ]

Form T5

Most recent year for which data are available	From: 9/1/2008 To: 8/31/2009

Aggregates

Drug Abstinence – Clients with no drug use (all clients regardless of primary problem) (use Any Drug Use in last 30 days field) at admission vs. discharge.	Admission Clients (T_1)	Discharge Clients (T_2)
Number of Clients abstinent from illegal drugs [numerator]	8820	17227
Total number of clients with non-missing values on "used any drug" variable [denominator]	24867	24867
Percent of clients abstinent from drugs	35.47%	69.28%

(2) If State does not have a "used any drug" variable, calculate instead using frequency of use variables for all primary, secondary, or tertiary problem codes in which the coded problem is Drugs (e.g., TEDS Codes 03-20)

State Description of Other Drug Use Data Collection (Form T5)

STATE CONFORMANCE TO INTERIM STANDARD

States should detail exactly how this information is collected. Where data and methods vary from interim standard, variance should be described

Admission and Discharge records are collected at that time from all clients. A unique client id number is used to match clients across all admission and discharage episodes. The first admission during the year and the last discharge during the year are used to identify clients for the NOMS.

DATA SOURCE

What is the source of data for table T5? (Select all that apply)

- [x] Client Self Report
- Client self-report confirmed by another source:
  - [ ] urinalysis,blood test or other biological assay
  - [ ] Collateral source
  - [ ] Administrative data source
- [ ] Other: Specify

EPISODE OF CARE

How is the admission/discharge basis defined for table T5? (Select one)

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

Matched records for clients first admission and last discharge during the year were identified

DISCHARGE DATA COLLECTION

How was discharge data collected for table T5? (Select all that apply)

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

	☐ Discharge records are not collected for approximately [ ] % of clients who were admitted for treatment
RECORD LINKING	**Was the admission and discharge data linked for table T5? (Select all that apply)** ☑ Yes, all clients at admission were linked with discharge data using an Unique Client Identifier (UCID) Select type of UCID: ◉ Master Client Index or Master Patient Index, centrally assigned ○ Social Security Number (SSN) ○ Unique client ID based on fixed client characteristics (such as date of birth, gender, partial SSN, etc.) ○ Some other Statewide unique ID ○ Provider-entity-specific unique ID ☐ No, State Management Information System does not utilize UCID that allows comparison of admission and discharge data on a client specific basis (data developed on a cohorts basis) or State relied on other data sources for post admission data ☐ No, admission and discharge records were matched using probabilistic record matching
IF DATA IS UNAVAILABLE	**If data is not reported, why is State unable to report? (Select all that apply)** ☐ Information is not collected at admission ☐ Information is not collected at discharge ☐ Information is not collected by the categories requested ☐ State collects information on the indicator area but utilizes a different measure.
DATA PLANS IF DATA IS NOT AVAILABLE	**State must provide time-framed plans for capturing drug abstinence data on all clients, if data is not currently available. Plans should also discuss barriers, resource needs and estimates of cost.**

Form T6

Most recent year for which data are available	From: 9/1/2008 To: 8/31/2009

Social Support of Recovery – Clients participating in self-help groups, support groups (e.g., AA, NA, etc.) (prior 30 days) at admission vs. discharge	Admission Clients (T_1)	Discharge Clients (T_2)
Number of clients with one or more such activities (AA NA meetings attended, etc.) [numerator]	6628	20444
Total number of Admission and Discharge clients with non-missing values on social support activities [denominator]	28776	28776
Percent of clients participating in social support activities	23.03%	71.05%

State Description of Social Support of Recovery Data Collection (Form T6)

STATE CONFORMANCE TO INTERIM STANDARD

States should detail exactly how this information is collected. Where data and methods vary from interim standard, variance should be described

Admission and Discharge records are collected at that time from all clients. A unique client id number is used to match clients across all admission and discharage episodes. The first admission during the year and the last discharge during the year are used to identify clients for the NOMS.

DATA SOURCE

What is the source of data for table T6? (Select all that apply)

- [x] Client Self Report
  - Client self-report confirmed by another source:
    - [ ] Collateral source
    - [ ] Administrative data source
- [ ] Other: Specify

EPISODE OF CARE

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

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

Matched records for clients first admission and last discharge during the year were identified

DISCHARGE DATA COLLECTION

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

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

RECORD LINKING

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

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

IF DATA IS UNAVAILABLE	**If data is not reported, why is State unable to report? (Select all that apply)** ☐ Information is not collected at admission ☐ Information is not collected at discharge ☐ Information is not collected by the categories requested ☐ State collects information on the indicator area but utilizes a different measure.

DATA PLANS IF DATA IS NOT AVAILABLE	**State must provide time-framed plans for capturing self-help participation status data on all clients, if data is not currently available. Plans should also discuss barriers, resource needs and estimates of cost.**

Form T7

Length of Stay (in Days) of All Discharges

Most recent year for which data are available	From: 9/1/2008 To: 8/31/2009

Length of Stay			
Level of Care	**Average**	**Median**	**Interquartile Range**
Detoxification (24-Hour Care)			
1. Hospital Inpatient	5	5	4
2. Free-standing Residential	6	5	4
Rehabilitation / Residential			
3. Hospital Inpatient	30	28	37
4. Short-term (up to 30 days)	18	20	20
5. Long-term (over 30 days)	58	44	30
Ambulatory (Outpatient)			
6. Outpatient	79	71	80
7. Intensive Outpatient	72	63	65
8. Detoxification	10	7	7
Opioid Replacement Therapy (ORT)			
9. Opioid Replacement therapy	233	266	257

INSERT OVERALL NARRATIVE:

INSERT OVERALL NARRATIVE:

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

State Performance Management and Leadership

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

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

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

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

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

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

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

Treatment Performance Measures (Overall Narrative)

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

The practice of establishing and using performance measures as the basis for contract management is well established in the DSHS-MHSA Division's system. The Texas Department of State Health Services (DSHS) has implemented performance-based management of funded substance abuse treatment providers (contract management based on performance measures) since 1995. The performance measures targets for providers are established in the contracts. The contracts stipulate the services to be provided, the estimated number of individuals to be served, and a proposed budget. Each contract includes expected performance measures.

All funded providers are required to utilize the Behavioral Health Integrated Provider System (BHIPS), a system whereby providers submit via internet completed forms for each client admitted. The client's records include the Admission and Discharge Forms where TEDS information is collected, billings for services rendered, clinical records, and other information. DSHS is currently implementing an improved system CMBHS (Clinical Management Behavioral Health Services) which will replace BHIPS and provide improved functionality.

Performance measures are measured using clients' records and comparing status at admission and discharge.

To ensure continuity and a culture that incorporates this practice and to enhance the capacity of the leadership regarding performance measure management, it is necessary to emphasize the training of new hires as changes in both leadership and staff positions occur.

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

DSHS's Division of Mental Health and Substance Abuse Services develop quarterly reports for the Legislative Budget Board (LBB) on the Division's performance measures. The reports include financial and performance measures and justification of below-target performance, as required of all reporting government units. DSHS reviews and updates performance targets once a year.

DSHS's Division of Mental Health and Substance Abuse Services develops reports on performance measures and provides the reports to funded providers. The frequency of the reports depends on the program type. Substance abuse receives reports monthly, except the
methadone performance measures that are reported once a year after completion of the Methadone Annual Survey and Customer Satisfaction Survey. Funded providers may request ad-hoc reports at any time. In addition, the BHIPS system makes summary reports available and accessible to service providers.

The DSHS-MHSA Decision Support Unit has developed a risk assessment report format that allows us to identify providers at risk. Risk status is determined by an analysis of selected variables, including financial,

programmatic, and performance measures. This report is submitted quarterly to the Quality Management Unit, the unit in charge of monitoring contract compliance. As a consequence of the risk report, several actions may result including calls to the providers requesting explanations and corrective actions, suspension of payments until further information is provided to the state, or in its most extreme cases, cancellation of contracts.

Monitoring of providers not at risk is done by conducting visits to interview the providers' staff, audit records, and contact clients to verify information. Program officers request performance measures be provided to the Decision Support Unit before visiting the providers for verification and monitoring. After the monitoring visits, Quality Management prepares a Final Report where the findings of the visit are discussed.

Performance measures data is analyzed at two levels: the provider level to identify under-performers, and the statewide level to identify trends and compare overall system performance with prior years to establish targets.

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

Performance targets are established by analyzing and comparing past performance data from prior years. The process for establishing targets also considers changes in population, policy decisions and/or other factors.

The selection of performance measure variables is based on reviews of the scientific literature on substance abuse treatment and substance abuse prevention.

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

If a provider is found to have performed under expectations (e.g., not meeting targets), DSHS follows a review procedure that consists of:

- informing the provider's executive management of its non-compliance status and requesting relevant and appropriate changes in the operational procedures;
- conducting site visits to inspect records and review programmatic issues; and
- providing technical assistance and training.

Continuous under-performance of a provider classified "at-risk" and non-compliant with rules and regulations may be cause for termination of state funding.

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

In 2004, DSHS began requiring all providers of prevention services to implement evidence-based curricula. To be funded, providers were asked to identify the population to be served based on the Institute of Medicine's (IOM) classification and to begin implementing model curricula included in SAMHSA's NREPP list.

For substance abuse treatment, DSHS promotes and encourages funded providers to implement evidence-based interventions such as motivational interviewing, clients' screening and assessment with instruments that

have scientifically established psychometric properties, and other best practices such as placement in the most appropriate level of care according to severity of addiction.

Provider Involvement

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

DSHS expects under-performing providers to review their program implementation procedures and other factors such as changes in the population served, personnel, documentation, and data reporting to identify feasible changes. The state will facilitate training and provide technical assistance, if necessary.

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

DSHS requires that funded providers enter demographic, service encounter and clinical information on individuals receiving substance abuse services via clinical and administrative screens in BHIPS. DSHS schedules and offers trainings for contracted treatment staff on how to use BHIPS in its entirety approximately twice a month. Substance abuse prevention and intervention providers submit performance measures electronically using another function within the BHIPS system. Trainings on the use of this BHIPS functionality are scheduled on an "as needed" basis.

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

DSHS contracts include performance measures stipulated in the contracts with substance abuse treatment and prevention providers. DSHS reports to providers include performance measures. DSHS's Technical Assistance and Training Unit provides training for providers regarding performance measures.

Does the state require providers to supply information abut the intensity or number of services received?

Substance abuse treatment providers enter service encounter data into BHIPS to generate a bill for reimbursement based on a fee-for-services method. Therefore, the number and amount (intensity) of substance abuse treatment services per individual data is readily available to DSHS.

Prevention service providers are paid on a cost-reimbursement basis. However, for primary prevention providers implementing universal, selective, or indicated services to groups of individuals, the state requires them to report the number of cycles and sessions implemented by curriculum. This is one of the procedures used by DSHS for monitoring the fidelity of the model programs implementation.

Treatment Corrective Action Plan (submit upon request)

1. Describe the corrective action plan, including critical steps and actions the State and its providers will employ to collect and report the National Outcome Measures data.

2. Discuss the timeframes for the State's corrective action plan detailing the planned milestones and other measures of progress the State has incorporated into its corrective action plan.

3. Describe the State's corrective action plan implementation monitoring activities including interventions or adjustments the State will employ when timeframes or milestones are not achieved.

This narrative response not included because it does not exist or has not yet been submitted.

Form P1
NOMs Domain: Reduced Morbidity—Abstinence from Drug Use/Alcohol Use
Measure: 30-Day Use

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
1. 30-day Alcohol Use	**Source Survey Item:** NSDUH Questionnaire. "Think specifically about the past 30 days, that is, from **[DATEFILL]** through today. During the past 30 days, on how many days did you drink one or more drinks of an alcoholic beverage?" [Response option: Write in a number between 0 and 30.] **Outcome Reported:** Percent who reported having used alcohol during the past 30 days.	Ages 18+ - CY 2008	51.30	
		Ages 12–17 - CY 2008	13.90	
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.	Ages 12–17 - CY 2008	8.30	
		Ages 18+ - CY 2008	25.60	
3. 30-day Use of Other Tobacco Products	**Source Survey Item:** NSDUH Questionnaire: "During the past 30 days, that is, since **[DATEFILL]**, on how many days did you use [other tobacco products] † ?" [Response option: Write in a number between 0 and 30.] **Outcome Reported:** Percent who reported having used a tobacco product other than cigarettes during the past 30 days, calculated by combining responses to questions about individual tobacco products (snuff, chewing tobacco, pipe tobacco).	Ages 18+ - CY 2008	8.60	
		Ages 12–17 - CY 2008	5.50	
4. 30-day Use of Marijuana	**Source Survey Item:** NSDUH Questionnaire: "Think specifically about the past 30 days, from **[DATEFILL]** up to and including today. During the past 30 days, on how many days did you use marijuana or hashish?" [Response option: Write in a number between 0 and 30.] **Outcome Reported:** Percent who reported having used marijuana or hashish during the past 30 days.	Ages 12–17 - CY 2008	6	
		Ages 18+ - CY 2008	4.40	
5. 30-day Use of Illegal Drugs Other Than Marijuana	**Source Survey Item:** NSDUH Questionnaire: "Think specifically about the past 30 days, from **[DATEFILL]** up to and including today. During the past 30 days, on how many days did you use [any other illegal drug] ‡ ?" **Outcome Reported:** Percent who reported having used illegal drugs other than marijuana or hashish during the past 30 days, calculated by combining responses to questions about individual drugs (heroin, cocaine, stimulants, hallucinogens, inhalants, prescription drugs used without doctors' orders).	Ages 12–17 - CY 2008	5	
		Ages 18+ - CY 2008	3	

((s)) Suppressed due to insufficient or non-comparable data

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

Form P2
NOMs Domain: Reduced Morbidity—Abstinence from Drug Use/Alcohol Use
Measure: Perception of Risk/Harm of Use

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
1. Perception of Risk From Alcohol	**Source Survey Item:** NSDUH Questionnaire: "How much do people risk harming themselves physically and in other ways when they have five or more drinks of an alcoholic beverage once or twice a week?" [Response options: No risk, slight risk, moderate risk, great risk] **Outcome Reported:** Percent reporting moderate or great risk.	Ages 18+ - CY 2008	79.90	
		Ages 12–17 - CY 2008	77.80	
2. Perception of Risk From Cigarettes	**Source Survey Item:** NSDUH Questionnaire: "How much do people risk harming themselves physically and in other ways when they smoke one or more packs of cigarettes per day?" [Response options: No risk, slight risk, moderate risk, great risk] **Outcome Reported:** Percent reporting moderate or great risk.	Ages 12–17 - CY 2008	91.90	
		Ages 18+ - CY 2008	92.60	
3. Perception of Risk From Marijuana	**Source Survey Item:** NSDUH Questionnaire: "How much do people risk harming themselves physically and in other ways when they smoke marijuana once or twice a week?" [Response options: No risk, slight risk, moderate risk, great risk] **Outcome Reported:** Percent reporting moderate or great risk.	Ages 18+ - CY 2008	79.20	
		Ages 12–17 - CY 2008	81.40	

((s)) Suppressed due to insufficient or non-comparable data

Form P3
NOMs Domain: Reduced Morbidity—Abstinence from Drug Use/Alcohol Use
Measure: Age of First Use

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
1. Age at First Use of Alcohol	**Source Survey Item:** NSDUH Questionnaire: "Think about the first time you had a drink of an alcoholic beverage. How old were you the first time you had a drink of an alcoholic beverage? Please do not include any time when you only had a sip or two from a drink." [Response option: Write in age at first use.] **Outcome Reported:** Average age at first use of alcohol.	Ages 12–17 - CY 2008	13.30	
		Ages 18+ - CY 2008	17.50	
2. Age at First Use of Cigarettes	**Source Survey Item:** NSDUH Questionnaire: "How old were you the first time you smoked part or all of a cigarette?" [Response option: Write in age at first use.] **Outcome Reported:** Average age at first use of cigarettes.	Ages 18+ - CY 2008	16.40	
		Ages 12–17 - CY 2008	12.80	
3. Age at First Use of Tobacco Products Other Than Cigarettes	**Source Survey Item:** NSDUH Questionnaire: "How old were you the first time you used [any other tobacco product] † ?" [Response option: Write in age at first use.] **Outcome Reported:** Average age at first use of tobacco products other than cigarettes.	Ages 18+ - CY 2008	19.50	
		Ages 12–17 - CY 2008	13.30	
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.	Ages 12–17 - CY 2008	13.40	
		Ages 18+ - CY 2008	18	
5. Age at First Use of Illegal Drugs Other Than Marijuana or Hashish	**Source Survey Item:** NSDUH Questionnaire: "How old were you the first time you used [other illegal drugs] ‡ ?" [Response option: Write in age at first use.] **Outcome Reported:** Average age at first use of other illegal drugs.	Ages 18+ - CY 2008	20.60	
		Ages 12–17 - CY 2008	12.70	

((s)) Suppressed due to insufficient or non-comparable data

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

Form P4
NOMs Domain: Reduced Morbidity—Abstinence from Drug Use/Alcohol Use
Measure: Perception of Disapproval/Attitudes

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
1. Disapproval of Cigarettes	**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.	Ages 12–17 - CY 2008	89.50	
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.	Ages 12–17 - CY 2008	87.10	
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.	Ages 12–17 - CY 2008	83.30	
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.	Ages 12–17 - CY 2008	83.70	
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.	Ages 12–17 - CY 2008	85.70	

((s)) Suppressed due to insufficient or non-comparable data

Form P5
NOMs Domain: Employment/Education
Measure: Perception of Workplace Policy

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
Perception of Workplace Policy	**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.	Ages 18+ - CY 2008	48.70	
		Ages 15–17 - CY 2008	33.50	

((s)) Suppressed due to insufficient or non-comparable data

Form P6
NOMs Domain: Employment/Education
Measure: ATOD-Related Suspensions and Expulsions

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
In Development	In Progress	In Progress	((s))	

((s)) Suppressed due to insufficient or non-comparable data

Form P7
NOMs Domain: Employment/Education
Measure: Average Daily School Attendance Rate

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
Average Daily School Attendance Rate	**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.	CY 2008	92.50	

((s)) Suppressed due to insufficient or non-comparable data

Form P8
NOMs Domain: Crime and Criminal Justice
Measure: Alcohol-Related Traffic Fatalities

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
Alcohol-Related Traffic Fatalities	**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 2008	43.30	

((s)) Suppressed due to insufficient or non-comparable data

Form P9
NOMs Domain: Crime and Criminal Justice
Measure: Alcohol- and Drug-Related Arrests

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
Alcohol- and Drug-Related Arrests	**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 2008	111.90	

((s)) Suppressed due to insufficient or non-comparable data

Form P10
NOMs Domain: Social Connectedness
Measure: Family Communications Around Drug and Alcohol Use

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
1. Family Communications Around Drug and Alcohol Use (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.	Ages 12–17 - CY 2008	56.10	
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?" † [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.	Ages 18+ - CY 2008	91.50	

((s)) Suppressed due to insufficient or non-comparable data

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

Form P11
NOMs Domain: Retention
Measure: Percentage of Youth Seeing, Reading, Watching, or Listening to a Prevention Message

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
Exposure to Prevention Messages	**Source Survey Item:** NSDUH Questionnaire: "During the past 12 months, do you recall [hearing, reading, or watching an advertisement about the prevention of substance use] † ?" **Outcome Reported:** Percent reporting having been exposed to prevention message.	Ages 12–17 - CY 2008	88.70	

((s)) Suppressed due to insufficient or non-comparable data

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

P-Forms 12a- P-15 – Reporting Period

Reporting Period - Start and End Dates for Information Reported on Forms P12A, P12B, P13, P14 and P15

Forms	A. Reporting Period Start Date	B. Reporting Period End Date
Form P12a Individual-Based Programs and Strategies—Number of Persons Served by Age, Gender, Race, and Ethnicity	9/1/2008	8/31/2009
Form P12b Population-Based Programs and Strategies—Number of Persons Served by Age, Gender, Race, and Ethnicity	9/1/2008	8/31/2009
Form P13 (Optional) Number of Persons Served by Type of Intervention	9/1/2008	8/31/2009
Form P14 Number of Evidence-Based Programs and Strategies by Type of Intervention	9/1/2008	8/31/2009
Form P15 FY 2008 Total Number of Evidence Based Programs and Total SAPT BG Dollars Spent on Evidence-Based Programs/Strategies	9/1/2008	8/31/2009

Form P12a
Individual-Based Programs and Strategies—Number of Persons Served by Age, Gender, Race, and Ethnicity

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

Data is collected by the BHIPS data system. Providers submit data directly to the state on the number served. Aggregate numbers served are submitted by providers.

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.

Number served by providers is reported in the race categories described below.

Category	Description	Total Served
A. Age	1. 0-4	3665
	2. 5-11	99793
	3. 12-14	63897
	4. 15-17	31702
	5. 18-20	908
	6. 21-24	806
	7.25-44	4883
	8. 45-64	1587
	9. 65 And Over	169
B. Gender	Male	105588
	Female	101822
C. Race	White	141487
	Black or African American	35286
	Native Hawaiian/Other Pacific Islander	1675
	Asian	2639
	American indian/Alaska Native	3412
	More Than One Race (not OMB required)	10974
	Race Not Known or Other (not OMB required)	11937
D. Ethnicity	Hispanic or Latino	99525
	Not Hispanic or Latino	107885

Form 12b
Population-Based Programs and Strategies—Number of Persons Served by Age, Gender, Race, and Ethnicity

Category	Description	Total Served
A. Age	1. 0-4	467197
	2. 5-11	592012
	3. 12-14	253924
	4. 15-17	265131
	5. 18-20	186210
	6. 21-24	462032
	7.25-44	1695002
	8. 45-64	1316267
	9. 65 And Over	565050
	10. Age Not Known	
B. Gender	Male	2879250
	Female	2923575
	Gender Unknown	
C. Race	White	4909794
	Black or African American	661914
	Native Hawaiian/Other Pacific Islander	1344
	Asian	45686
	American indian/Alaska Native	6719
	More Than One Race (not OMB required)	25530
	Race Not Known or Other (not OMB required)	151838
D. Ethnicity	Hispanic or Latino	2248789
	Not Hispanic or Latino	3554036
	Ethnicity Unknown	

Form P13 (Optional)
Number of Persons Served by Type of Intervention

Intervention Type	Number of Persons Served by Individual- or Population-Based Program or Strategy	
	A. Individual-Based Programs and Strategies	B. Population-Based Programs and Strategies
1. Universal Direct	36567	N/A
2. Universal Indirect	N/A	5802825
3. Selective	40065	N/A
4. Indicated	130778	N/A
5. Total	207410	5802825

Form P14
Number of Evidence-Based Programs and Strategies by Type of Intervention

NOMs Domain: Retention
NOMs Domain: Evidence-Based Programs and Strategies
Measure: Number of Evidence-Based Programs and Strategies

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

- Inclusion in a Federal List or Registry of evidence-based interventions
- Being reported (with positive effects) in a peer-reviewed journal
- Documentation of effectiveness based on the following guidelines:
  - Guideline 1: The intervention is based on a theory of change that is documented in a clear logic or conceptual model; and
  - Guideline 2: The intervention is similar in content and structure to interventions that appear in registries and/or the peer-reviewed literature; and
  - Guideline 3: The intervention is supported by documentation that it has been effectively implemented in the past, and multiple times, in a manner attentive to Identifying and Selecting Evidence-Based Interventions scientific standards of evidence and with results that show a consistent pattern of credible and positive effects; and
  - Guideline 4: The intervention is reviewed and deemed appropriate by a panel of informed prevention experts that includes: well-qualified prevention researchers who are experienced in evaluating prevention interventions similar to those under review; local prevention practitioners; and key community leaders as appropriate, e.g., officials from law enforcement and education sectors or elders within indigenous cultures.

1. Describe the process the State will use to implement the guidelines included in the above definition.
YPI, YPS, and YPU programs are based on curriculum listed in the NREPP.

2. Describe how the State collected data on the number of programs and strategies. What is the source of the data?
1. YPI, YPS and YPU programs enter aggregate data reflecting numbers served and demographics into a state database. 2. Univerisal Indirect programs serve entire geographic areas. Numbers served are based on county level data from the Texas State Population Center, which is based on Census data.

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

	A. Universal Direct	B. Universal Indirect	C. Universal Total	D. Selected	E. Indicated	F. Total
1. Number of Evidence-Based Programs and Strategies Funded	56	0	56	54	51	161
2. Total number of Programs and Strategies Funded	56	29	85	54	51	190
3. Percent of Evidence-Based Programs and Strategies	100.00%	0.00%	65.88%	100.00%	100.00%	84.74%

Form P15 - FY 2008 Total Number of Evidence Based Programs and Total SAPT BG Dollars Spent on Evidence-Based Programs/Strategies

IOM Categories	FY 2008 Total Number of Evidence-Based Programs/Strategies for each IOM category	FY 2008 Total SAPT Block Grant $Dollars Spent on evidence-based Programs/Strategies
1. Universal Direct	56	$ 11558597
2. Universal Indirect	0	$ 0
3. Selective	54	$ 8347201
4. Indicated	51	$ 9796693
5. Totals	161	$29,702,491.00

Note: See definitions for types of interventions in the instructions for P-14 (Universal Direct, Universal Indirect, Selective, and Indicated)

Prevention Corrective Action Plan (submit upon request)

1. Describe the corrective action plan, including critical steps and actions the State and its providers will employ to collect and report the National Outcome Measures data.

2. Discuss the timeframes for the State's corrective action plan detailing the planned milestones and other measures of progress the State has incorporated into its corrective action plan.

3. Describe the State's corrective action plan implementation monitoring activities including interventions or adjustments the State will employ when timeframes or milestones are not achieved.

This narrative response not included because it does not exist or has not yet been submitted.

Approved Substitute Data Submission Form

Substitute data has not been submitted for prevention forms.

Prevention Attachment D

FFY 2008 (Optional Worksheet for Form P-15)–Total Number of Evidence-based Programs/Strategies and the Total FFY 2008 SAPT Block Grant Dollars Spent on Substance Abuse Prevention Worksheet . Note: Total EBPs and Total dollars spent on EBPs may be transferred to Form P-15.

Note: The Sub-totals for each IOM category and the Total FFY 2008 SAPT Block Grant Dollars spent on Evidence-based programs/strategies may be transferred to Form P-15.

See: The instructions for Form P-14 for the Definition, Criteria and Guidance for identifying and selecting Evidence-Based Programs and Strategies.

Form P15 Table 1: Program/Strategy Detail for Computing the Total Number of Evidence-based Programs and Strategies, and for Reporting Total FFY 2008 SAPT Block Grant Funds Spent on Evidence-Based Programs and Strategies.

1	2	3	4
FFY 2008 Program/Strategy Name Universal Direct	**FFY 2008 Total Number of Evidence-based Programs and Strategies by Intervention**	**FFY 2008 Total Costs of Evidence based Programs and Strategies for each IOM Category**	**FFY 2008 Total SAPT Block Grant Funds Spent on Evidence-Based Programs/Strategies**
1.			
2.			
3.			
4.			
Subtotal			
Universal Indirect Programs and Strategies			
1.			
2.			
3.			
4.			
Subtotal			
Selective Programs and Strategies			
1.			
2.			
3.			
4.			
Subtotal			
Indicated Programs and Strategies			

1.			
2.			
3.			
4.			
Subtotal			
Total Number of (EBPs)/Strategies and cost of these EBPs/Strategies	#	$	
Total FFY 2008 SAPT Block Grant Dollars $ Spent on Evidence-Based Programs and Strategies			$

Description of Supplemental Data

States may also wish to provide additional data related to the NOMs. An approved substitution is not required to provide this supplemental data. The data can be included in the Block Grant appendix. When describing the supplemental data, States should provide any relevant Web addresses (URLs) that provide links to specific State data sources. Provide a brief summary of the supplemental data included in the appendix:

This narrative response not included because it does not exist or has not yet been submitted.

Attachment A, Goal 2: Prevention

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

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

○ Yes ◉ No ○ Unknown

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

◉ Yes ○ No ○ Unknown

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

SAPT Block Grant	Other State Funds	Drug Free Schools
○ Yes	○ Yes	○ Yes
◉ No	◉ No	◉ No
○ Unknown	○ Unknown	○ Unknown

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

○ Yes ◉ No ○ Unknown

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

Education Bureau? ◉ Yes ○ No ○ Unknown

Dissemination of materials? ◉ Yes ○ No ○ Unknown

Media campaigns? ◉ Yes ○ No ○ Unknown

Product pricing strategies? ◉ Yes ○ No ○ Unknown

Policy to limit access? ◉ Yes ○ No ○ Unknown

6. Does your State now have laws that provide for administrative suspension or revocation

of drivers' licenses for those determined to have been driving under the influence of intoxication? (HP 26-24)

◉ Yes ○ No ○ Unknown

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

	Yes	No	Unknown
Restrictions at recreational and entertainment events at which youth made up a majority of participants/consumers:	○	◉	○
New product pricing:	○	○	◉
New taxes on alcoholic beverages:	○	◉	○
New laws or enforcement of penalties and license revocation for sale of alcoholic beverages to minors:	○	◉	○
Parental responsibility laws for a child's possession and use of alcoholic beverages:	○	◉	○

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

◉ Yes ○ No ○ Unknown

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

	Age 0 - 5	Age 6 - 11	Age 12 - 14	Age 15 - 18
Cigarettes	○	○	◉	○
Alcohol	○	○	◉	○
Marijuana	○	○	◉	○

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

Motor vehicle drivers age 21 and older? 0.08
Motor vehicle drivers under age 21? 0

11. How many communities in your State have comprehensive, community-wide coalitions for alcohol and other drug abuse prevention? (HP 26-23)

Communities: 81

12. Has your State enacted statutes to restrict promotion of alcoholic beverages and

tobacco that are focused principally on young audiences? (HP 26-11 and 26-16)

◉ Yes ○ No ○ Unknown

Appendix A - Additional Supporting Documents (Optional)

Appendix A - Additional Supporting Documents (Optional)

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

This narrative response not included because it does not exist or has not yet been submitted.