New Jersey

UNIFORM APPLICATION
FY 2022 Substance Abuse Block Grant Report

SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT

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Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

I: State Information

State Information

I. State Agency for the Block Grant

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III. Expenditure Period

State Expenditure Period

From	7/1/2020
To	6/30/2021

Block Grant Expenditure Period

From	10/1/2018
To	9/30/2020

IV. Date Submitted

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II: Annual Update

Table 1 Priority Area and Annual Performance Indicators - Progress Report

Priority #: 1

Priority Area: Pregnant Women/Women with Dependent Children

Priority Type: SAT

Population(s): PWWDC

Goal of the priority area:

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

Objective:

Increase number of pregnant women or women with children entering substance abuse treatment.

Strategies to attain the goal:

• Annual provider meetings include licensed women's treatment providers who provide gender specific treatment and system partners. Attendees, the Division of Mental Health and Addiction Services (DMHAS) women's treatment coordinator, representatives from NJ Department of Children and Families (DCF), Division of Family Development (DFD), Work First New Jersey Substance Abuse Imitative (WFNJ-SAI) and other relevant stakeholders. Meeting address issues related to best practices such as retention, engagement, access and referrals, recovery supports, medication assisted treatment, systems collaboration, Substance Exposed Infants (SEI) and Neonatal Abstinence Syndrome (NAS) and training needs.

• Professional development – women's treatment provider contract requirements include service elements and language from the National Association of State Alcohol/Drug Abuse Directors (NASADAD) "Guidance to States: Treatment Standards for Women with Substance Use Disorders" document that emphasizes best practice. Contracted providers are required to address the full continuum of treatment services: family-centered treatment, evidence-based parenting programs, trauma-informed and trauma-responsive treatment using Seeking Safety, Strengthening Families, evidence-based parenting classes, recovery supports, etc. and assist women with housing supports by linking women to transitional, permanent and/or supportive or sober living homes such as an Oxford House. Contracted women's treatment providers new staff are required to complete National Center on Substance Abuse and Child Welfare (NCSACW) online tutorials "Understanding Child Welfare and the Dependency Court: A Guide for Substance Abuse Treatment Professionals" and document completion of tutorials in their employee personnel files.

• Plans of Safe Care - women's treatment provider contract language requires providers to develop Plans of Safe Care for pregnant and postpartum women. Plans of Safe Care will address the needs of the mother, infant and family to ensure coordination of, access to, and engagement in services. For a pregnant woman, the Plan shall be developed prior to the birth event whenever possible and in collaboration with treatment providers, health care providers, early childhood service providers, and other members of the multidisciplinary team as appropriate. Documentation of the Plan shall be included in the woman's file.

• In Depth Technical Assistance (IDTA). In 2014 as a SAMHSA Prescription Drug Abuse Policy Academy State, New Jersey applied for a unique technical assistance opportunity through the SAMHSA supported National Center on Substance Abuse and Child Welfare (NCSACW) to address the multi-faceted problems of Substance Exposed Infants (SEI) and Neonatal Abstinence Syndrome (NAS). New Jersey Department of Human Services (DHS)/DMHAS as the lead State agency partnered with DCF and Department of Health (DOH) and submitted a successful application for IDTA (no funding attached). The IDTA goal was to develop uniform policies/guidelines that address the entire spectrum of NAS and SEI from pre-pregnancy, prevention, early intervention, assessment and treatment, postpartum and early childhood. The IDTA provided technical assistance to New Jersey to strengthen collaboration and linkages across multiple systems such as addictions treatment, child welfare, and medical communities to improve services for pregnant women with opioid and other substance use disorders and outcomes for their babies. The New Jersey IDTA Core Team included over 60 individuals representing multiple State Departments and Divisions, community stakeholders, treatment providers, and the medical community.

The IDTA established three goals: (1) Increase perinatal SEI screening at multiple intervention points (Health system, substance use disorder (SUD)/ mental health (MH) system); (2) Leverage existing programs and policy mechanisms to collaboratively increase the rate at which women screening positive on the 4P's Plus get connected for a comprehensive assessment by establishing formal warm-handoffs and other safety net measures; (3) Leverage existing programs and policy mechanisms to collaboratively increase the rate at which women delivering SEIs and their babies and any other eligible children, receive early support services for which they are eligible.

Three workgroups convened: (1) Data Workgroup looked at statewide data systems (Medicaid ICD codes and DOH) that capture prenatal screening, linkage to treatment services, follow-up for parenting women, prevalence of NAS and associated costs. During the initiative, the team analyzed 2013 and 2014 Medicaid data to establish prevalence and costs of treatment NAS. (2) Prenatal Screening, Early Identification of Infants & Referral to Service Workgroup focused on how to increase connections to appropriate treatment and supportive services such as Central Intake and Perinatal Cooperatives, by mapping out current screening and referral practices across the state using Pregnancy Risk Assessment (PRA) data; New Jersey

implemented the 4Ps+ across the State and embedded the tool within the PRA. The workgroup found high utilization (over 80%) of 4Ps+ within doctors serving pregnant women on Medicaid. The mapping allowed the team to target low utilization areas to increase the prevalence of prenatal screening. (3) Labor, Delivery and Engagement (Infants) Workgroup developed a comprehensive survey with input from the medical community and perinatal cooperatives. The Hospital Birth Survey was disseminated statewide March 2017 to the labor and delivery hospitals. The survey sought to understand how pregnant women with SUD and substance-exposed infants are identified, treated, and triaged with partners at discharge, and if treatment for NAS was explored. The Hospital Birth Survey results was intended to guide Departments in establishing statewide guidelines for best practice; aid in the development of cross system models to ensure families get access to services; establish education needs on issues of SEI/NAS and identify high risk areas. The IDTA commenced in 2017, however DMHAS as the IDTA lead state agency, requested modified technical assistance from the NCSACW to support New Jersey to interpret the key findings from the Birthing Hospital Survey, and apply these findings to the Project ECHO program design.

In late Fall of 2018, Robert Wood Johnson and the Nicholson Foundation, in partnership with the three Departments (Health, Human Services, and Children and Families) and other stakeholders began planning to launch Project ECHO (Extension for Community Outcomes) for SEIs. The New Jersey Project ECHO is aimed at Statewide adoption of best practice clinical care and community-based interventions to support SEIs and their parents to support recovery, family formation, and child development through a multidisciplinary case-based learning platform. Project ECHO for SEI and parents focuses on prevention, birth, and the infant's first year of life. DCF is the lead State agency on Plans of Safe Care for SEI, mothers and their families and has developed protocols for integrating Plans of Safe Care into child protection services and child welfare and child welfare assessments.

• Maternal Wrap Around Program (MWRAP) – MWRAP provides intensive case management and recovery support services for opioid dependent pregnant and postpartum women. Opioid dependent women are eligible for services during pregnancy and up to one year after the birth event. Intensive case management focuses on developing a single, coordinated care plan for pregnant/postpartum women, their infants and families. Intensive Case Managers work as liaisons to all relevant entities involved with each woman. The Recovery Support Specialists provide non-clinical assistance and recovery supports while maintaining follow-up with the women and their infants.

The MWRAP goal is to alleviate barriers to services for pregnant opioid dependent women through comprehensive care coordination that is implemented within the five major timeframes when intervention in the life of the substance exposed infants (SEI) can reduce potential harm of prenatal substance exposure: pre-pregnancy, prenatal, birth, neonatal and early childhood. MWRAP is intended to promote maternal health, improve birth outcomes, and reduce the risks and adverse consequences of prenatal substance exposure. MWRAP is a statewide program located in seven regions with each region serving approximately 30 unduplicated opioid dependent pregnant women, their infants and families.

Edit Strategies to attain the objective here:
(if needed)

• Annual Provider Meetings - with licensed contracted women's treatment providers system partners representing NJ Department of Children and Families (DCF), Division of Family Development (DFD), Work First New Jersey Substance Abuse Initiative (WFNJ-SAI), the Maternal Wrap Around Program (MWRAP) providers, and Integrated Opioid Treatment and Substance Exposed Infants (IOT-SEI) providers. Meetings address a variety of topics such as information sharing, best practices, continuum of care, medication assisted treatment, referrals and access to services, recovery supports, medication assisted treatment, systems collaboration, Substance Exposed Infants (SEI) and Neonatal Abstinence Syndrome (NAS) and training needs.

• Professional Development – Contracted licensed women's treatment providers who receive women's set aside block grant funds are required to address the full continuum of treatment services: family-centered treatment, evidence-based parenting programs, trauma-informed and trauma-responsive treatment using Seeking Safety, Strengthening Families, evidence-based parenting classes, recovery supports, etc. and assist women with housing supports by linking women to transitional, permanent and/or supportive or sober living homes such as an Oxford House. All providers who have DMHAS contracts for specialty services ranging from prevention, treatment and recovery supports for pregnant and parenting women (PPW) with opioid use disorder are required to have new staff successfully complete the National Center on Substance Abuse and Child Welfare (NCSACW) online tutorials "Understanding Child Welfare and the Dependency Court: A Guide for Substance Abuse Treatment Professionals" and document completion of tutorials in their employee personnel files.

• Plans of Safe Care – all women's treatment and pregnant and parenting specialty services (MWRAP and IOT-SEI Initiatives) provider contract language requires Plans of Safe Care for pregnant and postpartum women. Plans of Safe Care will address the needs of the mother, infant and family to ensure coordination of, access to, and engagement in services. For a pregnant woman, the Plan shall be developed prior to the birth event whenever possible and in collaboration with treatment providers, health care providers, early childhood service providers, and other members of the multidisciplinary team as appropriate. Documentation of the Plan shall be included in the woman's file.

• Interim Services - In 2019 NJ DMHAS added language to Fee for Service (FFS) Network Annex A's to ensure all FFS funded treatment agencies provide Interim Services as an engagement service at all levels of care to ensure priority PPW consumers awaiting admission to their assessed level of care anywhere in the state could receive interim services within 48 hours at facilities closer to home. Interim services for PPW consumers is designed to reduce the adverse health effects of substance use, promote individual health, and reduce the risk of transmitting disease to sexual partners and their infants by providing individualized education, case management, referrals and MAT if needed, while awaiting admission. Statewide technical assistance on interim services was provided to all provider contractees.

• In Depth Technical Assistance (IDTA) Neonatal Abstinence Syndrome and Substance Exposed Infants (NAS SEI) - As a SAMHSA Prescription Drug Abuse Policy Academy State, NJ applied for a unique technical assistance opportunity through the SAMHSA supported NCSACW to address the multi-faceted problems of NAS and SEI. NJ DHS/DMHAS as the lead State agency, partnered with DCF and DOH, and submitted a successful application (no funding attached). The IDTA goal was to develop uniform policies/guidelines that address the entire spectrum of NAS and SEI from pre-pregnancy, prevention,

early intervention, assessment and treatment, postpartum and early childhood. The IDTA provided technical assistance to NJ to strengthen collaboration and linkages across multiple systems such as addictions treatment, child welfare, and medical communities to improve services for pregnant women with opioid and other substance use disorders and outcomes for their babies. The Core Team included over 60 individuals representing multiple State Departments and Divisions, community stakeholders, treatment providers, and the medical community. Three goals were established (1) Increase perinatal SEI screening at multiple intervention points (2) Leverage existing programs and policy mechanisms to collaboratively increase the rate at which women screening positive on the 4P's Plus get connected for a comprehensive assessment by establishing formal warm-handoffs and other safety net measures; (3) Leverage existing programs and policy mechanisms to collaboratively increase the rate at which women delivering SEIs and their babies and any other eligible children, receive early support services for which they are eligible. Workgroups were formed.

• IDTA Birthing Hospital Survey: Labor, Delivery and Engagement (Infants) Workgroup developed a comprehensive survey with input from the medical community and perinatal cooperatives. The Birthing Hospital Survey was disseminated statewide March 2017 to the labor and delivery hospitals. The survey sought to understand how pregnant women with SUD and SEI are identified, treated, and triaged with partners at discharge, and if treatment for NAS was explored. The results was intended to guide Departments in establishing statewide guidelines for best practice; aid in the development of cross system models to ensure families get access to services; establish education needs on issues of SEI/NAS and identify high risk areas. In an effort to increase access to SUD treatment and reduce unmet treatment needs of pregnant or parenting women with an Opioid Use Disorder (OUD), based from the Birthing Hospital Survey findings, the DMHAS engaged Rutgers/Robert Wood Johnson Medical School (Rutgers/RWJ) to provide technical assistance and training through the ECHO Program.

• Project ECHO Maternal Child Health. Pregnant and Parenting Women with Opioid Use Disorder (MCH PPW OUD) - This ECHO provides education and training to primary care practitioners, SUD treatment providers, behavioral health practitioners, and other stakeholders in multiple clinic settings and at home, utilizing a web-based video collaboration between a multi-disciplinary team of specialists and primary care practitioners on best practices for the assessment, case management, intervention, treatment and recovery support services for PPW with an OUD. The goal is to increase the capacity and competency of providers, community support organizations and clinical teams to support prevention, treatment and recovery of PPW with OUD. ECHO will position communities to reduce the NAS birth rates, improve use of medication assisted treatment, family formation and early infant development; improve access to physical and mental health care by educating more providers, midwives, doulas, and other health care professionals on best practices during prenatal and perinatal periods. The anticipated start date for the Program was set for March 2020. However, with the advent of the global COVID-19 pandemic, and the national and state orders to shelter in place effective late March 2020, limitations on who could go to the hospital added a level of complexity to care for those mothers expecting to give birth during this time or in recovery at home. These events required an immediate response to address the public health emergency. In late March, 2020 the DMHAS agreed to postpone the traditional MCH PPW-OUD ECHO Series until such time that the providers could return to a focus on pregnant and parenting women with an OUD. The ECHO team (DMHAS, Rutgers/RWJ and Hub members) refocused resources to provide COVID-19 MCH & OUD ECHO sessions. This temporary change in scope enabled the MCH PPW-OUD ECHO team to address treatment issues, access to healthcare services and how to meet the needs of specific populations of women during this crisis. The MCH PPW-OUD Hub team completed a 7 COVID-19 maternal child health and OUD sessions between April and the first week of June. The MCH PPW-OUD ECHO with COVID-19 (included as a discussion topic) reconvened June 15, 2020 and will complete in November 2020, with series 2 starting January 2021; series 3 starting July of 2021. Each series is designed as 12 bi-weekly sessions.

• Maternal Wrap Around Program (MWRAP) – MWRAP is a statewide program located in six regions with each region serving approximately 30 unduplicated opioid dependent pregnant women, their infants and families. MWRAP provides intensive case management and recovery support services for opioid dependent pregnant and postpartum women. Opioid dependent women are eligible for services during pregnancy and up to one year after the birth event. The MWRAP goal is to alleviate barriers to services for pregnant opioid dependent women through comprehensive care coordination that is implemented within the five major timeframes when intervention in the life of the SEI can reduce potential harm of prenatal substance exposure: pre-pregnancy, prenatal, birth, neonatal and early childhood. MWRAP is intended to promote maternal health, improve birth outcomes, and reduce the risks and adverse consequences of prenatal substance exposure.

• Integrated Opioid Treatment and Substance Exposed Infants (IOT-SEI) Initiative: Five awards across the State, funded with the Governor's State Opioid funds. This Initiative provides an array of integrated services for opioid dependent pregnant women, their infants and family. Providers are required to ensure a full continuum of services and to establish mechanisms to develop a coordinated and cohesive approach for working together across systems that include, SUD treatment, medical community, maternal child health, and child welfare. Initiative focuses on alleviating barriers to services. Services range from: mother's medical/prenatal and obstetrical care, SUD treatment for OUD including MAT, new born/infant medical care, child welfare services as identified, intensive case management, recovery supports, assistance with housing, case management and other wraparound services. Providers must ensure that there is comprehensive care coordination from prenatal through the birth event, postpartum, and early childhood

• Data Collection (MWRAP and IOT-SEI) - DMHAS Researcher is collecting and analyzing data to understand the impact of each program on outcomes for the mother and her child, to evaluate program effectiveness, make recommendations for program improvement and sustainability. As of July 2020 COVID-19 specific data is also being collected; the purpose of this data is to understand how individual participants are being affected and what specific steps are being taken to address COVID-19 related challenges – Data is on impact of social determinants of health on health outcomes in the time of COVID-19 such as housing, transportation and healthcare.

• Project ECHO Maternal Child Health. Pregnant and Parenting Women with Opioid Use Disorder (MCH PPW OUD) - The Program consisted of two (2) educational/training Series, and one (1) special COVID-19 series, and occurred as follows : Series 1, start date of January, 2020 through December, 2020; Series 2, start: July 1 2021 through December 2021. The COVID-19 Series start: March 2020 through June 2020 . Each series is designed as 12 bi-weekly sessions. This ECHO's target audience for education and training is: primary care practitioners; maternal child health practitioners;OB/GYNs; ER physicians; APNs ;midwives;doulas; SUD practitioners; mental health practitioners; other health care practitioners; recovery support specialists; intensive case managers; and SUD provider agency staff and child welfare agency staff who engage in providing case management, screening and recovery support services for mothers and infants with substance dependency during the prenatal and postpartum period.

• Maternal Wrap Around Program (MWRAP) - In July, 2021 MWRAP was expanded to include pregnant women with substance use disorder, not limited to opioid misuse. The expansion also serves more women with each region serving approximately 30 unduplicated pregnant women with substance use disorder.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase the number of pregnant women or women with children entering substance abuse treatment.

Baseline Measurement: SFY 2019: 32,276 admissions count

First-year target/outcome measurement: Increase number of pregnant women or women with children entering substance abuse treatment in SFY 2020 by 1%.

Second-year target/outcome measurement: Increase number of pregnant women or women with children entering substance abuse treatment by 2% by the end of SFY 2021. The change in SFY 2021 will be measured by calculating the percent difference from SFY 2019 to SFY 2021.

New Second-year target/outcome measurement*(if needed)*: A return to SFY 2019 baseline measurement. This target/outcome measurement is based on the FDA approval of COVID-19 vaccine and distribution to the population.

Data Source:

The number of pregnant women and women with children from SFY 2019 – 2021 will be tracked by the SSA's New Jersey Substance Abuse Monitoring System (NJSAMS).

New Data Source*(if needed)*:

Description of Data:

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

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

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

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

Reason why target was not achieved, and changes proposed to meet target:
SFY 2019: 32,276 admissions count
SFY 2020: 28,629 admissions count

In SFY 2020, there were 3,647 less admissions than in SFY 2019 or an approximately 11.30% decrease in admissions count.

The COVID-19 pandemic has affected new admissions to treatment negatively, in that there are many individuals in our State that have either been in quarantine, mandated to stay-at-home orders, or fearful to attend a new program in person.

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

Second Year Target: ☐ Achieved ☑ Not Achieved *(if not achieved,explain why)*

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

SFY 2019: 32,276 admissions count
SFY 2020: 28,629 admissions count

SFY 2021: 27,282 admissions count

In SFY 2021, there were 4,994 less admissions than in SFY 2019 or an approximately 15.5% decrease in admissions count from baseline year.

As of November 3, 2021, New Jersey has the third highest death rate from COVID-19 among states in the US (www.statistica.com). The COVID-19 pandemic has continued to affect new admissions to treatment negatively, in that there are many individuals in our State that have either been in quarantine, mandated to stay-at-home orders, or fearful to attend a new program in person, Also, some programs were closed.

DMHAS' goal is to increase the number of pregnant women or women with children to enter substance use disorder treatment. New Jersey requires that Department of Health licensed substance use disorder treatment providers enter treatment data into the New Jersey Substance Abuse Monitoring System (NJSAMS). NJSAMS indicates an increase in substance using pregnant women accessing treatment services. Data collected includes pregnancy and Medication for Opioid Use Disorder (MOUD) utilization. In 2019, New Jersey rolled out the Office Based Addictions Treatment (OBAT) Initiative. Hospital-based programs, MAT-waivered physicians, and other community office-based treatment providers provide services to pregnant women and are not required to enter this data into NJSAMS. Treatment data from OBAT Initiative providers is not captured in NJSAMS or shared with DMHAS. Thus, it is likely that OBAT Initiative providers provided treatment to pregnant and parenting women with opioid use disorder, more so during the COVID-19 pandemic. This population was reluctant to enter treatment during the pandemic. They may have had more anxiety due to fear of the virus, childcare issues, remote learning and public transportation restrictions. Also, our licensed treatment facilities had restrictions on number of individuals permitted into the facilities.

In January 2022, Governor Phil Murphy reinstated a Public Health Emergency in order to ensure that the State is able to respond to the continued threat of COVID-19 and the rapidly spreading Omicron variant. Executive Order No. 280 declares a Public Health Emergency and restates the existing State of Emergency across all 21 counties in New Jersey, allowing state agencies and departments to utilize state resources to assist the State's healthcare system and affected communities responding to and recovering from COVID-19 cases. Executive Order No. 281 continues Executive Orders Nos. 111, 112, and 207, allows Executive Orders Nos. 251, 252, 253, 264, and 271 to remain in effect, and extends various regulatory actions taken by the departments in response to COVID-19. Governor Murphy's public health emergency declaration also empowers all State agencies to take all appropriate steps to continue to address the public health hazard resulting from new variants of COVID-19.

The COVID-19 pandemic continues to present challenges for individuals seeking treatment in NJ. Early intervention, SUD treatment, intensive case management, recovery supports and coordination of services for PPW is critical in preparing the mother, her infant and family in her recovery. In an effort to increase the number of PPW women entering SUD treatment, DMHAS has implemented several steps to achieve this goal:

1. In SFY 2022, DMHAS expanded the Maternal Wraparound Program (MWRAP) from 30 pregnant women to 50 per region and opened up eligibility criteria to include all substances. MWRAP links pregnant women with SUD to treatment delivered in a variety of settings such as residential facilities, outpatient clinics or private physicians who provide MAT, etc., using a combination of therapeutic approaches. MWRAP providers are required to have affiliation agreement(s) with FQHCs, maternal and child health consortia, licensed SUD treatment providers including Opioid Treatment Programs (OTPs), labor and delivery hospitals, county Central Intake, hubs, formal services such as other systems and other related support services. Affiliation agreements must ensure all providers (SUD treatment and MAT, medical community, social services, child welfare, etc.) will share information to support service coordination and ensure pregnant women are linked into SUD treatment with the voluntary consent of the women.

2. In SFY 2022, DMHAS issued a Request for Proposals (RFP) in the amount of $1,300,000 to expand services for PPW with OUD in the northern region. Intensive Opioid Treatment – Substance Exposed Infants (IOT-SEI) initiative provides comprehensive array of services for opioid dependent pregnant women, their infants and family. Services include OUD treatment, prenatal and postpartum medical/obstetric services, care coordination, sober living arrangements, wraparound services, intensive case management and recovery supports. IOT-SEI focuses on three of the five major timeframes when intervention in the life of the SEI can reduce potential harm of prenatal substance exposure: the prenatal phase, the birth event, and neonatal phase. IOT-SEI will ensure barriers to services for pregnant women with an OUD are alleviated through integrated care that includes a multi-services approach that best serves the needs of pregnant women and their infants. IOT-SEI promotes maternal health, improves birth outcomes and reduce the risks and adverse consequences of prenatal substance exposure.

3. In SFY 2022, DMHAS extended Rutgers PROJECT ECHO (MCH PPW OUD) through 9/23/2023. The extension will provide online education on key topics associated with increasing the medical, addictions, child welfare and other community providers' knowledge of the physical and behavior health impact of OUD on PPW. The curriculum will also address best practice guidelines, social determinants of health, and access to treatment and care during the prenatal and postpartum period for PPW with an OUD.

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

Priority #: 2

Priority Area: Persons Who Inject Drugs

Priority Type: SAT

Population(s): PWID

Goal of the priority area:

To expand access to comprehensive treatment, including Medication Assisted Treatment (MAT), in combination with other treatment modalities, for individuals with an opioid use disorder, including persons who inject drugs (PWID), through mobile medication units and other innovative approaches.

Objective:

Increase the number of PWID entering treatment and number of heroin and other opiate dependent individuals entering treatment.

Strategies to attain the goal:

• Referral to substance use disorder (SUD) treatment from statewide Harm Reduction Centers (HRCs) that are operational throughout New Jersey.
• Providing services in convenient locations, specifically utilizing mobile medication units, in order to reduce barriers and engage individuals in care as easily as possible.
• Promoting the use of medication assisted treatment (MAT) (e.g., methadone, buprenorphine, injectable naltrexone) for individuals with an opioid use disorder (OUD).
• Educating providers, individuals with an OUD, family members and the public about the benefits of MAT through a planned statewide public awareness campaign as well as public presentations on this topic.
• Contracts to three regional providers to provide community education and trainings for individuals at risk for an OUD, their families, friends and loved ones to recognize an opioid overdose and to subsequently provide naloxone kits to individuals in attendance.
• Increase the number of naloxone trainings specifically for underserved populations, such as schools, jails, licensed SUD treatment providers, Offices of Emergency Management, Emergency Medical Services teams, fire departments, homeless shelters and community health clinics.
• Contracts awarded to implement an opioid overdose recovery program with recovery specialists and patient navigators in all 21 counties for individuals who present in emergency departments following an opioid overdose reversal with naloxone in order to link them to treatment or other recovery support services in their communities.
• Contracts awarded to 11 providers for the Support Team for Addiction Recovery (STAR) program to provide case management and wraparound services for individuals with an OUD. Goals include linking clients to needed services, housing, primary care and treatment including MAT.
• Maternal Wraparound Program (M-WRAP) provides intensive case management and recovery support services for opioid dependent pregnant and postpartum women. Opioid dependent pregnant women are eligible for M-WRAP services during pregnancy and up to one year after birth event. Intensive case management focuses on developing a single, coordinated care plan for pregnant/postpartum women, their infants and families. Intensive Case Managers provide care coordination and warm hand-offs to appropriate service providers when necessary. Recovery Support Specialists provide non-clinical assistance and recovery supports while maintaining follow-up with the women and their infants. The M-WRAP program covers all 21 counties of NJ and alleviates barriers through comprehensive care coordination using a multi-system approach with the goal to improve outcomes for pregnant/postpartum opioid dependent women and their children.
• In September 2016, DMHAS was awarded a five-year grant to "Prevent Prescription Drug/Opioid Overdose-Related Deaths (PDO)" from SAMHSA to implement the Opioid Overdose Prevention Network (OOPN) initiative which entails the development and implementation of a comprehensive prescription drug/ opioid overdose prevention program which includes Naloxone training and distribution. Plans are to train 3,000 individuals and distribute 2,500 naloxone kits annually.
• In September 2016, DMHAS was awarded a "Strategic Prevention Framework for Prescription Drugs (SFP Rx)" five-year grant from SAMHSA to implement the NJAssessRx initiative. NJAssessRx expands interagency sharing of the state's Prescription Drug Monitoring Program data and gives DMHAS the capability to use data analytics to identify prescribers, prescriber groups and patients at high risk for inappropriate prescribing and nonmedical use of opioid drugs. Informed by the data, DMHAS and its prevention partners will strategically target communities and populations needing services, education or other interventions. The target population is youth (ages 12-17) and adults (18 years of age and older) who are being prescribed opioid pain medications, controlled drugs, or human growth hormone (HGH), and are at risk for their nonmedical use.
• In May 2017, SAMHSA awarded $12,9995,621 through the State Targeted Response (STR) to New Jersey annually for two years. The program aims to address the opioid crisis by increasing access to treatment, reduce unmet treatment need and reduce opioid overdose related deaths through the provision of prevention, treatment and recovery activities for OUD. A major activity of the grant is to implement and expand access to clinically appropriate evidence-based practices (EBPs) for OUD treatment, particularly, the use of MAT. To address these objectives, a new State Targeted Opioid Response Initiative (STORI) fee-for-service (FFS) treatment initiative was developed within the existing addiction fee for service treatment network, which provides access to treatment for under-insured and uninsured clients. It includes a wide range of services, specifically including MAT. DMHAS was awarded a no-cost extension for the STR grant to continue funding the STORI FFS treatment for part of SFY 2020.
• In September 2018, SAMHSA awarded $21.5 million through the State Opioid Response (SOR) to New Jersey annually for two years to continue to address the opioid crisis. The key objectives of the SOR grant are to increase access to MAT, reduce unmet treatment need and reduce opioid related deaths.
• In March 2019, DMHAS received notification from SAMHSA that its plan for an additional $11.2 million was approved through the SOR Grant for the period through FFY 2020. DMHAS submitted a plan proposing to use the SOR supplemental award to fund additional treatment, recovery support, prevention and education/training efforts to address the opioid epidemic.
• As part of SOR funding, the Low Threshold Buprenorphine Induction program (Low Threshold) is designed to make Buprenorphine treatment easily accessible to individuals who access syringes at Harm Reduction Centers (HRCs) located at South Jersey AIDS Alliance (SJAA) in Atlantic City and the Visiting Nurse Association (VNA) of Central Jersey in Asbury Park. Through the Low Threshold program, individuals will be offered same day, immediate

enrollment in Buprenorphine treatment and care management services. The program will offer services to individuals who seek this type of service in a safe and nonjudgmental environment, despite continued drug use or lapses in care.
• As part of SOR and state funding, DMHAS is collaborating with NJ's 21 counties to establish MAT programs or enhance existing MAT services for inmates with OUD at county correctional facilities. In addition, DMHAS is working with county correctional facilities to establish justice involved re-entry services for detainees where case managers at county jails will conduct intake assessments and establish pre-release plans for needed services in the community.
• An attempt to increase access to MAT, specifically buprenorphine, has been the development of statewide buprenorphine training courses utilized as an educational component for physicians, Advanced Practical Nurses (APNs) and Physician Assistants (PAs) to attain their Buprenorphine Waiver. The State plans to hold a total of 16 trainings through both Rutgers University (northern region) and Rowan University (southern region) in CY 2019 in an effort to train over 1,000 prescribers in CY 2019.
• Interim Services have been a requirement of provider contracts, but a new initiative allows DMHAS to pay for these services through a fee-for-service (FFS) mechanism. The Interim Services initiative provides funding to agencies to support individuals awaiting admission to treatment following a SUD assessment. Interim Services are an engagement level of service intended to link individuals to services they may not be able to access due to lack of provider capacity. This service is designed to be provided by agencies contracted for any licensed ASAM level of care. Interim services will be made available to any individual eligible for treatment within the public system who cannot be admitted for the assessed level of care within 72 hours. Prior to this initiative agencies enrolled in the Block Grant initiatives were required to provide this service. Once launched in October 2019, funding for Interim Services will be open to all contracted FFS providers.

Edit Strategies to attain the objective here:
(if needed)

• Expand low threshold buprenorphine induction programming at all statewide Harm Reduction Centers (HRCs) while also continuing to encourage collaboration and affiliation agreements between the HRCs and substance use disorder agencies to ensure referral to comprehensive treatment programs, when clinically indicated.
• Providing services in convenient locations, specifically continuing to utilize and start-up new mobile medication programming, in order to reduce barriers and engage individuals in care as easily as possible.
• Development and expansion of its expanded hour Opioid Treatment Program (OTP) initiative in efforts to provide increased (i.e. evening) hours that are not typically provided in efforts to assist individuals with easier access to services.
• Promoting the use of medication assisted treatment (MAT) (e.g., methadone, buprenorphine, injectable naltrexone) for individuals with an opioid use disorder (OUD) who seek treatment at any level of care.
• Providing substance use disorder treatment services for individuals who are Deaf and hard of hearing and whose primary language is American Sign Language (ASL) and have a primary diagnosis of an opioid use disorder or stimulant use disorder. The goal is to provide regional services that are both culturally and linguistically accessible and utilize substance use counselors, case managers, and qualified ASL interpreters at three (3) site locations and refer to MAT programming, when appropriate.
• Educating providers, individuals with an OUD, family members and the public about the benefits of MAT through its public awareness campaign that was launched in 2020, as well as providing public presentations, in-person or virtually, on this topic when requested..
• Contracts with three regional Opioid Overdose Prevention Program (OOPP) providers and an Opioid Overdose Prevention Network (OOPN) provider to continue to offer community education and trainings for individuals at-risk for an opioid use disorder, their families, friends and loved ones to recognize an opioid overdose and to subsequently provide naloxone kits to individuals in attendance. A component of these trainings have been and will continue to be to discuss treatment, including medications to support recovery.
• Increase the number of naloxone trainings, specifically for underserved populations, such as schools, jails, licensed substance use disorder (SUD) treatment providers, Offices of Emergency Management, Emergency Medical Services teams, fire departments, homeless shelters and community health clinics.
• Linking individuals, reversed from an opioid overdose, who are seen bedside by recovery specialists and patient navigators at emergency departments, via the 21 county Opioid Overdose Recovery Programs (OOPP) to treatment and/or recovery support services in their communities.
• Statewide contracts awarded to providers in all 21 counties for a Support Team for Addiction Recovery (STAR) program to provide case management and wraparound services for individuals with an OUD. Goals include linking clients to needed services, housing, primary care and treatment, to include MAT.
• Maternal Wraparound Program (M-WRAP) provides intensive case management and recovery support services for opioid dependent pregnant and postpartum women. Opioid dependent pregnant women are eligible for M-WRAP services during pregnancy and up to one year after birth event. Intensive case management focuses on developing a single, coordinated care plan for pregnant/postpartum women, their infants and families. Intensive Case Managers provide care coordination and warm hand-offs to appropriate service providers when necessary. Recovery Support Specialists provide non-clinical assistance and recovery supports while maintaining follow-up with the women and their infants. The M-WRAP program covers all 21 counties of NJ and alleviates barriers through comprehensive care coordination using a multi-system approach with the goal to improve outcomes for pregnant/postpartum opioid dependent women and their children.
• In September 2016, DMHAS was awarded a "Strategic Prevention Framework for Prescription Drugs (SPF Rx)" five-year grant from SAMHSA to implement the NJAssessRx initiative. NJAssessRx expands interagency sharing of the state's Prescription Drug Monitoring Program data and gives DMHAS the capability to use data analytics to identify prescribers, prescriber groups and patients at high risk for inappropriate prescribing and nonmedical use of opioid drugs. Informed by the data, DMHAS and its prevention partners will strategically target communities and populations needing services, education or other interventions. The target population is youth (ages 12-17) and adults (18 years of age and older) who are being prescribed opioid pain medications, controlled drugs, or human growth hormome (HGH), and are at risk for their nonmedical use .
• In FY 2020, New Jersey received a total of $120.3 million through SOR for a two-year period. In FY 2021, NJ received $65.97 million through SOR 2.0. The goal of the SOR is to address the State's opioid crisis as well as a rising issue of stimulant use disorder by providing treatment, family and peer recovery support, community prevention and education programs and training. The key objectives of funding are to increase access to medication-assisted treatment (MAT), reduce unmet treatment need, reduce opioid-related deaths, and provide services to address individuals who have a

stimulant use disorder.
• As part of SOR and state funding, DMHAS collaborates with 20 of 21 counties in NJ who have established MAT programs or enhanced existing MAT services for inmates with OUD at county correctional facilities. DMHAS will utilize funds to have its Centers of Excellence provide technical assistance to correctional facilities to assist them in the provision of these services. In addition, DMHAS has worked with county correctional facilities to establish justice involved re-entry services for detainees where case managers at county jails conduct intake assessments and establish pre-release plans for needed services in the community.
• Interim Services is a requirement of DMHAS provider contracts. A new initiative developed in October 2019 has allowed DMHAS to pay for these services through a fee-for-service (FFS) mechanism. The Interim Services initiative provides funding to all contracted FFS agencies to support individuals awaiting admission to treatment following a substance use disorder (SUD) assessment. Interim Services are an engagement level of service intended to link individuals to services they may not be able to access due to lack of provider capacity. This service has been designed to be provided by agencies contracted for any licensed ASAM level of care. Interim services have been made available to any individual eligible for treatment within the public system who cannot be admitted for the assessed level of care within 72 hours. Prior to this initiative, agencies enrolled in the Block Grant initiatives were required to provide this service.
• DMHAS is proposing to increase access to buprenorphine and other ancillary services for individuals with a substance use disorder through current programming available at homeless shelters. It is proposed that providers will develop the capacity to provide low threshold medication as well as other support services for individuals who reside or drop in at the shelters, linking them to treatment services when appropriate.
• DMHAS will continue a train-the-trainer program through Rutgers University on MAT and NJ-specific treatment and recovery resources for graduate students. The goal of this project is to educate, support, and mentor graduate students to give free educational talks to community groups throughout the State.
• DMHAS will be issuing a Request for Proposal (RFP) which will fund cultural competence training that will be provided to narrow the treatment gap experienced by Black/African Americans (AA) who are diagnosed with opioid and stimulant use disorders and who are statistically less likely to receive or access services. A second goal of this initiative is to increase access to MAT through increased prescribing to the Black/AA community.
• DMHAS to develop a pilot program to fund one of its university partners to develop a few pilot paramedicine programs in the State to administer buprenorphine for opioid withdrawal symptoms and provide next day linkage to care to community MAT providers.
• The Division of Medical Assistance and Health Services, in collaboration with DMHAS, launched a program to cover and support MAT and Office Based Addiction Treatment (OBAT). This program coordinates the delivery of multiple reimbursable services provided by primary care providers and community behavioral health specialists to NJ FamilyCare members with an addiction diagnosis. OBAT providers link patients to OTP or other treatment services when appropriate.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase the number of PWID entering treatment.

Baseline Measurement: SFY 2019: 29,053 admissions count

First-year target/outcome measurement: Increase the number of PWID entering treatment by 1%.

Second-year target/outcome measurement: Increase the number of PWID entering treatment by 2% by the end of SFY 2021. The change in SFY 2021 will be measured by calculating the percent difference from SFY 2019 to SFY 2021.

New Second-year target/outcome measurement*(if needed)*: A return to SFY 2019 baseline measurement. This target/outcome measurement is based on the FDA approval of COVID-19 vaccine and distribution to the population.

Data Source:

The number of PWID in SFY 2019 through SFY 2021 will be tracked by the SSA's New Jersey Substance Abuse Monitoring System (NJSAMS).

New Data Source*(if needed)*:

Description of Data:

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

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

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

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

Reason why target was not achieved, and changes proposed to meet target:
SFY 2019: 29,053 admissions count
SFY 2020: 25,391 admissions count

In SFY 2020, there were 3,662 less admissions than in SFY 2019 or an approximately 12.60% decrease in admissions count.

The COVID-19 pandemic has affected new admissions to treatment negatively, in that there are many individuals in our State that have either been in quarantine, mandated to stay-at-home orders, or fearful to attend a new program in person, specifically an OTP for methadone, as the initial visit is required to be face-to-face. Also, various options to receive medications for OUD now exist (i.e. Federally Qualified Healthcare Centers, Office Based Addiction Treatment programs) that are not licensed SUD treatment programs, therefore are not required to enter data into our NJSAMS reporting system.

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

Second Year Target: ☐ Achieved ☑ Not Achieved *(if not achieved,explain why)*

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

SFY 2019: 29,053 admissions count
SFY 2020: 25,391 admissions count
SFY 2021: 21,957 admissions count

In SFY 2021, there were 7,096 less admissions than in SFY 2019 or an approximately 24.4% decrease in admissions count from baseline year.

As of November 3, 2021, New Jersey has the third highest death rate from COVID-19 among states in the US (www.statistica.com). The COVID-19 pandemic has continued to affect new admissions to treatment negatively, in that there are many individuals in our State that have either been in quarantine, mandated to stay-at-home orders, or fearful to attend a new program in person, specifically an OTP for methadone, as the initial visit is required to be face-to-face. Also, various options to receive medications for OUD now exist (i.e. Federally Qualified Healthcare Centers, Office Based Addiction Treatment programs) that are not licensed SUD treatment programs, and therefore, are not required to enter data into the NJSAMS reporting system.

The Division of Mental Health and Addiction Services (DMHAS) has implemented the following steps in an effort to increase the number of PWID entering SUD treatment.

1. DMHAS launched a public awareness campaign to reduce stigma and discrimination regarding the use of medications to treat opioid use disorder in SFY 2020 through use of State Opioid Response (SOR) grant funds. DMHAS will continue to work with the contracted advertising agency to update/improve this campaign which utilizes social media, as well as television and radio campaigns. DMHAS believes the public awareness campaign that advertises the 24/7 substance use disorder hotline for New Jersey will assist individuals in being connected directly through a warm hand-off to licensed SUD treatment agencies.

2. DMHAS contracted with six licensed Opioid Treatment Programs (OTPs) in SFY 2021 to expand their hours of operations by six hours per day, six days per week. DMHAS believes this innovative approach will increase access to treatment services, including the use of medication throughout the State. OTPs traditionally offer early AM to early PM services and increasing services into the evening provides greater ability for individuals to access services, specifically those individuals being released from jails, or discharged from emergency departments. As these new programs continue to advertise these services to the community, DMHAS believes this will help in increasing number of admissions.

3. DMHAS is in development of an initiative that would support access to additional mobile medication units to provide methadone, buprenorphine and other treatment services in communities with less access to these types of services. This initiative is expected to launch in SFY 2023.

4. DMHAS is in development of a new initiative that would provide access to medication and other treatment services at homeless shelters in the State. This initiative is expected to launch in SFY 2023.

5. DMHAS is in development to expand a pilot initiative in which paramedics provide buprenorphine to treat withdrawal symptoms of those individuals reversed from an opioid use disorder. The program will utilize patient navigators to link these individuals to treatment services. The expansion of this initiative is expected in SFY 2023.

6. DMHAS continues to work to expand low threshold buprenorphine induction programming throughout the State. Many of these

new and innovative programs (i.e. homeless shelters, harm reduction centers, paramedicine) are not taking place in traditional licensed SUD treatment programs. As is such, DMHAS has implemented new modules into its reporting system (NJSAMS) that would capture admissions at programming that does not take place at traditional licensed SUD programs. DMHAS believes capturing this information will lead to an increase in those accessing treatment services through our system.

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

Indicator #: 2

Indicator: Increase the number of heroin and other opiate dependent individuals entering treatment.

Baseline Measurement: SFY 2019: 47,007 admissions count

First-year target/outcome measurement: Increase the number of heroin and other opiate dependent individuals entering treatment by 1%.

Second-year target/outcome measurement: Increase number of opiate dependent individuals entering treatment by 2% by the end of SFY 2021. The change in SFY 2021 will be measured by calculating the percent difference from SFY 2019 to SFY 2021.

New Second-year target/outcome measurement*(if needed)*: A return to SFY 2019 baseline measurement. This target/outcome measurement is based on the FDA approval of COVID-19 vaccine and distribution to the population.

Data Source:

The number of opiate dependent individuals in SFY 2019 and SFY 2021 will be tracked by the SSA's New Jersey Substance Abuse Monitoring System (NJSAMS).

New Data Source*(if needed)*:

Description of Data:

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

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

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

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

Reason why target was not achieved, and changes proposed to meet target:
SFY 2019: 47,007 admissions count
SFY 2020: 43,038 admissions count

In SFY 2020, there were 3,969 less admissions than in SFY 2019 or an approximately 8.44% decrease in admissions count.

The COVID-19 pandemic has affected new admissions to treatment negatively, in that there are many individuals in our State that have either been in quarantine, mandated to stay-at-home orders, or fearful to attend a new program in person, specifically an OTP for methadone, as the initial visit is required to be face-to-face. Also, various options to receive medications for OUD now exist (i.e. Federally Qualified Healthcare Centers, Office Based Addiction Treatment programs) that are not licensed SUD treatment programs, therefore are not required to enter data into our NJSAMS reporting system.

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

Second Year Target: ☐ Achieved ☑ Not Achieved *(if not achieved,explain why)*

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

SFY 2019: 47,007 admissions count
SFY 2020: 43,038 admissions count
SFY 2021: 39,839 admissions count

In SFY 2021, there were 7,168 less admissions than in SFY 2019 or an approximately 15.2% decrease in admissions count from baseline year.

As of November 3, 2021, New Jersey has the third highest death rate from COVID-19 among states in the US (www.statistica.com). The COVID-19 pandemic continues to affect new admissions to treatment, in that there are many individuals in our State that have either been in quarantine, mandated to stay-at-home orders, or fearful to attend a new program in person, specifically an OTP for methadone, as the initial visit is required to be face-to-face. Also, various options to receive medications for OUD now exist (i.e. Federally Qualified Healthcare Centers, Office Based Addiction Treatment programs) that are not licensed SUD treatment programs, and therefore, are not required to enter data into the NJSAMS reporting system.

The Division of Mental Health and Addiction Services (DMHAS) has implemented the following steps in an effort to increase the number of heroin and other opiate dependent individuals entering SUD treatment.

1. DMHAS launched a public awareness campaign to reduce stigma and discrimination regarding the use of medications to treat opioid use disorder in SFY 2020 through use of State Opioid Response (SOR) grant funds. DMHAS will continue to work with the contracted advertising agency to update/improve this campaign which utilizes social media, as well as television and radio campaigns. DMHAS believes the public awareness campaign that advertises the 24/7 substance use disorder hotline for New Jersey will assist individuals in being connected directly through a warm hand-off to licensed SUD treatment agencies.

2. DMHAS contracted with six licensed Opioid Treatment Programs (OTPs) in SFY 2021 to expand their hours of operations by six hours per day, six days per week. DMHAS believes this innovative approach will increase access to treatment services, including the use of medication throughout the State. OTPs traditionally offer early AM to early PM services and increasing services into the evening provides greater ability for individuals to access services, specifically those individuals being released from jails, or discharged from emergency departments. As these new programs continue to advertise these services to the community, DMHAS believes this will help in increasing number of admissions.

3. DMHAS is in development of an initiative that would support access to additional mobile medication units to provide methadone, buprenorphine and other treatment services in communities with less access to these types of services. This initiative is expected to launch in SFY 2023.

4. DMHAS is in development of a new initiative that would provide access to medication and other treatment services at homeless shelters in the State. This initiative is expected to launch in SFY 2023.

5. DMHAS is in development to expand a pilot initiative in which paramedics provide buprenorphine to treat withdrawal symptoms of those individuals reversed from an opioid use disorder. The program will utilize patient navigators to link these individuals to treatment services. The expansion of this initiative is expected in SFY 2023.

6. DMHAS continues to work to expand low threshold buprenorphine induction programming throughout the State. Many of these new and innovative programs (i.e. homeless shelters, harm reduction centers, paramedicine) are not taking place in traditional licensed SUD treatment programs. As is such, DMHAS has implemented new modules into its reporting system (NJSAMS) that would capture admissions at programming that does not take place at traditional licensed SUD programs. DMHAS believes capturing this information will lead to an increase in those accessing treatment services through our system.

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

Priority #: 3

Priority Area: Heroin/Opioid Users

Priority Type: SAT

Population(s): Other

Goal of the priority area:

To ensure medication assisted treatment (MAT) is provided as an option to individuals with an opioid use disorder (OUD) who are entering into substance use disorder (SUD) treatment.

Objective:

Increase the number of heroin/other opiate admissions for whom MAT is planned.

Strategies to attain the goal:

• Utilize a public awareness campaign focusing on reducing stigma/discrimination regarding MAT to assist in engaging individuals with an OUD, their families, friends, loved ones, providers and other community members so that they understand the use of MAT is a best practice in the treatment of an OUD.
• Buprenorphine Medical Support- This new initiative will focus on the challenges faced by licensed ambulatory SUD programs that require start-up funds to increase their capacity to offer MAT, specifically buprenorphine to their clients. Ambulatory SUD treatment programs will be expected to build capacity to offer MAT in compliance with all federal and New Jersey state regulations. Agencies will be required to receive referrals from other programs that offer MAT where clients stabilized on MAT.
• DMHAS will continue its Vivitrol Enhancement through its Fee-for-Service (FFS) Network. This enhancement allows providers to be reimbursed for the provision of Vivitrol as well as other ancillary services in FFS initiatives. Licensed SUD agencies can apply for the enhancement by submitting applications to DMHAS and are reviewed for approval on a quarterly basis.
• DMHAS is collaborating with NJ's 21 counties to establish MAT programs or enhance existing MAT services for inmates with OUD at county correctional facilities. In addition, DMHAS is working with county correctional facilities to establish justice involved re-entry services for detainees where case managers at county jails will conduct intake assessments and establish pre-release plans for needed services in the community, which include linking individuals to community MAT services.
• DMHAS will continue to distribute American Society of Addiction Medicine (ASAM) booklets entitled "Opioid Addiction Treatment: A Guide for Patients, Families and Friends" which provide facts about treatment, including MAT as a best practice, and provides NJ-specific resources to accessing treatment and recovery services.
• DMHAS has a Memorandum of Agreement (MOA) with Rutgers University, Robert Wood Johnson Medical School to develop a train-the-trainer program on MAT, the opioid epidemic (specific to New Jersey) and concepts of SUD (specific to OUD) for a minimum of 40 graduate students at Rutgers University. The goal of this project is to educate, support, and mentor graduate students to give free educational talks, through use of PowerPoint presentations, to the community.

Edit Strategies to attain the objective here:
(if needed)

• Continue to utilize a public awareness campaign focusing on reducing stigma/discrimination regarding MAT to assist in engaging individuals with an OUD, their families, friends, loved ones, providers and other community members so that they understand the use of MAT is a best practice in the treatment of an OUD and to support recovery.
• Buprenorphine Medical Support Initiative- Continuing this initiative which will focus on the challenges faced by licensed mental health programs that require start-up funds to increase their capacity to offer MAT, specifically buprenorphine to their clients. MH programs will be expected to build capacity to offer MAT in compliance with all federal and New Jersey state regulations.
• DMHAS will continue the Vivitrol Enhancement through its Fee-for-Service (FFS) Network. This enhancement allows providers to be reimbursed for the provision of Vivitrol as well as other ancillary services in FFS initiatives. Licensed SUD agencies can be enrolled in the enhancement if have proper approval of policies and procedures from the Department of Health, Certificate of Need & Licensing (CN&L).
• DMHAS will launch a Buprenorphine Enhancement, similar to the one created for Vivitrol, that will reimburse FFS Network providers for the provision of buprenorphine at their agencies. Licensed SUD agencies will be able to participate in the enhancement will proper approval from CN&L.
• DMHAS collaborates with 20 county jails that have established MAT programs or enhanced existing MAT services for inmates.. In addition, DMHAS works with county correctional facilities and have established justice involved re-entry services for detainees where case managers at county jails conduct intake assessments and establish pre-release plans for needed services in the community, which include linking individuals to community MAT services.
• DMHAS will continue to provide a statewide distribution of American Society of Addiction Medicine (ASAM) booklets entitled "Opioid Addiction Treatment: A Guide for Patients, Families and Friends" which provide facts about treatment, including MAT as a best practice, and provides NJ-specific resources to accessing treatment and recovery services. These guides are provided in English, Spanish and Braille, as well as are working with the NJ Division of Deaf and Hard of Hearing to have a video link of the booklet made in American Sign Language (ASL).
• DMHAS developed and will continue its Memorandum of Agreement (MOA) with Rutgers University, Robert Wood Johnson Medical School for a train-the-trainer program on Medication Assisted Treatment (MAT), the opioid epidemic (specific to New Jersey) and concepts of SUD (specific to OUD) for a minimum of 40 graduate students at Rutgers University. The goal of this project has been to educate, support, and mentor graduate students to give free educational talks, through use of PowerPoint presentations, to community businesses and organizations.
• Expand low threshold buprenorphine induction programming at all statewide Harm Reduction Centers (HRCs) while also continuing to encourage collaboration and affiliation agreements between the HRCs and substance use disorder agencies to ensure referral to comprehensive treatment programs, when clinically indicated.
• Development and expansion of its expanded hour Opioid Treatment Program (OTP) initiative in efforts to provide increased (i.e. evening) hours that are not typically provided in efforts to assist individuals with easier access to services.
• DMHAS will be issuing a Request for Proposal (RFP) which will fund cultural competence training that will be provided to narrow the treatment gap experienced by Black/African Americans (AA) who are diagnosed with opioid and stimulant use disorders and who are statistically less likely to receive or access services. A second goal of this initiative is to increase access to MAT through increased prescribing to the Black/AA community.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase the number of heroin/other opiate admissions for whom MAT was planned.

Baseline Measurement: SFY 2019: 20,887 heroin/other opiate admissions for whom MAT was planned.

First-year target/outcome measurement: Increase the number of heroin/other opiate admissions for whom MAT is planned by 1%

Second-year target/outcome measurement: Increase the number of heroin/other opiate admissions for whom MAT is planned by 2%. The change in SFY 2021 will be measured by calculating the percent difference from SFY 2019 to SFY 2021.

New Second-year target/outcome measurement*(if needed)*: A return to SFY 2019 baseline measurement. This target/outcome measurement is based on the FDA approval of COVID-19 vaccine and distribution to the population.

Data Source:

The number of heroin/other opiate admissions for whom MAT was planned from SFY 2019 - 2021 will be tracked by the SSA's New Jersey Substance Abuse Monitoring System (NJSAMS).

New Data Source*(if needed)*:

Description of Data:

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

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

None

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

Reason why target was not achieved, and changes proposed to meet target:
SFY 2019: 20,887 heroin/other opiate admissions for whom MAT was planned
SFY 2020: 19,134 heroin/other opiate admissions for whom MAT was planned

In SFY 2020, there were 1,753 less heroin/other opiate admissions for whom MAT was planned than in SFY 2019 or an approximately 8.39% decrease in admissions count.

The COVID-19 pandemic has affected new admissions to treatment negatively, in that there are many individuals in our State that have either been in quarantine, mandated to stay-at-home orders, or fearful to attend a new program in person, specifically an OTP for methadone, as the initial visit is required to be face-to-face. Also, various options to receive medications for OUD now exist (i.e. Federally Qualified Healthcare Centers, Office Based Addiction Treatment programs) that are not licensed SUD treatment programs, therefore are not required to enter data into our NJSAMS reporting system.

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

Second Year Target: ☑ Achieved ☐ Not Achieved *(if not achieved,explain why)*

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

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

SFY 2019: 20,887 heroin/other opiate admissions for whom MAT was planned
SFY 2020: 19,134 heroin/other opiate admissions for whom MAT was planned
SFY 2021: 21,284 heroin/other opiate admissions for whom MAT was planned

In SFY 2021, there were 397 more heroin/other opiate admissions for whom MAT was planned than in SFY 2019 or an approximately 1.9% increase from baseline year.

The NJ Department of Health, Certificate of Need & Licensing (CN&L) continues to license new opioid treatment programs (OTPs) throughout the State. In SFY 2021 (during the COVID-19 pandemic), CN&L licensed four new ambulatory OTPs. Statewide licensed ambulatory OTPs now total 46, with a minimum of one in each of the State's 21 counties, ensuring better access of medications to be planned in an individual's treatment episode. DMHAS also continues to fund a public awareness campaign through State Opioid Response (SOR) grant funds, to focus on reducing stigma and discrimination for the use of medications in treatment of opioid use disorder (OUD). This is a statewide campaign that utilizes television and radio advertisements, billboards and social media to promote the use of medication to support an individual's recovery. The target audience for the campaign are individuals with a substance use disorder, as well as their families and friends.

Priority #: 4

Priority Area: Tobacco

Priority Type: SAP

Population(s): PP, Other (Persons aged 12 – 17)

Goal of the priority area:

Reduce the percentage of persons aged 12 – 17 who report using any type of tobacco product in the past month

Objective:

Decreased past month use of tobacco products among persons aged 12 to 17.

Strategies to attain the goal:

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

Environmental Strategies
• Enhance Access/Reduce Barriers – Enhance access to effective prevention strategies and information through the use of a social media campaign and the development of human capital and networks of support.
• Enhance Barriers/Reduce Access - Increase education among merchants who sell tobacco products.
• Enhance Barriers/Reduce Access – Work with municipal and county government to ban smoking from restaurants and other public places, including schools, workplaces, and hospitals.
• Change Consequences/Enhance Access/Reduce Barriers – Work with municipal and county government to assure that tobacco laws are enforced at the local level.
• Change Physical Design – Through the compliance check report and GIS mapping, provide municipalities and state tobacco control with details regarding how outlet density and location impact tobacco availability to youth.
• Modify/Change Policies – Enhance or create policies related to smoking among 12-17 years olds on a countywide level.

Individual Strategies
• Provide information – Educate parents and youth on the dangers of tobacco use by youth through awareness efforts, workshops, and countywide events. These programs will be provided through county alcohol and drug funding, municipal alliances, and other community organizations.
• Provide Information – Educate youth on the dangers of tobacco use through by means of evidence-based middle and elementary school prevention programs and other community-based initiatives.

Legislation
• The State of New Jersey enacted a statute to raise the age to sell tobacco products from persons 19 years of age to 21 years of age effective November 1, 2017 (P.L.2017, Chapter 118).

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

Edit Strategies to attain the objective here:
(if needed)

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Past month tobacco product use (any) among persons aged 12 to 17.

Baseline Measurement: According to 2016-2017 NSDUH data, 4.14 percent of the target population reported tobacco product use (any) during the month prior to participating in the survey.

First-year target/outcome measurement: A reduction of .50% below the baseline measure.

Second-year target/outcome measurement: An additional reduction of .25% below the first year measure.

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

Data Source:

National Survey on Drug Use and Health: Model-Based Prevalence Estimates (50 States and the District of Columbia), Tobacco Product Use in the Past Month, by Age Group and State: Percentages, Annual Averages Based on 2016 and 2017 NSDUH – data for New Jersey

New Data Source*(if needed)*:

National Survey on Drug Use and Health: Model-Based Prevalence Estimates (50 States and the District of Columbia), Tobacco Product Use in the Past Month, by Age Group and State: Percentages, Annual Averages Based on 2016-2017, 2017-2018, and 2018-2019 NSDUH data for New Jersey.

Description of Data:

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

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

None

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

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

How first year target was achieved *(optional)*:
According to 2017-2018 NSDUH data, 3.59 percent of the target population reported tobacco product use (any) during the month prior to participating in the survey. The measure was .55 percent less than in the previous year

Second Year Target: ☑ Achieved ☐ Not Achieved *(if not achieved,explain why)*

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

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

According to 2018-2019 NSDUH data, 2.96 percent of the target population reported tobacco product use (any) during the month prior to participating in the survey. The measure was .63 percent less than in the previous year.

Our regional coalitions conducted extensive tobacco merchant education during this period.

Priority #: 5

Priority Area: Alcohol

Priority Type: SAP

Population(s): PP, Other (Persons aged 12-17)

Goal of the priority area:

Reduce the percentage of persons aged 12 – 17 who report binge drinking in the past month

Objective:

Decreased past month of binge drinking among persons aged 12 to 17

Strategies to attain the goal:

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

Environmental Strategies
• Enhance Access/Reduce Barriers – Enhance access to effective prevention strategies and information through the use of a social media campaign and the development of human capital and networks of support.
• Enhance Barriers/Reduce Access - Increase education among merchants, bars, and restaurants who sell alcoholic beverages. Also, provide education to parents and guardians.
• Change Consequences/Enhance Access/Reduce Barriers – Work with municipal and county government to assure that underage drinking laws are enforced at the local level.
• Change Physical Design – Through the compliance check report and GIS mapping, provide municipalities and state Alcoholic Beverage Commission with details regarding how outlet density and location impact tobacco availability to youth.
• Modify/Change Policies – Enhance or create policies related to underage drinking among 12-17 years olds on a countywide level.

Individual Strategies
• Provide information – Educate parents and youth on the dangers of underage drinking by youth through awareness efforts, workshops, and countywide events. These programs will be provided through county alcohol and drug funding, municipal alliances, and other community organizations.
• Provide Information – Educate youth on the dangers of underage drinking by means of evidence-based middle and elementary school prevention programs and other community-based initiatives.

Edit Strategies to attain the objective here:
(if needed)

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Binge Alcohol Use in the Past Month by persons aged 12-17.

Baseline Measurement: According to 2016-2017 NSDUH data, 5.48 percent of the target population reported binge drinking during the month prior to participating in the survey.

First-year target/outcome measurement: A reduction of .20% below the baseline measure.

Second-year target/outcome measurement: An additional reduction of .20% below the baseline measure.

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

Data Source:

Binge Alcohol Use in the Past Month, by Age Group and State: Percentages, Annual Averages Based on 2016 and 2017 NSDUH – data for New Jersey

New Data Source*(if needed)*:

Binge Alcohol Use in the Past Month, by Age Group and State: Percentages, Annual Averages Based on 2016-2017, 2017-2018, and 2018 -2019 NSDUH data for New Jersey.

Description of Data:

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

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

None

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

Reason why target was not achieved, and changes proposed to meet target:
According to 2017-2018 NSDUH data, 5.77 percent of the target population reported binge drinking during the month prior to participating in the survey. The number for 2016-2017 was 5.48 percent.

Research on binge drinking has shown it to be a behavior that is strongly related to social circumstances. Binge drinking is more prevalent among males, and occurs at much higher rates in specific social environments. Interventions designed to change perceptions of harm and acceptability of binge drinking are particularly important for young people in high risk circumstances. Therefore, DMHAS-funded prevention agencies and coalitions will intensify their efforts by implementing additional evidence-based programs and approaches designed to affect perceptions among 12-17 year olds.

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

Second Year Target: ☐ Achieved ☑ Not Achieved *(if not achieved,explain why)*

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

According to 2018-2019 NSDUH data, 5.26 percent of the target population reported binge alcohol use during the month prior to participating in the survey. The measure was .51 percent less than in the previous year. However, even though very close, this does not represent a target reduction of .40 percent from the baseline measure of 5.48 percent.

Research on binge drinking has shown it to be a behavior that is strongly related to social circumstances. Binge drinking is more prevalent among males, and occurs at much higher rates in specific social environments. Interventions designed to change perceptions of harm and acceptability of binge drinking are particularly important for young people in high risk circumstances. Therefore, DMHAS-funded prevention agencies and coalitions will intensify their efforts by implementing additional evidence-based programs and approaches designed to affect perceptions among 12-17 year olds.

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

Priority #: 6

Priority Area: Marijuana

Priority Type: SAP

Population(s): PP, Other (Persons aged 12-17)

Goal of the priority area:

Decrease the percentage of persons aged 12 – 17 who report Marijuana Use in the Past Year.

Objective:

Decreased use of marijuana in the past year among persons aged 12 to 17.

Strategies to attain the goal:

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

Environmental Strategies
• Enhance Access/Reduce Barriers – Enhance access to effective prevention strategies and information through the use of a social media campaign and the development of human capital and networks of support.
• Change Consequences/Enhance Access/Reduce Barriers – Work with municipal and county government to assure that marijuana use and possession laws are enforced at the local level.
• Modify/Change Policies – Enhance or create policies, laws, and ordinances related to marijuana use among 12-17 years olds on a countywide level.

Individual Strategies
• Provide information – Educate parents and youth on the dangers of marijuana use by youth through awareness efforts, workshops, and countywide events. These programs will be provided through county alcohol and drug funding, municipal alliances, and other community organizations.
• Provide Information – Educate youth on the dangers of marijuana use by means of evidence-based middle and elementary school prevention programs and other community-based initiatives.

Edit Strategies to attain the objective here:
(if needed)

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Marijuana Use in the Past Year by persons aged 12-17.

Baseline Measurement: According to 2016-2017 NSDUH data, 10.28 percent of the target population reported marijuana use during the year prior to participating in the survey.

First-year target/outcome measurement: A reduction of .10% below the baseline measure.

Second-year target/outcome measurement: An additional reduction of .10% below the baseline measure.

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

Data Source:

Marijuana Use in the Past Year, by Age Group and State: Percentages, Annual Averages Based on 2016 and 2017 NSDUH – data for New Jersey

New Data Source*(if needed)*:

Marijuana Use in the Past Year, by Age Group and State: Percentages, Annual Averages Based on 2016-2017, 2017-2018, and 2018-2019 NSDUH data for New Jersey

Description of Data:

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

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

None

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

Reason why target was not achieved, and changes proposed to meet target:
According to 2017-2018 NSDUH data, 11.07 percent of the target population reported marijuana use during the year prior to participating in the survey.

The increase was slight (.79 percent) and can possibly be attributed to easier access related to medical marijuana. When it becomes easier for people to get marijuana, it means that they use more and have more in their homes. This in turn means that those who don't have medical marijuana cards – including teens and young adults – have increased access to the drug and may be more inclined to use and abuse it.

On November 3, 2020, NJ legalized the recreational use of marijuana. The issue of access will increase dramatically and require a strong and unified approach from the prevention community. We will be guided by the successful efforts of other states that have faced the same challenge.

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

Second Year Target: ☑ Achieved ☐ Not Achieved *(if not achieved,explain why)*

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

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

According to 2018-2019 NSDUH data, 6.69 percent of the target population reported marijuana use during the month prior to participating in the survey. The measure was 4.38 percent less than in the previous year. This was a dramatic reduction beyond the .20 reduction we targeted.

In advance of the 2020 vote to legalize the recreational use of marijuana in NJ, there was a coordinated and unified effort in NJ's prevention community (public and private entities) to reduce marijuana use among youth.

Priority #: 7

Priority Area: Prescription Drugs

Priority Type: SAP

Population(s): PP, Other (All residents in New Jersey)

Goal of the priority area:

Decrease the percentage of persons who were prescribed opioids in the past year.

Objective:

Decreased prescribing of analgesic opioids in the past year to all persons in New Jersey.

Strategies to attain the goal:

Education: Educational programs and webinars regarding CDC Guideline for Prescribing Opioids for Chronic Pain.

Edit Strategies to attain the objective here:
(if needed)

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Opioid Dispensations in New Jersey.

Baseline Measurement: According to data from NJ CARES – A Realtime Dashboard of Opioid-Related Data and Information (maintained by the Office of the New Jersey Attorney General), in 2018, 4,266,645 prescriptions for opioids were provided in New Jersey.

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

Second-year target/outcome measurement: An additional reduction of .50% below the baseline measure.

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

Data Source:

NJ CARES – A Realtime Dashboard of Opioid-Related Data and Information (maintained by the Office of the New Jersey Attorney General)

New Data Source*(if needed)*:

Description of Data:

Prescription Drug Monitoring Program data provided by the NJ Attorney General's Office

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

None

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

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

How first year target was achieved *(optional)*:
According to data from NJ CARES – A Realtime Dashboard of Opioid-Related Data and Information (maintained by the Office of the New Jersey Attorney General), in 2019, 3,990,809 prescriptions for opioids were provided in New Jersey.

6.46 percent fewer opioid prescriptions were written in 2019 than in 2018.

Second Year Target: ☑ Achieved ☐ Not Achieved *(if not achieved,explain why)*

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

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

According to data from NJ CARES – A Realtime Dashboard of Opioid-Related Data and Information (maintained by the Office of the New Jersey Attorney General), in 2020, 3,637,522 prescriptions for opioids were provided in New Jersey.

8.85 percent fewer opioid prescriptions were written in 2020 than in 2019 .

In order to address the public health crisis presented by the substance use disorder, P.L. 2017, Chapter 28, The New Jersey Substance Use Disorder Law was enacted in NJ on February 15, 2017. The law sets certain coverage requirements for the treatment of substance use disorders and regulates prescriptions of opioid drugs. Effective March 1, 2017, the law placed a five-day limit on initial opioid prescriptions and certain requirements for subsequent prescriptions for opioid drugs.

Funded through SAMHSA's State Opioid Response grant and Governor Murphy's initiative to address the opioid epidemic in New Jersey, DMHAS issued an RFP to increase awareness and focus on non-opioid pain management strategies, reduce the use of opioids in Emergency Departments (EDs) and the subsequent prescribing of opioids at ED discharge. Funding was available for FFY 2019 and FFY 2020. According to a 2015 study of opioid prescribing in a cross section of U.S. EDs, 17% of discharged patients received an opioid prescription; DMHAS seeks a reduction in opioid prescriptions written in New Jersey's EDs at discharge to 12% or lower.

Though there are numerous pain management programs, most deal with chronic pain, not acute pain, the type of pain that ED physicians treat. In its effort to help stem the over-prescribing of opioids, DMHAS developed an Opioid Reduction Options (ORO) Plan that is geared to assisting health facilities in minimizing the use of opioids as the first line of treatment in New Jersey EDs where clinically indicated. The ORO program promotes the CERTA concept: channels, enzymes, receptors, targeted, analgesia. The CERTA concept optimizes the following medication classes in place of opioids: Cox-1, 2, 3 inhibitors, N-methyl-D-aspartate ("NMDA") receptor antagonists, sodium channel blockers, nitrous oxide, inflammatory cytokine inhibitors and gamma-Aminobutyric acid ("GABA") agonists/modulators. Specific agents include NSAIDs and acetaminophen, ketamine, lidocaine, nitrous oxide, corticosteroids, benzodiazepines and gabapentin.

Three tiers were established which have different levels of expectation: Gold, Silver, and Bronze. Hospitals could apply for one of the tiers and were required to participate in a Learning Community tailored to the tier. In July 2019, DMHAS granted ORO awards to 11 hospitals, 10 Gold and 1 Silver. A new RFP was released in March 2021. Awards were made in May 2021 to four hospitals, 3 Gold and 1 Sliver tier.

Priority #: 8

Priority Area: Heroin

Priority Type: SAP

Population(s): PP, Other (Persons aged 12-17)

Goal of the priority area:

Increase the percentage of persons aged 12 – 17 who report perceptions of Great Risk from Trying Heroin Once or Twice

Objective:

Increased perceptions of Great Risk from Trying Heroin Once or Twice among persons aged 12 to 17.

Strategies to attain the goal:

Beginning in January 2012, DMHAS funded 17 Regional Prevention Coalitions, all of whom utilize the SPF model to guide their work. These coalitions are all required to address the use of illegal substances (including heroin) among youth. The coalitions use, primarily, environmental strategies along with occasional individual approaches as appropriate. Below is a listing of approaches used by the coalitions to address perceptions of risk regarding heroin use among adolescents in their regions.

Environmental Strategies
• Enhance Access/Reduce Barriers – Enhance access to effective prevention strategies and information through the use of a social media campaign and the development of human capital and networks of support.
• Change Consequences/Enhance Access/Reduce Barriers – Work with municipal and county government to assure that laws regarding the use of illegal substance (including heroin) are enforced at the local level.
• Modify/Change Policies – Enhance or create policies designed to increase perceptions of risk and harm related to the use of heroin among 12-17

years olds on a countywide level.

Individual Strategies
• Provide information – Educate parents and youth on the dangers of illegal substances (including heroin) by youth through awareness efforts, workshops, and countywide events. These programs will be provided through county alcohol and drug funding, municipal alliances, and other community organizations.
• Provide Information – Educate youth on the dangers of illegal substance and heroin use by means of evidence-based middle and elementary school prevention programs and other community-based initiatives.

Edit Strategies to attain the objective here:
(if needed)

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Perceptions of Great Risk from Trying Heroin Once or Twice among persons aged 12-17.

Baseline Measurement: According to 2016-2017 NSDUH data, 68.23 percent of the target population reported Perceptions of Great Risk from Trying Heroin Once or Twice.

First-year target/outcome measurement: An increase of .50% above the baseline measure.

Second-year target/outcome measurement: An additional increase of .50% above the baseline measure.

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

Data Source:

Perceptions of Great Risk from Trying Heroin Once or Twice, by Age Group and State: Percentages, Annual Averages Based on 2016 and 2017 NSDUH – data for New Jersey

New Data Source*(if needed)*:

Perceptions of Great Risk from Trying Heroin Once or Twice, by Age Group and State: Percentages, Annual Averages Based on 2016-2017, 2017-2018, and 2018-2019 NSDUH data for New Jersey

Description of Data:

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

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

None

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

Reason why target was not achieved, and changes proposed to meet target:
According to 2017-2018 NSDUH data, 68.32 percent of the target population reported Perceptions of Great Risk from Trying Heroin Once or Twice.

The increase in perception of risk and harm related the use of heroin once or twice was negligible (.09 percent). However, in 2018 NJ-DMHAS implemented programs that focus specifically on the misuse of opioid pain relievers among adolescents. One program addresses perceptions of risk and harm regarding the use of opioid analgesics by young athletes for sports-related injuries. The positive effects of these programs would not yet be reflected in 2017-2018 NSDUH data.

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

Second Year Target: ☐ Achieved ☑ Not Achieved *(if not achieved,explain why)*

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

Uncertain as to why the target was not achieved. Multiple state government departments and divisions (as well as community-based organizations) provide evidence-based programs and strategies that focus on the harms associated with opioids. However, there is little coordination of effort among the various providers. A more unified approach would certainly have greater impact. According to NSDUH, however, NJ's rate (66.82), is higher than that for the US (63.72) or the Northeast (65.69).

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

Priority #: 9

Priority Area: TB

Priority Type: SAT

Population(s): TB

Goal of the priority area:

Increase compliance rate of DMHAS' SAPT Block Grant contracted agencies offering every client a tuberculosis evaluation.

Objective:

Increase the percentage of DMHAS' SAPT Block Grant contracted agencies offering every client a tuberculosis evaluation

Strategies to attain the goal:

• Notifications. All block grant recipients will be notified of the contractual and regulatory requirements to screen all clients for TB symptoms. Methods used will be a formal letter to all block grant recipients and an overview presented at the next quarterly Professional Advisory Committee (PAC) and other upcoming Division/agency meetings.
• Ongoing monitoring. Monitors will review compliance during the annual site visit, and require an acceptable plan of correction for non-compliance. If repeat deficiencies are found, an alternate plan of correction and proof of implementation will be required.

Edit Strategies to attain the objective here:
(if needed)

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Annual Site Monitoring Report of DMHAS' SAPT Block Grant contracted agency indicating that client was offered a tuberculosis evaluation.

Baseline Measurement: According to SFY 2019 Annual Site Monitoring Reports of DMHAS' SAPT Block Grant contracted agencies, 75% of the agencies that were monitored (27 of 36 agencies) were in compliance with offering every client a tuberculosis evaluation.

First-year target/outcome measurement: An increase of 5% above the baseline measure.

Second-year target/outcome measurement: An additional increase of 5% above the baseline measure.

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

Data Source:

Annual Site Monitoring Reports of DMHAS' SAPT Block Grant Contracted Agencies

New Data Source*(if needed)*:

Description of Data:

The grants monitoring program at DMHAS monitor SAPT Block Grant recipients. Onsite visits are made to each SAPT Block Grant recipient a minimum of one time per calendar year. The reviewer conducts chart reviews for the selected sample and completes an Annual Site Monitoring Report. The Annual Site Monitoring Report addresses at a minimum five core areas of performance: Facility, Staff, Treatment Records, Quality Assurance, Specialized Services, and Other contract requirements.

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

None

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

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

How first year target was achieved *(optional)*:
The planned agency notification and monitoring strategies were implemented.

According to SFY 2020 Annual Site Monitoring Reports of DMHAS' SAPT Block Grant contracted agencies, 87% of the agencies that were monitored (26 of 30 agencies) were in compliance with offering every client a tuberculosis evaluation.

Second Year Target: ☐ Achieved ☑ Not Achieved *(if not achieved,explain why)*

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

According to SFY 2021 Annual Site Monitoring Reports of DMHAS' SAPT Block Grant contracted agencies, 83% of the agencies that were monitored (30 of 36 agencies) were in compliance with offering every client a tuberculosis evaluation.

DMHAS did not meet its second year goal of 85% compliance rate by 2%. The notification to agencies reminding them of the requirement was not planned for or conducted in year two.

In addition to annual monitoring and plan of correction requirements, a letter will be sent to each agency at the end of each FY reminding them of the Tb screening requirements.

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

Priority #: 10

Priority Area: In coordination with New Jersey's Aligning Early Childhood with Medicaid (AECM) technical assistance project, DCF/ Children's System of Care (CSOC) will develop and implement screening, identification, and intervention among at risk children age 0-3

Priority Type: MHS

Population(s): SED

Goal of the priority area:

NJ Children's System of Care (CSOC) will collaborate with system partners to develop and implement screening, identification, and intervention among at risk children age 0-3.

Objective:

CSOC will develop a completed plan for screening, care coordination, and development of infant mental health service capacity for at risk children age 0-3.

Strategies to attain the goal:

New Jersey has joined Aligning Early Childhood and Medicaid, a multi-state initiative aimed at improving the health and social outcomes of low-income infants, young children, and families through cross-agency collaboration. This national program is led by the Center for Health Care Strategies (CHCS) in partnership with the National Association of Medicaid Directors and ZERO TO THREE. Through this 20-month initiative, participating states will:

1.Align state programs and investments between Medicaid and other early childhood systems to drive more strategic, evidence-based investments for infants and toddlers in low-income families; and
2.Demonstrate the value of early childhood cross-sector alignment for improving near- and long-term health and social outcomes.

NJ DCF/CSOC has identified the following goals:

1. Identify and adopt best practice standards to identify social-emotional, behavioral, and social determinant health risk in the pediatric medical home, including creating a plan to implement a strategy to increase capacity for stratified care coordination in the pediatric medical home to effect linkage to behavioral health and other services by January 2020.

2. Develop a written strategy, including programmatic recommendations and funding options to provide infant mental health services on a statewide

basis by July 2020.

3. Drafting a State Plan Amendment expanding the use of care coordination and community health workers to ensure new mothers and their infants stay connected to physical and behavioral health care, and other health influencing benefits, such as food, housing and child care across the health care delivery system.

Edit Strategies to attain the objective here:
(if needed)

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Completed plan for screening, care coordination, and development of infant mental health srvice capacity for at risk children age 0-3

Baseline Measurement: To be determined after the first year of implementation of screening services to children age 0-3

First-year target/outcome measurement: An increase in the percentage of children age 0-3 receiving screening srvices in SFY 2021. The percentage will be determined when the baseline measure is set.

Second-year target/outcome measurement: An increase in the percentage of children age 0-3 receiving screening srvices in SFY 2022. The percentage will be determined when the baseline measure is set.

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

Data Source:

DCF will implement their anticipated project-related goals(s) and activities, and track progress over time.
PerformCare NJ - the CSOC Administrative Services Organization

New Data Source*(if needed)*:

Description of Data:

DCF self- assessment and written organizational plans.
The number of children age 0-3 receiving screening services during a specified state fiscal year.

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

The baseline measurement of will be determined after the first year of implementation of screening services to children age 0-3.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

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

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

Second Year Target: ☐ Achieved ☐ Not Achieved *(if not achieved,explain why)*

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

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

Priority #: 11

Priority Area: NJ Children's System of Care (CSOC) will continue to increase the integration of community-based physical and behavioral health services for children, youth and young adults with mental/behavioral health challenges and/or substance use challenges and

chronic medical conditions

Priority Type: MHS

Population(s): SED

Goal of the priority area:

The New Jersey Children's System of Care (CSOC) will increase integration of community-based physical and behavioral health services for children, youth and young adults with mental/behavioral health challenges and/or substance us challenges and chronic medical conditions.

Objective:

1. Implement at least one expansion or enhancement of integrated health and behavioral health services.

2. Increase the number of children youth and young adults receiving integrated physical and behavioral health care services.

Strategies to attain the goal:

In order to further operationalize the DCF vision of ensuring New Jersey children and families are safe, healthy and connected, the Department of Children and Families has revised its Strategic Plan to best align the priorities of CSOC with the DCF vision and values. The Strategic Plan identifies promoting integrated health and behavioral health as a priority. Integrated care and wellness activities will be incorporated across the CSOC continuum by expanding existing integration models and exploring development of other primary health-behavioral health integration models.

Currently, NJ's Behavioral Health Homes (BHH) are operational in Bergen, Mercer, Cape/Atlantic, and Monmouth counties. Each BHH is a designated Care Management Organization (CMO) with enhanced care management teams that include medical expertise and health/wellness education for purposes of providing fully integrated and coordinated care for youth remaining in their home and who have chronic medical conditions. Each BHH employs Nurse Managers (1-40 ratio) and Health and Wellness coaches (1-65 ratio). Nurse Managers are required to hold a New Jersey Registered Nurse (RN) license or higher nursing credential. Health and Wellness Coaches are required to have a Bachelor's Degree and two years of experience in nutrition, health education or a related field.

BHH services are a "bridge" that connects prevention, primary care, and specialty care. Medical and wellness staff are integrated into the existing CMO Child Family Team (CFT) structure responsible for care coordination and comprehensive treatment planning for youth and their families which includes planning for the holistic needs of the youth. The CFT structure and approach (CMO, FSO, Family, Youth and other designated service providers and supports) enhanced with BHH RN, Health/Wellness Coach staffing plans for the holistic needs of a youth with both behavioral health and medical needs (inclusive of substance use and developmental and intellectual challenges). Nurse Manager and Health/Wellness staff communicate with youth's medical providers (primary care specialty providers, urgent or emergent medical care) and connect the medical domain and planning with the existing CFT process.

New Jersey is among the first states using Targeted Case Management (TCM) to deliver Behavioral Health Home services for youth only.

The structure of the CMO is a strategic fit for the health home program. The BHH Core Team builds on the current CMO array of staff with the intent to provide a holistic approach to care for children. This expanded team will constitute the services of the BHH and will broaden the current CMO care coordination and care management functions to include the ability to identify, screen and coordinate both primary care and specialty medical care.

During SFY 2018, 484 youth were enrolled in BHH services. To be eligible, youth must meet the criteria for CMO and have a qualifying medical condition which is inclusive of intellectual and developmental challenges as well as substance use.

Place background information on Certified Community Behavioral Health Clinics (CCBHCs) here. Include number of children served during SFY 2018

Edit Strategies to attain the objective here:
(if needed)

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Increased number of children, youth or young adults provided with integrated physical and behavioral health services.
Baseline Measurement:	In SFY 2019 CSOC proved Behavioral Health Home services to 503 youth.
First-year target/outcome measurement:	CSOC will increase the number of youth served by Behavioral Health Homes/other

Integrated Care models by 5%. Target outcome measurement is 528 youth.

Second-year target/outcome measurement: CSOC will increase the number of youth served by Behavioral Health Homes/other Integrated Care models by 5%. Target outcome measurement is 554 youth.

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

Data Source:

Performcare NJ - the NJ DCF/CSOC Administrative Services Organization

New Data Source*(if needed)*:

Description of Data:

Number of youth receiving Behavioral Health Home/integrated physical and behavioral health services in a specified state fiscal year.

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

None.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

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

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

Second Year Target: ☐ Achieved ☐ Not Achieved *(if not achieved,explain why)*

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

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

Priority #: 12

Priority Area: NJ Children's System of Care (CSOC) will increase access to evidence-based services and supports across the CSOC service continuum

Priority Type: MHS

Population(s): SED

Goal of the priority area:

CSOC will increase access to evidence-based services and supports across the CSOC service continuum.

Objective:

Plan, implement, and evaluate at least 1 evidence-based program, the In-Home Recovery Program, to support youth and families with substance use disorders who are involved with the Department of Children and Families Division of Child Protection and Permanency. The In-Home Recovery Program is an innovative pilot program seeking to improve outcomes for parents who have a substance use disorder and are actively parenting a child under 36 months.

Strategies to attain the goal:

In order to further operationalize the DCF vision of ensuring New Jersey children and families are safe, healthy and connected, the Department of Children and Families has revised its Strategic Plan to best align the priorities of CSOC with the DCF vision and values. The Strategic Plan identifies building capacity to deliver evidence-based interventions and services as a priority. CSOC will support evidence-based practices in the continuum by increasing EBP capacity in both community-based and out of home services

The Nicholson Foundation, in partnership with New Jersey Department of Children and Families (NJDCF), issued a Request for Proposals (RFP) to solicit proposals for a family-based recovery program from New Jersey–based mental health and substance use disorder treatment providers serving adults,

families, and/or young children.

The goals of the In-Home Recovery Program (the Program) are to improve outcomes for parents who have a substance use disorder and are actively parenting a child under 36 months old and to expand the service array for these families through implementation of a specific evidence-informed, in-home treatment program. Post-intervention changes on parental substance use and involvement with child protective services will be evaluated. The RFP process will result in one award for the implementation of two (2) Project sites within Ocean County, NJ managed by one agency. Each Project team will treat a caseload of twelve (12) families concurrently and serve a minimum of eighteen (18) families over the 18-month grant period, beginning on September 1, 2019, for a budget not to exceed $1,064,855.

An important objective of the Program is to demonstrate the effectiveness of a trauma informed in-home treatment for families involved with the NJDCF Division of Child Protection and Permanency (DCP&P) who have an index parent (client) with a substance use disorder and an index child (child) under the age of 36 months. Outcome measures will include parental substance use, child placement at discharge, and a client's repeat involvement with child protective services.

Key model components include toxicology testing (for clinical purposes only); positive reinforcement in the form of gift cards/vouchers for positive behavioral change (negative toxicology screen); collaboration with DCF regarding the clients progress, success, or any concerns about functioning; collaboration with MAT providers; outreach to support client's participation; utilization of standardized measures to inform and guide treatment, and identify and track symptoms over the course of the intervention; and tools for obtaining family history and the fit between the client and the clients family system.

Measures are divided into three domains: client, child, and parent-child relationship. Areas of focus in the three domains are as follows:
a. client: depression, anxiety, post-traumatic stress, and childhood trauma history;
b. child: development, resilience, behaviors, and trauma exposure; and
c. parent-child relationship: parenting stress, parental reflective capacity, attachment styles, and parenting attitudes.

The full text of the RFP is available here:
https://thenicholsonfoundation.org/news-and-resources/request-proposals-trauma-informed-recovery-program-ocean-county

Additionally,the following evidence based programs are currently provided by CSOC

Functional Family Therapy for Foster Care (FFT-FC)

CSOC in partnership with the Division of Child Protection and Permanency (DCP&P) and a local provider offer access to and service delivery of Functional Family Therapy – Foster Care (FFT-FC) through the CSOC Mobile Response and Stabilization Service and Intensive In-Community service lines. FFT is a relationally focused, trauma informed, evidence-based treatment model for youth in resource care that increases the likelihood of successful adjustment for youth in their resource placements as well as positive permanency outcomes. This treatment model is targeted toward youth aged 12-18 who are demonstrating behaviors that place them at risk of disruption in their resource care placement and are in the legal custody of the DCP&P and have the intellectual capacity to benefit from the treatment intervention. The model uses the relationally focused techniques of Functional Family Therapy (FFT) in a comprehensive and systemic approach adapted to helping youth and families involved with DCP&P to overcome individual and relational trauma to promote placement stability, increase youths' lifelong connections and improve youths' permanency outcomes.

Function Family Therapy (FFT) and Multi-Systemic Therapy (MST)

Beginning in 2008, through an RFP process DCF established providers of Multi-systemic Therapy (MST) and Functional Family Therapy (FFT) in New Jersey. MST and FFT have proven efficacy with youth involved in the juvenile justice system through dozens of empirically validated and peer-reviewed studies. Too often, the child welfare system endeavors to serve these youth and families with inadequate resources and misdirected efforts. Consistent with the needs of many families served by the child welfare system, the challenges at hand are best served by intensive, "whatever it takes" treatment by well-trained and qualified professionals. As evidence-based practices, the licensing and program requirements for providers of MST and FFT, from start-up through on-going delivery of service, are stringent. The goal was to have national organizations ensure that local implementation maintains fidelity to the treatment model to ensure outcomes are consistent with other states. Awards were granted around June 2008. There are currently 5 CSOC-contracted agencies providing FFT/MST. During SFY XXXchildren, youth and young adult received FFT/MST services.

ARC-GROW Model
CSOC, through the Intensive In-Community (IIC) service line, in partnership with the Children's Center for Resilience and Trauma Recovery (CCRTR), and MRSS and CMO partners, offers access to and delivery of the ARC-GROW model. The ARC-GROW Model is an adaptation of the Attachment, Regulation, and Competency framework for intervention with youth and families who have experienced multiple and/or prolonged traumatic stress. The Attachment, Self-Regulation, and Competency (ARC) framework is a core-components treatment model, developed to provide a guiding framework for thoughtful clinical intervention with complexly traumatized youth from early childhood to adolescence and their caregiving systems. GROW is a caregiver skill building intervention designed to enhance resilient outcomes for families who are impacted by chronic adversity or stress (Kinniburgh et al. 2011). This parenting support program is delivered as a 12-session home visiting service by parent support workers or clinical staff providing safety and stabilization support. The home visiting hours include psychoeducation and skill practice in areas including, but not limited to, caregiver self-care, attunement to the developmental impact of trauma, supporting child/youth regulation, effective parenting practices and strategies for building daily routines.

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Under New Jersey's child welfare modified settlement agreement (MSA), the State was required to seek approval from the federal government for a Medicaid rate structure "to support the use of new services for children and families, including community-based and evidence-based informed, or support practices, such as Functional Family Therapy and Multi-Systemic Therapy" (Section II.C.2 of the MSA).

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There are currently 5 CSOC-contracted agencies providing evidence-based practices.

• Functional Family Therapy (FFT):
• Atlantic and Ocean Counties
Cape Counseling and Jewish Family Services
• Burlington and Ocean Counties
Community Treatment Solutions
• Cumberland, Gloucester and Salem Counties
Robins' Nest

• Multisystemic Therapy (MST):
• Camden County
Center for Family Services
• Hudson and Essex Counties
Community Solutions, Inc.

CSOC plans to undertake a comprehensive review of its evidence-based practices, in terms of utilization and outcomes, to ensure these services are having the expected, positive impact on the lives of children and families.

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There are currently 5 CSOC-contracted agencies providing evidence-based practices.

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• Camden County
Center for Family Services
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Community Solutions, Inc.

CSOC plans to undertake a comprehensive review of its evidence-based practices, in terms of utilization and outcomes, to ensure these services are having the expected, positive impact on the lives of children and families.

ARC-GROW Model
CSOC, through the Intensive In-Community (IIC) service line, in partnership with the Children's Center for Resilience and Trauma Recovery (CCRTR), and MRSS and CMO partners, offers access to and delivery of the ARC-GROW model. The ARC-GROW Model is an adaptation of the Attachment, Regulation, and Competency framework for intervention with youth and families who have experienced multiple and/or prolonged traumatic stress. The Attachment, Self-Regulation, and Competency (ARC) framework is a core-components treatment model, developed to provide a guiding framework for thoughtful clinical intervention with complexly traumatized youth from early childhood to adolescence and their caregiving systems. GROW is a caregiver skill building intervention designed to enhance resilient outcomes for families who are impacted by chronic adversity or stress (Kinniburgh et al. 2011). This parenting support program is delivered as a 12-session home visiting service by parent support workers or clinical staff providing safety and stabilization support. The home visiting hours include psychoeducation and skill practice in areas including, but not limited to, caregiver self-care, attunement to the developmental impact of trauma, supporting child/youth regulation, effective parenting practices and strategies for building daily routines.

Edit Strategies to attain the objective here:
(if needed)

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	In coordination with the NJ Department of Children and Families, the Nicholson Foundation will fund one award for the implementation of the In-Home Recovery Program (IHRP) which provides two (2) Project sites managed by one agency. Each Project team will treat a caseload of twelve (12) families concurrently and serve a minimum of eighteen (18) families over the 18-month grant period, beginning on September 1, 2019
Baseline Measurement:	This in-home service does not exist within NJ DCF at this time
First-year target/outcome measurement:	Total number of families served between January 1, 2020 and June 30, 2020
Second-year target/outcome measurement:	Each Project team will treat a caseload of twelve (12) families concurrentlyand serve a

minimum of eighteen (18) families over the 18-month grant period, beginning on September 1, 2019

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

Data Source:

Grant awardee

New Data Source*(if needed)*:

Description of Data:

Total number of families served over the 18-month grant period. Target measurement is 36 families served.

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

None.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

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

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

Second Year Target: ☐ Achieved ☐ Not Achieved *(if not achieved,explain why)*

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

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

Priority #: 13

Priority Area: Housing Services in Community Support Services

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

Maintain housing stability in community settings and improve utilization of housing service slots for mental health consumers served in Community Support Services (CSS).

Objective:

SMHA continues to increase opportunities for community living among mental health consumers by developing additional housing units and maintaining levels of occupancy to satisfy the needs of consumers served in Community Support Services.

Strategies to attain the goal:

Community Support Services (CSS) is a mental health rehabilitation service that assists the consumer in achieving mental health rehabilitative and recovery goals as identified in an individualized rehabilitation plan (IRP). CSS promotes community inclusion, housing stability, wellness, recovery, and resiliency. Consumers are expected to be full partners in identifying and directing the types of support activities that would be most helpful to maximize successful community living. This includes use of community mental health treatment, medical care, self-help, employment and rehabilitation services, and other community resources, as needed and appropriate. The adoption of CSS enhances Supportive Housing.

The SMHA will utilize a number of strategies to help attain the objective.
1. The Office of Olmstead, Compliance, Planning, and Evaluation works collaboratively with provider agencies, state hospital key personnel, DMHAS staff and other Divisions across the state to implement an overall paradigm of community integration.
2. Continued use of the Individual Needs for Discharge Assessment (INDA) facilitates the treatment and discharge planning processes. The INDA serves as both an assessment tool geared toward evaluating needs or barriers that the consumer may face upon discharge and a mechanism by which to

assign state hospital consumers to prospective community service providers. The INDA will be continually used by the SMHA to facilitate transition into the community and anticipate and address any barriers that may hinder or preclude placement within the community.
3. Separation of Housing and Services in service delivery has enabled consumers to choose a housing provider and a different service provider. Consumers will no longer be restricted to the same agency. This separation will also enable the SMHA to track expenditures, utilization, outcomes, and demands for services.
4. The Bed Enrollment Data System (BEDS)/Vacancy Tracking System was developed to help DMHAS manage and track vacancies. The system has replaced the process of cold calls to agencies and the utilization of quickly outdated paper tracking sheets. Utilization of a web-based system provides real-time access to vacancy information and helps facilitate assignments and avoid outdated spreadsheets. Analysis of the utilization of Supportive Housing vs. supervised settings (e.g. group homes and supervised apartments) allows for assessment of the Division's progress toward community integration. The system will also enable planning at both the individual consumer level for placement purposes and system-wide for purposes of enhancements in community resources.
5. Assignment Process - In May 2015, New Jersey DMHAS revised its Administrative Bulletin 5:11 directing engagements of consumers by community providers. Under this revision, assignments of consumers replaced the concept of referrals to community providers by hospital treatment teams, requiring providers to either accept the assigned consumer or communicate their needs to DMHAS for additional supports necessary to serving the assigned consumer. The goal of this new policy was the early familiarity of consumers and providers through mandatory provider participation in the discharge planning process and engagements such as recreational day trips; visits to prospective apartments for rent; discharge preparations; and overnight visits (upon request of the consumer and/or hospital treatment team).

SMHA staff will monitor the continued development of new Supportive Housing opportunities. The BEDS data system will foster more timely and accurate tracking of residential resources, as well as facilitate their more efficient utilization (e.g., to reduce vacancy rates and increase community placements), and enable monitoring of compliance with Administrative Bulletin 5:11 (Residential Placement from Psychiatric Hospital).

Edit Strategies to attain the objective here:
(if needed)

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Consumers who remain in Community Support Services (CSS) during the fiscal year as a proportion of total consumers served in Community Support Services.
Baseline Measurement:	The total number of clients served in CSS in SFY 2018 were 4,762. 80.72% of the total consumers served in CSS remained in CSS during SFY 2018. The total number of clients served in CSS in SFY 2019 will be available by September 2019. At that time, the percentage for SFY 2019 will be calculated.
First-year target/outcome measurement:	The percentage of consumers who remain in Community Support Services during SFY 2020 will be no less than 85% of total consumers served in Community Support Services.
Second-year target/outcome measurement:	The percentage of consumers who remain in Community Support Services during SFY 2021 will be no less than 87% of total consumers served in Community Support Services.

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

Data Source:

The number of consumers served by Community Support Services is tracked by the SMHA's QCMR database starting SFY 2018.

New Data Source*(if needed)*:

Description of Data:

The QCMR Database collects quarterly, cumulative, program-specific data from each of the service providers contracted by DMHAS. The current QCMR for Community Support Services contains 50 data elements. The key data fields relevant for this performance indicator are "Ending Active Caseload (Last Day of Quarter)" and Number of terminations in the Quarter. Currently 39 agencies contracted by the SMHA to provide QCMR data for Community Support Services.

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

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

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

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

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

Second Year Target: ☐ Achieved ☐ Not Achieved *(if not achieved,explain why)*

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

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

Priority #: 14

Priority Area: Olmstead Access to Service/Occupancy Rate

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

Maintain housing stability in community settings and improve utilization of housing service slots for mental health consumers served in Community Support Services (CSS).

Objective:

SMHA continues to increase opportunities for community living among mental health consumers by developing additional housing units and maintaining levels of occupancy to satisfy the needs of consumers served in Community Support Services.

Strategies to attain the goal:

Community Support Services (CSS) is a mental health rehabilitation service that assists the consumer in achieving mental health rehabilitative and recovery goals as identified in an individualized rehabilitation plan (IRP). CSS promotes community inclusion, housing stability, wellness, recovery and resiliency. Consumers are expected to be full partners in identifying and directing the types of support activities that would be most helpful to maximize successful meaningful community living. This includes use of community mental health treatment, medical care, self-help, employment and rehabilitation services, supported education, and other community resources, as needed and appropriate. The adoption of CSS enhances Supportive Housing.

Edit Strategies to attain the objective here:
(if needed)

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Improved Utilization of Housing Service Slots measured by occupancy rates of Community Support Services (CSS) housing units.

Baseline Measurement: In SFY2019, the occupancy rate (of CSS housing units that are occupied and/or have a consumer assigned to them) was 95.9%. Conversely, the vacancy rate (state-funded CSS housing units that are vacant and/or have no consumers assigned to them) was 4.1%.

First-year target/outcome measurement: In SFY 2020, the occupancy rate (i.e., occupied CSS housing units and those units with an assignment) is expected to be 97%.

Second-year target/outcome measurement: In SFY 2021, the occupancy rate (i.e., occupied CSS housing units and those units with an assignment) is expected to be 97%.

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

Data Source:

The 2019 baseline value was generated from newer and slightly improved Provider Weekly Reports. The denominator was the sum of capacity reported from 33 different CSS programs. The numerator was the number of needed assignments requested by those same organizations.

New Data Source*(if needed)*:

Description of Data:

For the 2020-2021 application, this priority indicator has been refined to focus on increased access to community-based housing among its largest segment—those served by Community Support Services (CSS). Although DMHAS has developed data systems (e.g., the Bed Enrollment Data System/BEDS) that are well-suited for the tracking of group homes and supervised apartments, different reporting mechanisms are preferable for the tracking of CSS housing—which is uniquely client-driven. Therefore, the data used for this indicator is from an analysis of Provider Weekly Reports, which are submitted to the SMHA on a weekly basis by each contracted CSS agency. Provider Weekly Vacancy Reports gather data from the community providers regarding their current census, current occupancy, and identify availability for state hospital assignments. These reports provide current information regarding active assignments, which includes any unforeseen post-assignment barriers, identifies any follow-up needed, and provides additional information used for tracking the progress of the assignment to allow for timely discharge and/or intervention. Prior to the development of this report, two of the three catchment areas implemented a similar tool. The new report has standardized the process in all three regions and across all providers. The Provider Weekly Vacancy Report provides information in order to validate the current BEDs Data System, as well as provide continuous updates to maintain its accuracy. This report is also used to develop and maintain the Hospital Vacancy Report, which is used for notifying state hospital treatment teams of bed vacancies and assignment opportunities. All DMHAS community providers were invited to participate in a webinar training on June 19, 2019. The Provider Weekly Vacancy Report went into effect on July 1st, 2019.

The 2019 values were calculated by dividing the sum of the reported number of requested assignments, by the sum of the reported capacities at each program. The SMHA collected this data from 33 CSS providers at the end of SFY19.

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

The reporting of occupancy strictly among CSS provider agencies necessitated the use of the Provider Weekly Reports (PWRs). The rollout of the standardized PWRs came late in SFY19, so there is a small number of providers who have yet to submit their data in the proscribed fashion. This performance indicator is expressed as a proportion, and the SMHA does not feel that the SFY19 occupancy rate of 95.9% would be materially different if/when all of the data was reported.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

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

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

Second Year Target: ☐ Achieved ☐ Not Achieved *(if not achieved,explain why)*

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

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

Priority #: 15

Priority Area: First Episode Psychosis (FEP)

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

Early treatment and intervention of psychosis helps change the trajectory of psychotic disorders in young adults by improving symptoms, reducing the likelihood of long-term disability and leading to productive independent meaningful lives.

Objective:

Among consumers who received coordinated specialty care services for individuals with first episode psychosis, a majority will show improved symptoms and adhere to psychotic medication after receiving treatment for six months.

Strategies to attain the goal:

Objectives will be addressed through the implementation of a Coordinated Specialty Care (CSC) model. CSC is an evidence-based recovery-oriented approach involving clients and family members as active participants. All services are highly coordinated with primary medical care.

New Jersey's CSC services are provided for youth and adults between the ages of 15 to 35 years who have experienced psychotic symptoms for less than 2 years with or without treatment. Since November 2016, three teams in New Jersey have been funded to provide CSC services. They cover all 21 counties using extensive outreach efforts. The three provider agencies are Oaks Integrated Care for Southern region, Rutgers University Behavioral Health Center for Central region, and CarePlus NJ for Northern region.

Each CSC team is comprised of six members, mostly masters level clinicians, who contribute to high levels of care. They take on the roles of Team Leader, Recovery Coach, Supported Employment and Education Specialist, Pharmacotherapist, Outreach and Referral Specialist, and Peer Support Specialist. The New Jersey CSC model emphasizes treatment through the following components: outreach, low-dosage medications, cognitive and behavioral skills training, Individualized Placement and Support (IPS), supported employment and supported education, peer support, case management, and family psychoeducation.

In SFY 2019, the three CSC programs had over 277 referrals and served 215 clients in their programs. New Jersey plans to continue utilizing the 10% set-aside funding in the FY 2020-21 to support these three CSC teams in providing evidence-based services for individual with FEP. With increased demand for FEP services, the CSC programs have expanded from serving 35 clients to 70 clients per agency and increased clinical staff from 5.2 FTE to 6.8 FTE levels in FY 2019.

Edit Strategies to attain the objective here:
(if needed)

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Medication adherence among clients who need psychotropic medication prescribed for FEP treatment.
Baseline Measurement:	In SFY 2018, among clients who were taking or in need of antipsychotic medication for the treatment of their psychosis at intake, 78.4% adhere to their medication regimen. In SFY 2019, out of 215 clients being served, 190 were taking or in need of antipsychotic medication. Among them, 86.8% (165) adhered to their psychotropic medication regimens.
First-year target/outcome measurement:	In SFY 2020, it is anticipated that at least 88% of the client who are taking or in need of antipsychotic medication adhere to the medication regimen.
Second-year target/outcome measurement:	In SFY 2021, it is anticipated that at least 90% of the client who are taking or in need of antipsychotic medication adhere to the medication regimen.

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

Data Source:

The Division of Mental Health and Addiction Services (DMHAS) maintains a CSC clinical diagnostic database, which is used for tracking medication monitoring in all 3 agencies.

New Data Source*(if needed)*:

Description of Data:

The three CSC service providers submit the client level clinical diagnostic data quarterly to DMHAS. The CSC clinical diagnostic database tracks client referral and intake; functional status; program involvement; education and employment; medication and substance use; suicide ideation; hospitalization; and client discharge information.

The DMHAS is in the process of creating a comprehensive client level data system that includes data elements from all DMHAS contracted community programs. The client level data system will include all CSC program elements currently collected through the CSC clinical diagnostic database and additional measures required by federal and state data reporting and evaluation. The client level data will provide a detailed description of the FEP population receiving CSC services in New Jersey and will help capture the treatment and recovery progress of CSC clients so that DMHAS can improve services for early serious mental illness (ESMI) population in New Jersey.

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

Clients who participate in medication monitoring may not always be forthright with service providers about medication adherence patterns and this may introduce possible errors in data interpretation.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

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

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

Second Year Target: ☐ Achieved ☐ Not Achieved *(if not achieved,explain why)*

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

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

Priority #: 16

Priority Area: System wide assessment for delivering services to diverse populations

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

System wide assessment for delivering services to diverse populations.

Objective:

All agencies are required to have a Cultural Competence Plan in place. The multicultural plans are required of both mental health and substance use agencies.

Strategies to attain the goal:

Since 1985, the Division of Mental Health and Addiction Services (DMHAS) has had the commitment to improve services to individuals from diverse backgrounds, including LGBTQ. The mechanism for addressing these system needs began with the 2015 reformation of DMHAS' multicultural activities into a Multicultural Services Advisory Committee (MSAC). The MSAC has developed a process for systems assessment that will begin by surveying all contracted agencies about their existing planning and service delivery to diverse populations. As the SMHA reviewed the results of these surveys, gaps in service and needs for technical assistance (TA) were identified. Beginning in early 2016, TA groups were held in the north and south to assist agencies in formulating multicultural plans. Those plans became a part of the SMHA's contracting process in FY 2017 and have been followed by the DMHAS Multicultural Training and Technical Assistance Center each year to ensure that the plans continue to grow. In addition, in FY 2018, DMHAS contracted with a diversity consultant to provide administrative and research-based assistance with this initiative. The diversity consultant was charged with securing scholarly presenters for trainings and workshops to further educate and engage providers with completing their Cultural Competence Plan. The diversity consultant's role expanded in FY 2019 to include qualitative and quantitative analysis of data in order to present a more robust picture of DMHAS' agency gaps and trends leading to greater concentration of creating and sustaining a culture of inclusion.

The MSAC, with assistance from DMHAS and the diversity consultant, is developing a "Center for Cultural Competency Excellence" designation for agencies that meet exemplary criteria in addition to completing their Cultural Competency Plans.

Each mental health community provider is required to develop a Cultural Competence Plan describing the integration of cultural and linguistic competence throughout the organization, including direct attention to issues of gender, age, and culture. An organizational self-assessment helps prioritize the steps needed to develop those congruent behaviors and improve culturally responsive services. The plan that results from that assessment, which has 47 items, should address all diverse groups that are served within the agency: for example, cultural, ethnic and linguistically diverse people, individuals who are deaf and hard of hearing, Lesbian, Gay, Bisexual, Transgender people, older people; and outline strategies for recruiting, hiring, retaining, and promoting culturally competent, diverse staff members; the use of interpreters or bilingual staff members; staff training, professional development, and education; fostering community involvement; facilities design and operation; development of cultural and diversity appropriate program materials; how to incorporate diverse treatment approaches; and development and implementation of supporting policies and procedures, including reassessment processes.

Edit Strategies to attain the objective here:
(if needed)

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Proportion of agencies that have three areas identified from their self-assessment included in their Cultural Competence Plans.

Baseline Measurement: The baseline variable is the number of provider agencies that complete their self-assessments and have a written Cultural Competence Plan containing at least three of the areas needed to enhance cultural competency. The establishment of a baseline is still in process and is expected to be completed in SFY 2020. The MSAC will complete the "Center for Cultural Competency Excellence" designation for agencies.

First-year target/outcome measurement: Thirty (30) percent of all providers will have written Cultural Competence Plans which include at least three areas identified in their self-assessment. Agencies will apply for "Center for Cultural Competency Excellence" designation.

Second-year target/outcome measurement: Fifty percent (50%) of all providers will have written Cultural Competence Plans which include at least three areas identified in their self-assessment. Agency "Center for Cultural Competency Excellence" designations will be reviewed and awarded.

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

Data Source:

Self assessments and written plans checked by SMHA, Multicultural Training and Technical Assistance Center staff, and analyzed by the diversity consultant.

New Data Source*(if needed)*:

Description of Data:

The establishment of written organizational plans for addressing culture and diversity based upon agency self-assessment. The areas covered: Governance, Leadership, and Workforce; Communication and Language Assistance and Engagement, Continuous Improvement, and Accountability. Plans identify a minimum of at least three activities from these areas.

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

Some agencies have been reluctant to initiate a multicultural plan due to staffing demands, cultural competency misinformation, and fiscal issues. The addition of the diversity consultant and "Center for Cultural Competency Excellence" agency designation may help in this regard.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

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

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

Second Year Target: ☐ Achieved ☐ Not Achieved *(if not achieved,explain why)*

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

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

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Footnotes:

Priority areas #10-16 of the State Mental Health Authority and the Children's System of Care are not applicable to this report.

SABG COVID Testing and Mitigation Program Report for 9/1/21 – 9/30/21: New Jersey	
Item/Activity	**Amount of Expenditure**
	Not Applicable. The Division of Mental Health and Addiction Services had no activities or expenditures for SABG COVID Testing and Mitigation during this period.
Total	

III: Expenditure Reports

Table 2A - State Agency Expenditure Report

Expenditure Period Start Date: 7/1/2020 Expenditure Period End Date: 6/30/2021

Activity (See instructions for entering expenses in Row 1)	A. SA Block Grant	B. MH Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. COVID-19[1]
1. Substance Abuse Prevention[2] and Treatment	$27,831,187.00		$0.00	$21,714,718.00	$127,416,406.00	$0.00	$0.00	$811,778.00
a. Pregnant Women and Women with Dependent Children[2]	$5,338,911.00		$0.00	$0.00	$2,832,293.00	$0.00	$0.00	$0.00
b. All Other	$22,492,276.00		$0.00	$21,714,718.00	$124,584,113.00	$0.00	$0.00	$811,778.00
2. Substance Abuse Primary Prevention	$12,303,108.00		$0.00	$15,140,548.00	$2,953,749.00	$0.00	$0.00	$0.00
3. Tuberculosis Services	$0.00		$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
4. Early Intervention Services Regarding the Human Immunodeficiency Virus (EIS/HIV)[3]	$0.00		$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
5. State Hospital								
6. Other 24 Hour Care								
7. Ambulatory/Community Non-24 Hour Care								
8. Mental Health Primary Prevention								
9. Evidenced Based Practices for First Episode Psychosis (10% of the state's total MHBG award)								
10. Administration (Excluding Program and Provider Level)	$1,746,902.00		$0.00	$2,781,377.00	$1,572,689.00	$0.00	$0.00	$0.00
11. Total	**$41,881,197.00**	**$0.00**	**$0.00**	**$39,636,643.00**	**$131,942,844.00**	**$0.00**	**$0.00**	**$811,778.00**

[1]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the "standard" SABG and MHBG. Per the instructions, the standard SABG expenditures are for the state expenditure period of July 1, 2021 – June 30, 2023, for most states.

[2]Prevention other than primary prevention

[3]Only designated states as defined in 42 U.S.C. § 300x-24(b)(2) and 45 CFR § 96.128(b) for the applicable federal fiscal year should enter information in this row. This may include a state or states that were previously considered "designated states" during any of the three prior federal fiscal years for which a state was applying for a grant. See EIs/HIV policy change in SABG Annual Report instructions.

Please indicate the expenditures are actual or estimated.

○ Actual ◉ Estimated

Please identify which of the information in is estimated rather than actual:

Column E. State Funds are estimated. The data in column E is estimated.
The State Substance Abuse Authority spent zero dollars on TB services in the state for SFY19 (whether SABG or state funds).

Identify the date by when all estimates can be replaced with actual expenditures: 06/01/2022

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Footnotes:

III: Expenditure Reports

Table 2B - COVID-19 Relief Supplemental Funds Expenditure by Service – Requested

Expenditure Period Start Date: 3/15/2021 Expenditure Period End Date: 9/30/2021

Service	Expenditures
Healthcare Home/Physical Health	
Specialized Outpatient Medical Services	
Acute Primary Care	
COVID-19 Screening (e.g., temperature checks, symptom questionnaires)	
COVID-19 Testing	
COVID-19 Vaccination	
Comprehensive Care Management	
Care Coordination and Health Promotion	
Comprehensive Transitional Care	
Individual and Family Support	
Referral to Community Services Dissemination	
Prevention (Including Promotion)	
Screening with Evidence-based Tools	
Risk Messaging	
Access Line/Crisis Phone Line/Warm Line	
Purchase of Technical Assistance	
COVID-19 Awareness and Education for Person with SUD	
Media Campaigns (Information Dissemination)	
Employee Assistance Programs (Problem Identification and Referral)	
Primary Substance Use Disorder Prevention (Education)	
Primary Substance Use Disorder Prevention (Alternatives)	
Primary Substance Use Disorder Prevention (Community-Based Processes)	

Intervention Services	
Fentanyl Strips	
Syringe Services Program	
Naloxone	
Overdose Kits/Dissemination of Overdose Kits	
Engagement Services	
Assessment	
Specialized Evaluations (Psychological and Neurological)	
Services Planning (including crisis planning)	
Consumer/Family Education	
Outreach (including hiring of outreach workers)	
Outpatient Services	
Evidence-based Therapies	
Group Therapy	
Family Therapy	
Multi-family Therapy	
Consultation to Caregivers	
Medication Services	
Medication Management	
Pharmacotherapy (including MAT)	
Laboratory Services	
Community Support (Rehabilitative)	
Parent/Caregiver Support	
Case Management	
Behavior Management	
Supported Employment	

Permanent Supported Housing	
Recovery Housing	
Recovery Supports	
Peer Support	
Recovery Support Coaching	
Recovery Support Center Services	
Supports For Self-Directed Care	
Supports (Habilitative)	
Personal Care	
Respite	
Supported Education	
Acute Intensive Services	
Mobile Crisis	
Peer-based Crisis Services	
Urgent Care	
23-hour Observation Bed	
Medically Monitored Intensive Inpatient for SUD	
24/7 Crisis Hotline	
Other	
Smartphone Apps	
Personal Protective Equipment	
Virtual/Telehealth/Telemedicine Services	
Purchase of increased connectivity (e.g., Wi-Fi)	
Cost-sharing Assistance (e.g., copayments, coinsurance and deductibles)	
Provider Stabilization Payments	
Transportation to COVID-19 Services (e.g., testing, vaccination)	
Other (please list)	

Total	**$0**

Please enter the five services (e.g., COVID-19 testing, risk messaging, group therapy, peer support) from any of the above service categories (e.g., Healthcare Home/Physical Health, prevention (including promotion), outpatient services, recovery supports) that reflect the five largest expenditures of COVID-19 Relief Supplement Funds.

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Footnotes:

III: Expenditure Reports

Table 3A SABG – Syringe Services Program

Expenditure Start Date: 07/01/2020 Expenditure End Date: 06/30/2021

Syringe Services Program SSP Agency Name	Main Address of SSP	Dollar Amount of SABG Funds Expended for SSP	Dollar Amount of COVID-19 Relief Supplemental Funds Expended for SSP	SUD Treatment Provider (Yes or No)	# Of locations (Include mobile, if any)	Narcan Provider (Yes or No)	Fentanyl Strips (Yes or No)
No Data Available							

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Footnotes:

DMHAS does not use SAPT Block Grant funds for Syringe Services Programs.

III: Expenditure Reports

Table 3B SABG – Syringe Services Program

Expenditure Start Date: 07/01/2020 Expenditure End Date: 06/30/2021

SABG							
Syringe Services Program Name	**# of Unique Individuals Served**		**HIV Testing** ***(Please enter total number of individuals served)***	**Treatment for Substance Use Conditions** ***(Please enter total number of individuals served)***	**Treatment for Physical Health** ***(Please enter total number of individuals served)***	**STD Testing** ***(Please enter total number of individuals served)***	**Hep C** ***(Please enter total number of individuals served)***
	0	ONSITE Testing	0	0	0	0	0
		REFERRAL to testing	0	0	0	0	0

COVID-19							
Syringe Services Program Name	**# of Unique Individuals Served**		**HIV Testing** ***(Please enter total number of individuals served)***	**Treatment for Substance Use Conditions** ***(Please enter total number of individuals served)***	**Treatment for Physical Health** ***(Please enter total number of individuals served)***	**STD Testing** ***(Please enter total number of individuals served)***	**Hep C** ***(Please enter total number of individuals served)***
	0	ONSITE Testing	0	0	0	0	0
		REFERRAL to testing	0	0	0	0	0

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Footnotes:

DMHAS does not use SAPT Block Grant funds for Syringe Services Programs.

III: Expenditure Reports

Table 4 - State Agency SABG Expenditure Compliance Report

This table provides a description of SABG expenditures for authorized activities to prevent and treat SUDs. For detailed instructions, refer to those in BGAS. Only one column is to be filled in each year.

Expenditure Period Start Date: 10/1/2018 Expenditure Period End Date: 9/30/2020

Expenditure Category	FY 2019 SA Block Grant Award
1. Substance Abuse Prevention[1] and Treatment	$33,911,272.00
2. Primary Prevention	$11,411,474.00
3. Tuberculosis Services	$0.00
4. Early Intervention Services Regarding the Human Immunodeficiency Virus (EIS/HIV)[2]	$1,404,554.00
5. Administration (excluding program/provider level)	$1,344,271.00
Total	**$48,071,571.00**

[1]Prevention other than Primary Prevention

[2]Only designated states as defined in 42 U.S.C. § 300x-24(b)(2) and 45 CFR § 96.128(b) for the applicable federal fiscal year should enter information in this row. This may include a state or states that were previously considered "designated states" during any of the three prior federal fiscal years for which a state was applying for a grant. See EIS/HIV policy change in SABG Annual Report instructions.

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Footnotes:

The total expense of $48,071,571 includes $3,146 in TA funding.

III: Expenditure Reports

Table 5a - SABG Primary Prevention Expenditures Checklist

The State or jurisdiction must complete either SABG Table 5a and/or 5b. There are six primary prevention strategies typically funded by principal agencies administering the SABG. Expenditures within each of the six strategies or Institute of Medicine Model (IOM) should be directly associated with the cost of completing the activity or task. For example, information dissemination may include the cost of developing pamphlets, the time of participating staff and/or the cost of public service announcements, etc. If a state or jurisdiction employs strategies not covered by these six categories, please report them under "Other," each in a separate row.

Expenditure Period Start Date: 10/1/2018 Expenditure Period End Date: 9/30/2020

Strategy	IOM Target	SA Block Grant Award	Other Federal	State	Local	Other
Information Dissemination	Selective					
Information Dissemination	Indicated					
Information Dissemination	Universal					
Information Dissemination	Unspecified					
Information Dissemination	**Total**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
Education	Selective					
Education	Indicated					
Education	Universal					
Education	Unspecified					
Education	**Total**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
Alternatives	Selective					
Alternatives	Indicated					
Alternatives	Universal					
Alternatives	Unspecified					
Alternatives	**Total**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
Problem Identification and Referral	Selective					
Problem Identification and Referral	Indicated					
Problem Identification and Referral	Universal					
Problem Identification and Referral	Unspecified					
Problem Identification and Referral	**Total**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**

Community-Based Process	Selective					
Community-Based Process	Indicated					
Community-Based Process	Universal					
Community-Based Process	Unspecified					
Community-Based Process	**Total**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
Environmental	Selective					
Environmental	Indicated					
Environmental	Universal					
Environmental	Unspecified					
Environmental	**Total**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
Section 1926 Tobacco	Selective					
Section 1926 Tobacco	Indicated					
Section 1926 Tobacco	Universal					
Section 1926 Tobacco	Unspecified					
Section 1926 Tobacco	**Total**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
Other	Selective	$0.00	$0.00	$0.00	$0.00	$0.00
Other	Indicated	$0.00	$0.00	$0.00	$0.00	$0.00
Other	Universal	$0.00	$0.00	$0.00	$0.00	$0.00
Other	Unspecified	$0.00	$0.00	$0.00	$0.00	$0.00
Other	**Total**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
	Grand Total					

Section 1926 – Tobacco: Costs associated with the Synar Program Pursuant to the January 19, 1996 federal regulation "Tobacco Regulation for Substance Abuse Prevention and Treatment Block Grants, Final Rule" (45 CFR § 96.130), a state may not use the SABG to fund the enforcement of its statute, except that it may expend funds from its primary prevention set aside of its Block Grant allotment under 45 CFR §96.124(b)(1) for carrying out the administrative aspects of the requirements, such as the development of the sample design and the conducting of the inspections. States should include any non-SABG funds* that were allotted for Synar activities in the appropriate columns under 7 below.

*Please list all sources, if possible (e.g.., Centers for Disease Control and Prevention, Block Grant, foundations, etc.)

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Footnotes:

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

III: Expenditure Reports

Table 5b - SABG Primary Prevention Expenditures by Institute of Medicine (IOM) Categories

The state or jurisdiction must complete SABG Table 5b if it chooses to report SUD primary prevention activities utilizing the IOM Model of Universal, Selective and Indicated. Indicate how much funding supported each of the IOM classifications of Universal, Selective, or Indicated. Include all funding sources (e.g., Centers for Disease Control and Prevention Block Grant, foundations).

Expenditure Period Start Date: 10/1/2018 Expenditure Period End Date: 9/30/2020

Activity	SA Block Grant Award	Other Federal Funds	State Funds	Local Funds	Other
Universal Direct	$1,929,846.00	$3,426,086.00	$0.00		
Universal Indirect	$3,083,986.00	$0.00	$0.00		
Selective	$2,891,237.00	$6,623,767.00	$655,586.00		
Indicated	$1,734,742.00	$1,370,435.00	$1,966,758.00		
Column Total	**$9,639,811.00**	**$11,420,288.00**	**$2,622,344.00**	**$0.00**	**$0.00**

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Footnotes:

Amount of SABG Primary Prevention funds (from Table 4, Row 2) used for SABG Prevention Resource Development Activities for SABG Prevention = $9,639,811.
Amount of SABG Administration funds (from Table 4, Row 5) used for SABG Prevention Resource Development Activities Activities for SABG Prevention = $0.

III: Expenditure Reports

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

The purpose of the first table is for the state or jurisdiction to identify the substance and/or categories of substances it identified through its needs assessment and then addressed with primary prevention set-aside dollars from the FY 2019 SABG NoA. The purpose of the second table is to identify each special population the state or jurisdiction selected as a priority for primary prevention set-aside expenditures.

Expenditure Period Start Date: 10/1/2018 Expenditure Period End Date: 9/30/2020

	SABG Award
Targeted Substances	
Alcohol	☑
Tobacco	☑
Marijuana	☑
Prescription Drugs	☑
Cocaine	☑
Heroin	☑
Inhalants	☑
Methamphetamine	☑
Bath salts, Spice, K2)	☑
Targeted Populations	
Students in College	☑
Military Families	☑
LGBTQ	☑
American Indians/Alaska Natives	☐
African American	☑
Hispanic	☑
Homeless	☑
Native Hawaiian/Other Pacific Islanders	☐
Asian	☑
Rural	☑

Underserved Racial and Ethnic Minorities	☑

Footnotes:

III: Expenditure Reports

Table 6 - Resource Development Expenditure Checklist

Expenditure Period Start Date: 10/1/2018 Expenditure Period End Date: 9/30/2020

Activity	A. SABG Treatment	B. SABG Prevention	C. SABG Combined[1]
1. Information Systems	$1,147,362.00	$0.00	$0.00
2. Infrastructure Support	$1,217,995.00	$0.00	$0.00
3. Partnerships, community outreach, and needs assessment	$59,401.00	$23,911.00	$0.00
4. Planning Council Activities (MHBG required, SABG optional)	$0.00	$0.00	$0.00
5. Quality Assurance and Improvement	$45,002.00	$0.00	$0.00
6. Research and Evaluation	$1,540,942.00	$1,747,752.00	$0.00
7. Training and Education	$0.00	$0.00	$0.00
8. Total	**$4,010,702.00**	**$1,771,663.00**	**$0.00**

[1]SABG integrated expenditures are expenditures for non-direct services/system development that cannot be separated out of the amounts devoted specifically to treatment or prevention. For Column C, do not include any amounts already accounted for in Column A, SABG Treatment and/or Column B, SABG Prevention.

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Footnotes:

III: Expenditure Reports

Table 7 - Statewide Entity Inventory

This table provides a report of the sub-recipients of SABG funds including community- and faith-based organizations which provided SUD prevention activities and treatment services, as well as intermediaries/administrative service organizations. Table 7 excludes resource development expenditures.

Expenditure Period Start Date: 10/1/2018 Expenditure Period End Date: 9/30/2020

										Source of Funds SAPT Block Grant					
	Entity Number	I-BHS ID (formerly I-SATS)		Area Served (Statewide or SubState Planning Area)	Provider / Program Name	Street Address	City	State	Zip	A. All SA Block Grant Funds	B. Prevention (other than primary prevention) and Treatment Services	C. Pregnant Women and Women with Dependent Children	D. Primary Prevention	E. Early Intervention Services for HIV	F. Syringe Services Program
	1000088	NJ103071	✗	99	Acenda, Inc. - 1000155	42 Delsea Dr. South	Glassboro	NJ	08028-2621	$1,023,037.00	$1,023,037.00	$0.00	$0.00	$0.00	$0.00
	2000813	NJ103071	✗	99	Acenda, Inc. - 2000813	128 CREST HAVEN ROAD	CAPE MAY COURT HOUSE	NJ	08210	$9,788.00	$9,788.00	$0.00	$0.00	$0.00	$0.00
	2000693	NJ102946	✗	99	Adult Family Health Services - 2000693	53 Orchard Street	Clifton	NJ	07013	$9,577.00	$9,577.00	$0.00	$0.00	$0.00	$0.00
	2000074	NJ902437	✗	99	Alfre, Inc. d.b.a. Mrs. Wilson's - 2000074	56 Mount Kemble Ave	Morristown	NJ	07960	$16,463.00	$16,463.00	$0.00	$0.00	$0.00	$0.00
	1000019	NJ902437	✗	99	ALFRE, Inc. d/b/a/ Mrs. Wilson's - 1000019	56 Mount Kemble Ave	Morristown	NJ	07960	$296,481.00	$296,481.00	$0.00	$0.00	$0.00	$0.00
	1000090	NJ106872	✗	99	Anderson House, A Turning Point Program - 1000090	532 ROUTE 523	WHITEHOUSE STATION	NJ	08889	$90,812.00	$90,812.00	$0.00	$0.00	$0.00	$0.00
	100776	NJ101850	✗	01	Atlantic Prevention Resources Inc - Individual and Group Counseling	1416 North Main Street	Pleasantville	NJ	08232	$244,400.00	$0.00	$0.00	$244,400.00	$0.00	$0.00
	100883	NJ101680	✓	01	ATLANTICARE BEHAVIORAL HEALTH	6010 Black Horse Pike Suite B-10	Egg Harbor Township	NJ	08234-9752	$35,055.00	$35,055.00	$35,055.00	$0.00	$0.00	$0.00
	2000071	NJ101656	✗	99	C-LINE COMMUNITY OUTREACH - 2000071	110 MARTIN LUTHER KING DRIVE	JERSEY CITY	NJ	07305	$17,351.00	$17,351.00	$0.00	$0.00	$0.00	$0.00
	2000511	NJ100774	✗	99	C-Line Counseling Center - 2000511	680 BROADWAY	PATERSON	NJ	07509	$1,241.00	$1,241.00	$0.00	$0.00	$0.00	$0.00
	306175	NJ101797	✗	04	CAMDEN COUNTY COUNCIL ON	1 Alpha Avenue Suite 22	Voorhees	NJ	08043	$267,500.00	$0.00	$0.00	$267,500.00	$0.00	$0.00
	750133	NJ750133	✗	05	Cape May Council on - Alcoholism and Drug Abuse Inc	3819 New Jersey Avenue	Wildwood	NJ	08260	$436,240.00	$0.00	$0.00	$436,240.00	$0.00	$0.00
	900247	NJ102278	✗	Mercer County	CATHOLIC CHARITIES	383 WEST STATE STREET	TRENTON	NJ	08618	$111,700.00	$0.00	$0.00	$111,700.00	$0.00	$0.00
	2000313	NJ902247	✗	99	Catholic Charities Alcoholism/Addictions Program - 2000313	10 SOUTHARD STREET	TRENTON	NJ	08609	$2,997.00	$2,997.00	$0.00	$0.00	$0.00	$0.00
	2000312	NJ902247	✗	99	Catholic Charities, Diocese of Trenton, Project Free/New Choices - 2000312	10 SOUTHARD STREET	TRENTON	NJ	08609	$7,681.00	$7,681.00	$0.00	$0.00	$0.00	$0.00
	2000041	NJ100603	✗	99	Center for Family Services, Inc. - 2000041	601 S BLACK HORSE PIKE	WILLIAMSTOWN	NJ	08094	$27,674.00	$27,674.00	$0.00	$0.00	$0.00	$0.00
	2000241	NJ000121	✗	99	Center for Family Services, Inc. - 2000241	108 SOMERDALE ROAD	VOORHEES	NJ	08043	$26,251.00	$26,251.00	$0.00	$0.00	$0.00	$0.00
	100853	NJ100853	✗	Sussex County	Center for Prevention and Counseling	61 Spring Street	Newton	NJ	07860	$328,700.00	$0.00	$0.00	$328,700.00	$0.00	$0.00
	101804	NJ101804	✗	Warren County	COMMUNITY PREVENTION RESOURCES	20 West Washington Avenue	WASHINGTON	NJ	07882	$142,700.00	$0.00	$0.00	$142,700.00	$0.00	$0.00
	2000341	NJ306399	✗	99	Community YMCA Family Services - 2000341	166 Main Street	Matawan	NJ	07747	$158.00	$158.00	$0.00	$0.00	$0.00	$0.00
	2000182	NJ300715	✗	99	Corner House - 2000182	One Monument Drive	Princeton	NJ	08540	$30,087.00	$30,087.00	$0.00	$0.00	$0.00	$0.00
	2000651	NJ102779	✗	99	CPC Aberdeen Counseling Center - 2000651	1088 HIGHWAY 34	ABERDEEN	NJ	07747	$3,396.00	$3,396.00	$0.00	$0.00	$0.00	$0.00

	2000332	NJ100392	✗	99	CPC Behavioral Healthcare, Inc. - 2000332	270 HIGHWAY 35	RED BANK	NJ	07701	$28,398.00	$28,398.00	$0.00	$0.00	$0.00	$0.00
	2000806	NJ103191	✗	99	CPC Behavioral Healthcare, Neptune City Counseling Center - 2000806	72 MORRIS AVE	NEPTUNE CITY	NJ	07753	$5,643.00	$5,643.00	$0.00	$0.00	$0.00	$0.00
	2000659	NJ102886	✗	99	CPC Freehold Counseling Center - 2000659	22 COURT STREET	FREEHOLD	NJ	07728	$1,991.00	$1,991.00	$0.00	$0.00	$0.00	$0.00
	2000679	NJ102895	✗	99	CPC Howell Counseling Center - 2000679	4535, 4537 & 4539 US HIGHWAY 9	HOWELL	NJ	07731	$4,812.00	$4,812.00	$0.00	$0.00	$0.00	$0.00
	305300	NJ100756	✗	07	CURA INCORPORATED	35 Lincoln Park, P.O. Box 180	Newark	NJ	07101 -0180	$185,046.00	$185,046.00	$185,046.00	$0.00	$0.00	$0.00
	1000026	NJ100756	✗	99	CURA, Inc. - 1000026	61 LINCOLN PARK	NEWARK	NJ	07101 -0180	$376,439.00	$376,439.00	$0.00	$0.00	$0.00	$0.00
	1000085	NJ100868	✗	99	CURA, Inc. - 1000085	595 COUNTY AVE	SECAUCUS	NJ	07094	$763,739.00	$763,739.00	$0.00	$0.00	$0.00	$0.00
	2000208	NJ107532	✗	99	CURA, Inc. - 2000208	729 E LANDIS AVE	VINELAND	NJ	08360	$52,106.00	$52,106.00	$0.00	$0.00	$0.00	$0.00
	2000263	NJ107870	✗	99	CURA, Inc. - 2000263	61 LINCOLN PARK	NEWARK	NJ	07101	$36,319.00	$36,319.00	$0.00	$0.00	$0.00	$0.00
	1000050	NJ306167	✗	99	Damon House, Inc. - 1000050	105 JOYCE KILMER AVE	NEW BRUNSWICK	NJ	08901	$165,699.00	$165,699.00	$0.00	$0.00	$0.00	$0.00
	2000037	NJ105551	✗	99	Discovery Institute for Addictive Disorder - 2000037	80 Conover Rd	Marlboro	NJ	07746	$11,292.00	$11,292.00	$0.00	$0.00	$0.00	$0.00
	1000051	NJ100477	✗	99	Discovery Institute for Addictive Disorders, Inc. - 1000051	80 CONOVER RD	MARLBORO	NJ	07746	$769,867.00	$769,867.00	$0.00	$0.00	$0.00	$0.00
	1000063	NJ301028	✗	99	Dismas House for Drug Rehabilitation - 1000063	396 STRAIGHT ST	PATERSON	NJ	07501	$602,736.00	$602,736.00	$0.00	$0.00	$0.00	$0.00
	2000136	NJ300806	✗	99	East Orange Substance Abuse Treatment Program - 2000136	110 S. Grove Street	East Orange	NJ	07018 -2693	$186,428.00	$186,428.00	$0.00	$0.00	$0.00	$0.00
	300806	NJ300806	✗	07	East Orange Substance Abuse Trt Prog	110 South Grove Street Floor 3	East Orange	NJ	07018	$21,590.00	$21,590.00	$21,590.00	$0.00	$0.00	$0.00
	2000336	NJ100521	✗	99	Epiphany House - 2000336	1110 GRAND AVE	ASBURY PARK	NJ	07712	$46,926.00	$46,926.00	$0.00	$0.00	$0.00	$0.00
	1000105	NJ103193	✗	99	Epiphany House, Inc.-Long Branch - 1000105	373 BRIGHTON AVE	LONG BRANCH	NJ	07740	$306,537.00	$306,537.00	$0.00	$0.00	$0.00	$0.00
	101329	NJ101329	✗	Passaic County	Evas Kitchen and Sheltering Prog Inc - Halfway House for Men	393 Main Street	Paterson	NJ	07501	$385,319.00	$385,319.00	$385,319.00	$0.00	$0.00	$0.00
	300855	NJ300855	✓	07	Family Connections Inc	395 South Center Street	Orange	NJ	07050	$430,000.00	$0.00	$0.00	$430,000.00	$0.00	$0.00
	2000318	NJ300855	✗	99	Family Connections, Inc. - 2000318	395 SOUTH CENTER STREET	ORANGE	NJ	07050	$2,542.00	$2,542.00	$0.00	$0.00	$0.00	$0.00
	2000005	NJ107359	✗	99	Family Guidance Center of Warren County - 2000005	370 MEMORIAL PKWY	PHILLIPSBURG	NJ	08865	$3,993.00	$3,993.00	$0.00	$0.00	$0.00	$0.00
	2000411	NJ902635	✗	99	Family Guidance Center of Warren County - 2000411	492 RT 57 W	WASHINGTON	NJ	07882	$7,304.00	$7,304.00	$0.00	$0.00	$0.00	$0.00
	101162	NJ101162	✗	Hunterdon County	FREEDOM HOUSE	2004 State Route 31 Unit 1	Clinton	NJ	08809 -2040	$48,879.00	$48,879.00	$48,879.00	$0.00	$0.00	$0.00
	1000023	NJ106864	✗	99	Freedom House - 1000023	200 SANITORIUM ROAD	GLEN GARDNER	NJ	08826	$925,571.00	$925,571.00	$0.00	$0.00	$0.00	$0.00
	2000518	NJ100516	✗	99	Freedom House - 2000518	2004 ROUTE 31, NORTH	CLINTON	NJ	08809	$142,978.00	$142,978.00	$0.00	$0.00	$0.00	$0.00
	2000650	NJ103267	✗	99	Freedom House Outpatient Services - 2000650	427-429 SOUTH MAIN STREET	PHILLIPSBURG	NJ	08865	$24,928.00	$24,928.00	$0.00	$0.00	$0.00	$0.00
	2000153	NJ101478	✗	99	Genesis Counseling Center - 2000153	1000 ATLANTIC AVE	CAMDEN	NJ	08105	$2,687.00	$2,687.00	$0.00	$0.00	$0.00	$0.00
	2000146	NJ101899	✗	99	Genesis Counseling Center, Inc. - 2000146	566 Haddon Avenue	Collingswood	NJ	08108	$31,130.00	$31,130.00	$0.00	$0.00	$0.00	$0.00
	2000171	NJ101573	✗	99	Genesis Counseling Center, Marlton - 2000171	2003 C LINCOLN DR , WEST	MARLTON	NJ	08053	$21,041.00	$21,041.00	$0.00	$0.00	$0.00	$0.00

	101477	NJ101477	✓	Hunterdon County	Good News Home for Women	33 Bartles Corner Road	Flemington	NJ	08822	$582,542.00	$582,542.00	$582,542.00	$0.00	$0.00	$0.00
	1000003	NJ101677	✗	99	Hansen House - 1000003	411 ALOE ST	EGG HARBOR CITY	NJ	08215	$657,418.00	$657,418.00	$0.00	$0.00	$0.00	$0.00
	1000007	NJ105270	✗	99	Hendricks House, Inc. - 1000007	542 N West Blvd	Vineland	NJ	08360	$383,813.00	$383,813.00	$0.00	$0.00	$0.00	$0.00
	2000218	NJ306357	✗	99	Hispanic Family Center of Southern New Jersey - 2000218	2700 WESTFIELD AVE	CAMDEN	NJ	08105	$4,603.00	$4,603.00	$0.00	$0.00	$0.00	$0.00
	306357	NJ306357	✗	04	Hispanic Family Center of Southern NJ - New Jersey Substance Abuse Services	2700 Westfield Avenue	Camden	NJ	08105	$272,000.00	$0.00	$0.00	$272,000.00	$0.00	$0.00
	2000184	NJ306241	✗	99	Hunterdon Drug Awareness Program, Inc. - 2000184	8 Main St	Flemington	NJ	08822	$56,092.00	$56,092.00	$0.00	$0.00	$0.00	$0.00
	104232	NJ750216	✗	Hunterdon County	HUNTERDON PREVENTION RESOURCES	4 Walter Foran Boulevard Suite 410	Flemington	NJ	08822	$319,500.00	$0.00	$0.00	$319,500.00	$0.00	$0.00
	2000631	NJ103517	✗	99	Integrity House - 2000631	310 MAIN STREET	TOMS RIVER	NJ	08753	$1,932.00	$1,932.00	$0.00	$0.00	$0.00	$0.00
	100420	NJ100420	✗	07	Integrity House Inc - Mens Facility	105 Lincoln Park	Newark	NJ	07102	$282,232.00	$279,381.00	$0.00	$0.00	$2,851.00	$0.00
	2000249	NJ103520	✗	99	Integrity Inc, The Wise Program - 2000249	659 MARTIN LUTHER KING BLVD	NEWARK	NJ	07102 -1119	$10,168.00	$10,168.00	$0.00	$0.00	$0.00	$0.00
	1000022	NJ107706	✗	99	Integrity, Inc. - 1000022	99 LINCOLN PARK	NEWARK	NJ	07102	$82,791.00	$82,791.00	$0.00	$0.00	$0.00	$0.00
	1000036	NJ103390	✗	99	Integrity, Inc. - 1000036	595 COUNTY AVENUE, BUILDING #6	SECAUCUS	NJ	07094	$473,848.00	$473,848.00	$0.00	$0.00	$0.00	$0.00
	1000070	NJ107722	✗	99	Integrity, Inc. - 1000070	43 LINCOLN PARK	NEWARK	NJ	07102	$53,908.00	$53,908.00	$0.00	$0.00	$0.00	$0.00
	1000072	NJ000163	✗	99	Integrity, Inc. - 1000072	101 LINCOLN PARK	NEWARK	NJ	07102	$117,827.00	$117,827.00	$0.00	$0.00	$0.00	$0.00
	1000081	NJ100420	✗	99	Integrity, Inc. - 1000081	105 LINCOLN PARK	NEWARK	NJ	07102	$63,316.00	$63,316.00	$0.00	$0.00	$0.00	$0.00
	2000333	NJ107821	✗	99	Integrity, Inc. - 2000333	26-28 LONGWORTH ST	NEWARK	NJ	07102	$102,067.00	$102,067.00	$0.00	$0.00	$0.00	$0.00
	2000530	NJ103518	✗	99	Integrity, Inc. - 2000530	360-398 MARTIN LUTHER KING DRIVE	JERSEY CITY	NJ	07305	$377.00	$377.00	$0.00	$0.00	$0.00	$0.00
	2000613	NJ103519	✗	99	Integrity, Inc. - 2000613	30-32 CENTRAL AVENUE	JERSEY CITY	NJ	07306	$29,467.00	$29,467.00	$0.00	$0.00	$0.00	$0.00
	2000435	NJ100594	✗	99	Inter County Council on Drug and Alcohol Abuse - 2000435	480 KEARNY AVE	KEARNY	NJ	07032	$152,917.00	$152,917.00	$0.00	$0.00	$0.00	$0.00
	306209	NJ306209	✗	09	Inter County Council on Drug/Alc Abuse - Administration/Drug Free Counseling	480 Kearny Avenue	Kearny	NJ	07032	$37,790.00	$21,590.00	$21,590.00	$0.00	$16,200.00	$0.00
	100461	NJ100461	✗	Mercer County	IRON RECOVERY AND WELLNESS CEN	132 Perry Street	Trenton	NJ	08618	$7,556.00	$7,556.00	$7,556.00	$0.00	$0.00	$0.00
	2000870	NJ103311	✗	99	Iron Recovery and Wellness Center, Inc. - 2000870	132 Perry St.	Trenton	NJ	08618	$37,223.00	$37,223.00	$0.00	$0.00	$0.00	$0.00
	2000519	NJ102035	✗	99	Jewish Family and Children's Service of Greater Monmouth County - 2000519	705 SUMMERFIELD AVE	ASBURY PARK	NJ	07712	$52,533.00	$52,533.00	$0.00	$0.00	$0.00	$0.00
	300103	NJ300103	✓	01	JOHN BROOKS RECOVERY CENTER	1315 Pacific Avenue	Atlantic City	NJ	08401	$85,914.00	$38,862.00	$38,862.00	$0.00	$47,052.00	$0.00
	1000044	NJ101989	✗	99	John Brooks Recovery Center - 1000044	20 S TENNESSEE AVE	ATLANTIC CITY	NJ	08401	$133,410.00	$133,410.00	$0.00	$0.00	$0.00	$0.00
	1000048	NJ000081	✗	99	John Brooks Recovery Center - 1000048	1455 PINEWOOD BOULEVARD	MAYS LANDING	NJ	08330	$552,856.00	$552,856.00	$0.00	$0.00	$0.00	$0.00
	2000275	NJ101038	✗	99	John Brooks Recovery Center - 2000275	660 Black Horse Pike	Pleasantville	NJ	08232	$1,180,577.00	$1,180,577.00	$0.00	$0.00	$0.00	$0.00
	2000637	NJ102037	✗	99	John Brooks Recovery Center - OTP Bacharach Blvd. - 2000637	1931 BACHARACH BLVD.	ATLANTIC CITY	NJ	08401	$326,248.00	$326,248.00	$0.00	$0.00	$0.00	$0.00
	100156	NJ100156	✗	Monmouth County	JSAS HEALTHCARE INC.	685 Neptune Boulevard Suite 101	Neptune	NJ	07753	$106,443.00	$73,406.00	$73,406.00	$0.00	$33,037.00	$0.00

	2000316	NJ100156	✗	99	JSAS Healthcare, Inc. - 2000316	685 NEPTUNE BLVD	NEPTUNE	NJ	07754	$1,233,658.00	$1,233,658.00	$0.00	$0.00	$0.00	$0.00
	100404	NJ100404	✗	07	LENNARD CLINIC INC.	164 Blanchard Street	Newark	NJ	07105	$306,896.00	$181,356.00	$181,356.00	$0.00	$125,540.00	$0.00
	1000140	NJ103431	✗	99	MARYVILLE, INC - 1000140	610 PEMBERTONTON BROWNS MILL ROAD	PEMBERTON	NJ	08068	$136,507.00	$136,507.00	$0.00	$0.00	$0.00	$0.00
	2000680	NJ103109	✗	99	MARYVILLE, INC - 2000680	1907 NEW ROAD	NORTHFIELD	NJ	08225	$3,895.00	$3,895.00	$0.00	$0.00	$0.00	$0.00
	1000028	NJ106237	✗	99	Maryville, Inc. - 1000028	1903 Grant Avenue	Williamstown	NJ	08094	$367,449.00	$367,449.00	$0.00	$0.00	$0.00	$0.00
	2000132	NJ107193	✗	99	Maryville, Inc. - 2000132	129 JOHNSON ROAD	TURNERSVILLE	NJ	08012	$83,470.00	$83,470.00	$0.00	$0.00	$0.00	$0.00
	2000300	NJ107813	✗	99	Maryville, Inc. - 2000300	1173 EAST LANDIS AVENUE	VINELAND	NJ	08360	$17,987.00	$17,987.00	$0.00	$0.00	$0.00	$0.00
	902924	NJ902924	✗	Mercer County	Mercer Council on Alcoholism and - Drug Addiction	408 Bellevue Avenue	Trenton	NJ	08618	$356,100.00	$0.00	$0.00	$356,100.00	$0.00	$0.00
	2000423	NJ100651	✗	99	Morris County Aftercare Center - 2000423	273 East Main Street	Denville	NJ	07834	$813,295.00	$813,295.00	$0.00	$0.00	$0.00	$0.00
	101818	NJ101818	✗	Morris County	Morris County Prevention is Key	25 West Main Street	Rockaway	NJ	07866	$408,000.00	$0.00	$0.00	$408,000.00	$0.00	$0.00
	750299	NJ101301	✗	Mercer County	National Council on Alcoholism and - Drug Dependence	60 South Fullerton Avenue	ROBBINSVILLE	NJ	08691	$299,180.00	$0.00	$0.00	$299,180.00	$0.00	$0.00
	103309	NJ103309	✗	09	National Council on Alcoholism and - Drug Dependence/Hudson County	309-311 Newark Avenue	EAST BRUNSWICK	NJ	08816	$980,380.00	$0.00	$0.00	$980,380.00	$0.00	$0.00
	302026	NJ302026	✓	Middlesex County	New Brunswick Counseling Center	320 Suydam Street	New Brunswick	NJ	08901	$79,334.00	$56,134.00	$56,134.00	$0.00	$23,200.00	$0.00
	2000164	NJ302026	✗	99	New Brunswick Counseling Center - 2000164	320 Suydam Street	New Brunswick	NJ	08901 -2417	$681,268.00	$681,268.00	$0.00	$0.00	$0.00	$0.00
	2000292	NJ100685	✗	99	New Brunswick Counseling Center d/b/a Burlington Comprehensive Counseling Center - 2000292	75 WASHINGTON ST	MOUNT HOLLY	NJ	08060	$277,759.00	$277,759.00	$0.00	$0.00	$0.00	$0.00
	1000053	NJ103194	✗	99	New Hope Foundation, Inc. - 1000053	80 Conover Road	Marlboro	NJ	07746	$905,630.00	$905,630.00	$0.00	$0.00	$0.00	$0.00
	1000058	NJ108183	✗	99	New Hope Foundation, Inc., Epiphany House, Inc. - 1000058	300 FOURTH AVENUE	ASBURY PARK	NJ	07712	$98,295.00	$98,295.00	$0.00	$0.00	$0.00	$0.00
	2000110	NJ107003	✗	99	New Hope Foundation, Inc., Phillips House Outpatient Services - 2000110	190 CHELSEA AVE	LONG BRANCH	NJ	07740	$77,597.00	$77,597.00	$0.00	$0.00	$0.00	$0.00
	2000319	NJ902445	✗	99	New Hope Foundation, Inc., The Open Door - 2000319	2-4 NEW AND KIRKPATRICK STS	NEW BRUNSWICK	NJ	08901	$135,400.00	$135,400.00	$0.00	$0.00	$0.00	$0.00
	1000020	NJ107003	✗	99	New Hope Foundations's Phillip House Halfway House - 1000020	190 CHELSEA AVE	LONG BRANCH	NJ	07740	$178,618.00	$178,618.00	$0.00	$0.00	$0.00	$0.00
	2000307	NJ106260	✗	99	New Hope Outpatient Services - 2000307	2 MONMOUTH AVE	FREEHOLD	NJ	07728	$12,453.00	$12,453.00	$0.00	$0.00	$0.00	$0.00
	2000345	NJ100461	✗	99	New Horizon Treatment Services, Inc. - 2000345	132 PERRY STREET	TRENTON	NJ	08618	$492,659.00	$492,659.00	$0.00	$0.00	$0.00	$0.00
	2000078	NJ103381	✗	99	New Horizon Treatment Services, Inc., Gryphon House - 2000078	144 PERRY STREET	TRENTON	NJ	08618	$196.00	$196.00	$0.00	$0.00	$0.00	$0.00
	759802	NJ100858	✗	Ocean County	NEW JERSEY PREVENTION NETWORK	150 AIRPORT ROAD	LAKEWOOD	NJ	08701	$1,673,933.00	$1,167,684.00	$0.00	$506,249.00	$0.00	$0.00
	2000281	NJ101635	✗	99	New Life Program - 2000281	331 White Horse Pike	Atco	NJ	08004	$5,617.00	$5,617.00	$0.00	$0.00	$0.00	$0.00
	306092	NJ306092	✗	07	Newark Renaissance House Inc	50 Norfolk Street	Newark	NJ	07103	$349,610.00	$349,610.00	$349,610.00	$0.00	$0.00	$0.00
	101821	NJ101821	✗	07	North Jersey Community Research	393 Central Ave	Newark	NJ	07103	$225,000.00	$0.00	$0.00	$225,000.00	$0.00	$0.00

					Initiative										
	100487	NJ100487	✓	Passaic County	Northeast Life Skills Associates Inc	121 Howe Avenue	Passaic	NJ	07055	$22,670.00	$22,670.00	$22,670.00	$0.00	$0.00	$0.00
	2000320	NJ100487	✗	99	Northeast Life Skills Associates, Inc. - 2000320	121 Howe Ave	Passaic	NJ	07055	$268,865.00	$268,865.00	$0.00	$0.00	$0.00	$0.00
	2000597	NJ101236	✗	99	Oaks Integrated Care - 2000597	770 Woodlane Rd.	Mount Holly	NJ	08060-1056	$20,144.00	$20,144.00	$0.00	$0.00	$0.00	$0.00
	100503	NJ100503	✗	Union County	Organization for Recovery Inc	519 North Avenue	Plainfield	NJ	07060-1416	$25,908.00	$25,908.00	$25,908.00	$0.00	$0.00	$0.00
	2000304	NJ100503	✗	99	Organization for Recovery, Inc. - 2000304	519 North Ave	Plainfield	NJ	07060	$673,480.00	$673,480.00	$0.00	$0.00	$0.00	$0.00
	100495	NJ100495	✓	Passaic County	Paterson Counseling Center Inc	319-321 Main Street	Paterson	NJ	07505	$137,814.00	$99,314.00	$99,314.00	$0.00	$38,500.00	$0.00
	2000108	NJ100495	✗	99	Paterson Counseling Center, Inc. - 2000108	319-321 Main St	Paterson	NJ	07505-1805	$302,926.00	$302,926.00	$0.00	$0.00	$0.00	$0.00
	2000330	NJ102454	✗	99	Preferred Behavioral Health of N.J., Inc. - 2000330	848 W BAY AVE	BARNEGAT	NJ	08005	$38,530.00	$38,530.00	$0.00	$0.00	$0.00	$0.00
	2000557	NJ102015	✗	99	Preferred Behavioral Health of New Jersey @ Toms River - 2000557	1191 LAKEWOOD ROAD	TOMS RIVER	NJ	08755	$21,235.00	$21,235.00	$0.00	$0.00	$0.00	$0.00
	2000152	NJ101295	✗	99	Preferred Behavioral Health of New Jersey, Inc. - 2000152	700 AIRPORT RD	LAKEWOOD	NJ	08701	$67,944.00	$67,944.00	$0.00	$0.00	$0.00	$0.00
	101295	NJ101295	✓	Ocean County	Preferred Behavioral Health of NJ	700 Airport Road P.O. Box 2036	Lakewood	NJ	08701-1010	$60,210.00	$60,210.00	$60,210.00	$0.00	$0.00	$0.00
	2000648	NJ102918	✗	99	Preferred Behavioral Health of NJ - 2000648	1405 HIGHWAY 35	OCEAN	NJ	07712	$16,364.00	$16,364.00	$0.00	$0.00	$0.00	$0.00
	101308	NJ101308	✗	Monmouth County	PREVENTION FIRST	1405 Highway 35	Ocean	NJ	07712	$202,000.00	$0.00	$0.00	$202,000.00	$0.00	$0.00
	750802	NJ750802	✗	Union County	Prevention Links Inc	35 Walnut Avenue Suite 17	Clark	NJ	07066	$432,500.00	$0.00	$0.00	$432,500.00	$0.00	$0.00
	999031	NJ101823	✗	03	PREVENTION PLUS OF BURLINGTON	1824 ROUTE 38 EAST	LUMBERTON	NJ	08048	$448,000.00	$0.00	$0.00	$448,000.00	$0.00	$0.00
	2000002	NJ100920	✗	99	Recovery Innovations, Inc. - 2000002	1 Corbett Way	Eatontown	NJ	07724	$11,809.00	$11,809.00	$0.00	$0.00	$0.00	$0.00
	1000030	NJ750687	✗	99	Rescue Mission of Trenton - 1000030	96 CARROLL ST	TRENTON	NJ	08609	$9,570.00	$9,570.00	$0.00	$0.00	$0.00	$0.00
	1000082	NJ750687	✗	99	Rescue Mission of Trenton - 1000082	96 CARROLL ST	TRENTON	NJ	08609	$441,661.00	$441,661.00	$0.00	$0.00	$0.00	$0.00
	2000107	NJ101115	✗	99	Rescue Mission of Trenton - 2000107	72 EWING ST	TRENTON	NJ	08609	$36,902.00	$36,902.00	$0.00	$0.00	$0.00	$0.00
	104315	NJ104315	✗	Middlesex County	RUTGERS THE STATE UNIV RBHS	100 JOYCE KILMER AVE	PISCATAWAY	NJ	08854	$1,122,637.00	$156,546.00	$156,546.00	$0.00	$966,091.00	$0.00
	102934	NJ102934	✗	Middlesex County	RUTGERS THE STATE UNIVERSITY OF NJ	33 Knightsbridge Road 2nd Fl East Wing	Piscataway	NJ	08854	$112,500.00	$0.00	$0.00	$112,500.00	$0.00	$0.00
	301069	NJ301069	✗	Ocean County	Seashore Family Services of New Jersey	35 Beaverson Boulevard Suite 6-A	Brick	NJ	08723	$175,307.00	$175,307.00	$175,307.00	$0.00	$0.00	$0.00
	2000302	NJ301309	✗	99	SODAT of NJ, Inc. - 2000302	124 NORTH BROAD STREET	WOODBURY	NJ	08096	$45,399.00	$45,399.00	$0.00	$0.00	$0.00	$0.00
	2000331	NJ108068	✗	99	SODAT of NJ, Inc. - 2000331	75 MARKET STREET	SALEM	NJ	08079-1108	$29,328.00	$29,328.00	$0.00	$0.00	$0.00	$0.00
	2000198	NJ100882	✗	99	SODAT of NJ, Inc. Camden Office - 2000198	805-815 FEDERAL STREET	CAMDEN	NJ	08101	$14,320.00	$14,320.00	$0.00	$0.00	$0.00	$0.00
	2000210	NJ108076	✗	99	SODAT of NJ, Inc. Mount Holly Office - 2000210	60 HIGH ST	MOUNT HOLLY	NJ	08060	$18,956.00	$18,956.00	$0.00	$0.00	$0.00	$0.00
	2000040	NJ101237	✗	99	SODAT of NJ, Inc., Cumberland - 2000040	92 VINE STREET	BRIDGETON	NJ	08302	$9,258.00	$9,258.00	$0.00	$0.00	$0.00	$0.00
	750612	NJ750612	✗	Somerset County	Somerset Council on - Alcoholism and Drug Dependency Inc	34 West Main Street Suite 307	Somerville	NJ	08876	$168,300.00	$0.00	$0.00	$168,300.00	$0.00	$0.00
	100693	NJ100693	✓	Somerset County	Somerset Treatment Services	118 West End Avenue	Somerville	NJ	08876	$37,790.00	$21,590.00	$21,590.00	$0.00	$16,200.00	$0.00
	2000200	NJ100693	✗	99	Somerset Treatment Services - 2000200	118 West End Avenue	Somerville	NJ	08876	$271,179.00	$271,179.00	$0.00	$0.00	$0.00	$0.00

	100677	NJ100677	✗	04	South Jersey Drug Treatment Center	162 Sunny Slope Drive, P.O. Box 867	Bridgeton	NJ	08302	$6,291.00	$0.00	$0.00	$0.00	$6,291.00	$0.00
	2000355	NJ100677	✗	99	South Jersey Drug Treatment Center - 2000355	162 Sunny Slope Dr	Bridgeton	NJ	08302	$135,385.00	$135,385.00	$0.00	$0.00	$0.00	$0.00
	109876	NJ109876	✗	04	Southern New Jersey Perinatal Cooperative	2500 McClellan Ave	Pennsauken	NJ	08109	$344,802.00	$344,802.00	$344,802.00	$0.00	$0.00	$0.00
	2000142	NJ306316	✗	99	Spectrum Health Care, Inc. - 2000142	74-80 Pacific Ave.	Jersey City	NJ	07304 -3216	$1,148,755.00	$1,148,755.00	$0.00	$0.00	$0.00	$0.00
	306316	NJ306316	✓	09	Spectrum Healthcare Inc	74-80 Pacific Avenue	Jersey City	NJ	07304	$162,566.00	$120,904.00	$120,904.00	$0.00	$41,662.00	$0.00
	105072	NJ100095	✗	01	St. Barnabas Health Care Inst. for Prevention	1695 US HIGHWAY 9	TOMS RIVER	NJ	08754	$1,004,880.00	$0.00	$0.00	$1,004,880.00	$0.00	$0.00
	2000491	NJ101996	✗	99	STAND4RECOVERY PROGRAM - 2000491	316 HADDON AVE	COLLINGSWOOD	NJ	08108	$40,181.00	$40,181.00	$0.00	$0.00	$0.00	$0.00
	999074	NJ102679	✗	Passaic County	STRAIGHT & NARROW INC	508 Straight Street, P.O. Box 2738	Paterson	NJ	07501	$1,708,272.00	$1,696,667.00	$1,696,667.00	$0.00	$11,605.00	$0.00
	1000061	NJ106799	✗	99	Straight & Narrow, Inc. - 1000061	595 COUNTY AVE	SECAUCUS	NJ	07094	$6,145.00	$6,145.00	$0.00	$0.00	$0.00	$0.00
	2000176	NJ306258	✗	99	Straight & Narrow, Inc. - 2000176	230 E RIDGEWOOD AVE	PARAMUS	NJ	07652	$455,222.00	$455,222.00	$0.00	$0.00	$0.00	$0.00
	1000143	NJ102682	✗	99	Straight & Narrow, Inc. - Alpha House I - 1000143	394 STRAIGHT STREET	PATERSON	NJ	07501	$50,121.00	$50,121.00	$0.00	$0.00	$0.00	$0.00
	1000040	NJ102682	✗	99	Straight and Narrow Alpha House - 1000040	396 STRAIGHT ST	PATERSON	NJ	07501	$8,764.00	$8,764.00	$0.00	$0.00	$0.00	$0.00
	2000308	NJ102679	✗	99	Straight and Narrow Outpatient Clinic - 2000308	508 Straight St	Paterson	NJ	07503 -3044	$15,854.00	$15,854.00	$0.00	$0.00	$0.00	$0.00
	2000321	NJ100720	✗	99	Team Management 2000, Inc. - 2000321	84 MAIN STREET	HACKENSACK	NJ	07601	$55,350.00	$55,350.00	$0.00	$0.00	$0.00	$0.00
	2000054	NJ101716	✗	99	Team Management 2000, Inc. CBO - 2000054	744 BROAD STREET	NEWARK	NJ	07102	$227.00	$227.00	$0.00	$0.00	$0.00	$0.00
	2000689	NJ102850	✗	99	The Appropriate Place, Inc. - 2000689	660 S. 21ST STREET	IRVINGTON	NJ	07111	$4,635.00	$4,635.00	$0.00	$0.00	$0.00	$0.00
	2000061	NJ100457	✗	99	The Bridge, Inc. - 2000061	50 UNION AVE	IRVINGTON	NJ	07111	$16,336.00	$16,336.00	$0.00	$0.00	$0.00	$0.00
	2000144	NJ370700	✗	99	The Bridge, Inc. - 2000144	860 Bloomfield Avenue	West Caldwell	NJ	07006	$3,953.00	$3,953.00	$0.00	$0.00	$0.00	$0.00
	101830	NJ101830	✗	02	The Center for Alcohol and - Drug Resource	241 Main Street	PARAMUS	NJ	07652	$655,600.00	$0.00	$0.00	$655,600.00	$0.00	$0.00
	107771	NJ107771	✗	Somerset County	THE CENTER FOR GREAT EXPECTATIONS	19 Dellwood Lane Suite B	Somerset	NJ	08873	$187,000.00	$187,000.00	$187,000.00	$0.00	$0.00	$0.00
	2000163	NJ101959	✗	99	The Center for Great Expectations - 2000163	303 GEORGE ST, 1ST FLOOR	NEW BRUNSWICK	NJ	08901	$1,574.00	$1,574.00	$0.00	$0.00	$0.00	$0.00
	2000196	NJ306449	✗	99	The Lennard Clinic, Inc. - 2000196	461 Frelinghuysen Avenue	Newark	NJ	07114	$642,664.00	$642,664.00	$0.00	$0.00	$0.00	$0.00
	2000417	NJ101215	✗	99	The Lennard Clinic, Inc. - 2000417	850 WOODRUFF LN	ELIZABETH	NJ	07201	$273,852.00	$273,852.00	$0.00	$0.00	$0.00	$0.00
	102467	NJ102467	✗	03	THE NEW HOPE FOUNDATION INC	80 Conover Road	Marlboro	NJ	07746	$886,360.00	$886,360.00	$886,360.00	$0.00	$0.00	$0.00
	101309	NJ101309	✗	06	THE SOUTHWEST COUNCIL INC.	1405 North Delsea Drive	Vineland	NJ	08360	$940,400.00	$0.00	$0.00	$940,400.00	$0.00	$0.00
	750729	NJ102675	✗	07	TURNING POINT INC	15 Bloomfield Avenue Suite 104	Verona	NJ	07044	$147,273.00	$147,273.00	$147,273.00	$0.00	$0.00	$0.00
	1000062	NJ101851	✗	99	Turning Point, Inc. - 1000062	680 BROADWAY	PATERSON	NJ	07514	$615,222.00	$615,222.00	$0.00	$0.00	$0.00	$0.00
	2000702	NJ100641	✗	99	Turning Point, Inc. - 2000702	101 PROSPECT STREET	LAKEWOOD	NJ	08701	$22,806.00	$22,806.00	$0.00	$0.00	$0.00	$0.00
	100939	NJ100939	✗	04	Urban Renewal Corp Sussex House	224 Sussex Avenue	CAMDEN	NJ	08102	$97,915.00	$21,590.00	$21,590.00	$0.00	$76,325.00	$0.00
	2000459	NJ000281	✗	99	Urban Treatment Associates, Inc. - 2000459	508 Atlantic Avenue	Camden	NJ	08104	$611,300.00	$611,300.00	$0.00	$0.00	$0.00	$0.00
	2000322	NJ102452	✗	99	Wayne Counseling and Family Services - 2000322	1022 Hamburg Turnpike	Wayne	NJ	07470 -3209	$14,959.00	$14,959.00	$0.00	$0.00	$0.00	$0.00

	371203	NJ371203	X	Passaic County	WAYNE COUNSELING CTR INC	1022 Hamburg Turnpike	Wayne	NJ	07470	$201,300.00	$0.00	$0.00	$201,300.00	$0.00	$0.00
	101836	NJ101836	X	Passaic County	William Paterson University	300 Pompton Road	Wayne	NJ	07444	$146,682.00	$0.00	$0.00	$146,682.00	$0.00	$0.00
Total										$40,944,935.00	$29,900,570.00	$5,953,086.00	$9,639,811.00	$1,404,554.00	$0.00

*** Indicates the imported record has an error.**

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Footnotes:

Amount of SABG Primary Prevention funds (from Table 4, Row 2) used for SABG Prevention Resource Development Activities for SABG Prevention, Column D = $9,639,811.

III: Expenditure Reports

Table 8a - Maintenance of Effort for State Expenditures for SUD Prevention and Treatment

This Maintenance of Effort table provides a description of non-federal expenditures to include funds appropriated by the state legislature; revenue funds (e.g., alcohol, tobacco, and gambling taxes; asset seizures); state Medicaid match expenditures; and third-party reimbursement (e.g., insurance payments) for authorized activities to prevent and treat SUDs flowing through the Single State Agency (SSA) during the state fiscal year immediately preceding the federal fiscal year for which the state is applying for funds.

Expenditure Period Start Date: 07/01/2020 Expenditure Period End Date: 06/30/2021

Total Single State Agency (SSA) Expenditures for Substance Abuse Prevention and Treatment		
Period **(A)**	**Expenditures** **(B)**	**B1(2019) + B2(2020)** **2** **(C)**
SFY 2019 (1)	$119,512,134.00	
SFY 2020 (2)	$155,469,198.00	$137,490,666.00
SFY 2021 (3)	$152,686,955.00	

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

SFY 2019	Yes		No	X
SFY 2020	Yes	X	No	
SFY 2021	Yes	X	No	

Did the state or jurisdiction have any **non-recurring expenditures** as described in 42 U.S.C. § 300x-30(b) for a specific purpose which were not included in the MOE calculation?

Yes ____ No X

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

If yes, SFY: _____

Did the state or jurisdiction include these funds in previous year MOE calculations?

Yes ____ No ____

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

If estimated expenditures are provided, please indicate when actual expenditure data will be submitted to SAMHSA: _____

Please provide a description of the amounts and methods used to calculate the total Single State Agency (SSA) expenditures for substance use disorder prevention and treatment 42 U.S.C. §300x-30.

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Footnotes:

MAINTENANCE OF EFFORT (MOE) CALCULATIONS FOR SFY 2021
SUBSTANCE ABUSE PREVENTION AND TREATMENT (SAPT) BLOCK GRANT

This Attachment explains how the following two SAPT Maintenance of Effort expenditure entries are calculated:

Table 8a - Maintenance of Effort for State Expenditures for SAPT
Table 8d - Expenditures for Services to Pregnant Women and Women with Dependent Children

It also summarizes the original procedures used to calculate the base amounts, which are the benchmarks against which current MOE expenditures are measured.

REQUIREMENTS for STATEWIDE MOE: 45 CFR Part § 96.134

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

Methodology: Calculation of SAPT Statewide Maintenance of Effort (MOE)

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

100-054-7700-158, Funds transferred from NJ Administrative Office of the Courts posted into this account
100-054-7700-161, Substance Abuse Treatment for DCP&P/Work First Mothers
100-054-7700-162, Community Based Substance Abuse Treatment and Prevention – State Share
100-054-7700-163, Medication Assisted Treatment Initiative
100-054-7700-165, Mutual Agreement Parolee Rehabilitation Project for Substance Abusers
100-054-7700-176, Alcohol Education Rehabilitation and Enforcement Fund (AEREF)
100-054-7700-178, Drug Enforcement and Demand Reduction Fund; Partnership for a Drug-Free NJ
100-046-4290-212, Recovery Coach Program
100-054-7700-232, Recovery Housing
100-054-7700-247, Substance Exposed Infants
760-054-7700-001, (4290-001) AEREF; funding for the Local Alcohol Authorities Expansion Program
100-054-7700-231, Supportive Housing Subsidies
100-054-7700-238, HOPE ONE -ST AID GRTS
100-054-7700-242, Jail MAT Reentry Initiative
100-054-7700-244, IME Addiction Call Center
100-054-7700-246, Media Campaign

Some State MOE expenditures occur via interagency Memoranda of Agreements (MOA) with other State agencies better positioned to administer certain program functions. Expenditures from the New Jersey Administrative Office of the Court (AOC) expenditures are posted to 100-054-7700-158 (046-4290-158); Department of Corrections (DOC) and the State Parole Board (SPB) expenditures are posted to 100-054-7700-165 (046-4290-165).

Expenditures related to the Intoxicated Driver Resources Center Fund (100-054-7700-175 (046-4290-175)), the Compulsive Gambling fund (100-054-7700-164 (046-4290-164)), the Racing Commission Fees (100-054-7700-173 (046-4290-173)) and Internet Gambling (100-054-7700-193 (046-4290-193)) continue to be expressly excluded from New Jersey's SAPT Statewide MOE calculation as per past practice. Also excluded are Department of Treasury expenditures for rent, fringe benefits, and indirect costs.

New Jersey's MOE calculation also does not include construction costs for Request for Proposal (RFP) awards. This conforms to 42.USC.300x-3 (a) and 45.CFR.96.135 (a), (3) and (d) barring the use of grant funds for the purchase of land, construction costs or to permanently improve (other than minor remodeling) any building or any other facility, or to purchase major medical equipment.

Process to calculate New Jersey SAPT Statewide MOE

New Jersey's State Fiscal Year (SFY) begins July 1 and runs through June 30. Prior to the beginning of each SFY, budget planning occurs that includes the identification of available resources from the SAPT MOE related accounts. Calculations are performed to closely project the total funds on hand for State SAPT MOE costs. Consideration is given to any changes in direct appropriations, revisions to MOA and MOU agreements with other agencies, and financial recording methodologies that may impact the MOE calculation. The projections are updated on the DMHAS quarterly spending plan reports presented to the Department of Human Services (DHS) senior management.

Monitoring occurs periodically (at least quarterly) to ascertain whether actual expenditures are in line with projections. This analysis is based on Year-To-Date encumbrances, expenditures and budgeted line-item amounts. The analysis also includes discussions with program officials who are best-positioned to have knowledge of problems with sub-grantees, work-schedule delays, and other issues that are likely to affect MOE spending. When the projection is finished, program officials are apprised of expenditures, obligations, projected expenditure deficiencies and other information that may impact the State MOE obligations. Any projected MOE deficiency is further reported to the DMHAS Chief Financial Officer.

No sooner than one month following the close of New Jersey's State Fiscal Year, a report is created. It is based on transactions downloaded from New Jersey's Comprehensive Financial System (NJCFS). An analysis to identify the allowability of all reported expenditures is conducted by the financial analyst responsible for the SAPT grant. Supporting backup documentation is compiled to support any needed adjustments that are identified. Adjustments may be required because any MOA reimbursement to DHS from another State agency will reduce the reimbursed DHS account by an amount equal to the reimbursement. The reimbursement distorts actual expenditures; the adjustment removes the distortion while correcting the total. Any required adjustment is reviewed by management who either approves, amends, or disapproves the adjustment which the analyst then includes or excludes from the report, whatever the case may be. The analyst notes any adjustment to the report. Reconciliation is performed to prove correctness of the report. After review and approval of the final report by management, the

final figures are entered in the appropriate boxes of WEBbGAS Table 8a, Maintenance of Effort for State Expenditures.

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

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

The final base amount applicable to the FFY 1994 SAPT BG Award (and all subsequent awards) was calculated in the following manner:

1. Begin with the FFY 1992 PW/WDC expenditure base of $2,752,187.
2. Calculate five percent of the FFY1993 SAPT BG award ($37,452,980*5%= $1,872,649)
3. Sum 1992 base and Calculated amount to establish FFY-**1993 PW-WDC Base** ($2,752,187+$1,872,649= **$4,624,836**)
4. Calculate five percent of FFY-1994 SAPT BG award ($37,452,980*5%= $1,872,649)
5. Sum 1993 Base and Calculated amount to establish FFY-**1994 PW-WDC Base** ($4,624,836+$1,872,649= **$6,497,485**).
6. The calculated amount of $6,497,485 is the PW-WDC Base that shall be used in 1995 and all subsequent years.
7. The Base amount is prepopulated in Column A of WEBbGAS Table 8d.

Prior to FFY 2008, DAS reported only SAPT Block Grant expenditures expended from a single SAPT BG Award as the revenue source for meeting the PW/WDC MOE. In subsequent years, consistent with the implementing rule and emerging SAMHSA policy, DMHAS has utilized a mix of State and SAPT BG funds to report a complete calculation of expenditures comprising the PW/WDC expenditure requirement. Consistent with the operative instructions for Table 8d, DMHAS continues to report State and BG expenditures on a State Fiscal Year (SFY) basis, i.e. SFY 2021.

Pregnant Women and Women with Dependent Children MOE Funding

1. Prior to the beginning of each State Fiscal Year, available resources for PW-WDC MOE requirements are identified.
2. Total resources available for PW/WDC are calculated.
3. Changes in appropriation amounts, MOAs or MOUs with other state agencies are identified and analyzed. Their impact on the MOE is estimated.
4. Financial recording methodologies are analyzed and their impact is calculated.
5. A projection is prepared. It is reviewed by senior management.
6. Upon approval of the projection, the DMHAS quarterly spending plan reports is updated to reflect the projected amount.
7. PW/WDC expenditures are periodically monitored by the analyst responsible for the SAPT block grant to ensure MOE spending is consistent with meeting the MOE requirement.

At the conclusion of the SFY, a data report is generated by fund source and cost center to include PW/WDC costs. An MOE analysis is performed based on expenditures. New Jersey's PW/WDC MOE includes expenditures by DMHAS from both State and Federal SAPT BG dollars made during the prior 12-month SFY (7/1 through 6/30) time period. State accounts Include funds appropriated to DHS:

- Work First Mothers account (100-054-7700-161).
- SAPT BG PW/WDC account set aside funds (100-054-7700-168) with lower level organization codes 4221.

The DMHAS combined SAPT Block Grant and State expenditures specifically includes funds classified and targeted to services for PW/WDC, based on object codes to properly classify those expenditures. For SFY 2021, it totals $8,171,204 as documented in Row B on Table 8d in Web BGAS.

III: Expenditure Reports

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

This Maintenance of Effort table provides a description of expenditures including SABG and state funds (e.g., state legislature appropriations; revenue funds; state Medicaid match funds; and third-party reimbursements) for specialized treatment and related services that meet the SABG requirements for pregnant women and women with dependent children flowing through the Single State Agency (SSA) during the state fiscal year immediately preceding the federal fiscal year for which the state is applying for funds.

Expenditure Period Start Date: 07/01/2020 Expenditure Period End Date: 06/30/2021

Base

Period	Total Women's Base (A)
SFY 1994	$ 6,497,485.00

Maintenance

Period	Total Women's Base (A)	Total Expenditures (B)	Expense Type
SFY 2019		$ 7,425,987.00	
SFY 2020		$ 7,662,799.00	
SFY 2021		$ 8,171,204.00	○ Actual ◉ Estimated
Enter the amount the State plans to expend in SFY 2022 for services for pregnant women and women with dependent children (amount entered must be not less than amount entered in Section III: Table 8b – Expenditures for Services to Pregnant Women and Women with Dependent Children, Base, Total Women's Base (A) for Period of (SFY 1994)): $ 7400000.00			

Please provide a description of the amounts and methods used to calculate the base and, for 1994 and subsequent fiscal years, report the Federal and State expenditures for such services for services to pregnant women and women with dependent children as required by 42 U.S.C. §300x-22(b)(1).
The description of the amounts and methods used to calculate the information is included in the document attached to Table 8a.

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Footnotes:

The estimate reported for SFY 2021 will be revised with actual results by 6/1/2022.

IV: Population and Services Reports

Table 9 - Prevention Strategy Report

This table requires additional information (pursuant to Section 1929 of Title XIX, Part B, Subpart II of the PHS Act(42 U.S.C.§ 300x29) about the primary prevention activities conducted by the entities listed on SABG Table 7.

Expenditure Period Start Date: 10/1/2018 Expenditure Period End Date: 9/30/2020

Column A (Risks)	Column B (Strategies)	Column C (Providers)
Children of Persons with Substance Use Disorders	**2. Education**	
	1. Parenting and family management	9
	2. Ongoing classroom and/or small group sessions	11
	4. Education programs for youth groups	7
	5. Mentors	4
	3. Alternatives	
	1. Drug free dances and parties	6
Violent and delinquent behavior	**2. Education**	
	1. Parenting and family management	12
	2. Ongoing classroom and/or small group sessions	5
	5. Mentors	6
Mental health problems	**1. Information Dissemination**	
	7. Health fairs and other health promotion, e.g., conferences, meetings, seminars	9
	2. Education	
	2. Ongoing classroom and/or small group sessions	4
Economically disadvantaged	**2. Education**	
	1. Parenting and family management	12
	2. Ongoing classroom and/or small group sessions	5
Already using substances	**2. Education**	
	2. Ongoing classroom and/or small group sessions	3
	4. Problem Identification and Referral	
	1. Employee Assistance Programs	1
	5. Community-Based Process	
	3. Multi-agency coordination and collaboration/coalition	3
Homeless and/or runaway youth	**2. Education**	
	2. Ongoing classroom and/or small group sessions	1

	3. Alternatives	
	1. Drug free dances and parties	5
	2. Youth/adult leadership activities	4
	3. Community drop-in centers	3
	6. Recreation activities	12
18 to 25 year olds statewide	**6. Environmental**	
	5. Enactment of municipal ordinances, merchant education, beverage server trainings	21

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Footnotes:

IV: Population and Services Reports

Table 10 - Treatment Utilization Matrix

This table is intended to capture the count of persons with initial admissions and subsequent admission(s) to an episode of care.

Expenditure Period Start Date: 7/1/2020 Expenditure Period End Date: 6/30/2021

Level of Care	SABG Number of Admissions ≥ Number of Persons Served		COVID-19 Number of Admissions ≥ Number of Persons Served		SABG Costs per Person (C, D & E)			COVID-19 Costs per Person (C, D & E)		
	Number of Admissions (A)	Number of Persons Served (B)	Number of Admissions (A)	Number of Persons Served (B)	Mean Cost of Services (C)	Median Cost of Services (D)	Standard Deviation of Cost (E)	Mean Cost of Services (C)	Median Cost of Services (D)	Standard Deviation of Cost (E)
DETOXIFICATION (24-HOUR CARE)										
1. Hospital Inpatient	13	13								
2. Free-Standing Residential	11,426	7,907								
REHABILITATION/RESIDENTIAL										
3. Hospital Inpatient	411	374								
4. Short-term (up to 30 days)	7,677	6,243								
5. Long-term (over 30 days)	4,768	3,793								
AMBULATORY (OUTPATIENT)										
6. Outpatient	24,215	20,937								
7. Intensive Outpatient	15,490	12,775								
8. Detoxification	195	169								
OUD MEDICATION ASSISTED TREATMENT										
9. OUD Medication-Assisted Detoxification[1]	4,279	3,367								
10. OUD Medication-Assisted Treatment Outpatient[2]	10,298	8,270								

Please explain why Column A (SABG and COVID-19 Number of Admissions) are less than Column B (SABG and COVID-19 Number of Persons Served)

[1] OUD Medication-Assisted Treatment Detoxification includes hospital detoxification, residential detoxification, or ambulatory detoxification services/settings AND Opioid Medication-Assisted Treatment.

[2] OUD Medication Assisted Treatment Outpatient includes outpatient services/settings AND Opioid Medication-Assisted Treatment.

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Footnotes:

There were no services purchased with SABG COVID-19 supplemental funds in SFY 2021.

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Tables 11A, 11B and 11C - Unduplicated Count of Persons Served for Alcohol and Other Drug Use

This table provides an aggregate profile of the unduplicated number of admissions to and persons served in SABG and COVID-19 Relief Supplement funded services.

Expenditure Period Start Date: 7/1/2020 Expenditure Period End Date: 6/30/2021

TABLE 11A – SABG Unduplicated Count of Person Served for Alcohol and Other Drug Use

Age	A. Total	B. WHITE		C. BLACK OR AFRICAN AMERICAN		D. NATIVE HAWAIIAN / OTHER PACIFIC ISLANDER		E. ASIAN		F. AMERICAN INDIAN / ALASKAN NATIVE		G. MORE THAN ONE RACE REPORTED		H. Unknown		I. NOT HISPANIC OR LATINO		J. HISPANIC OR LATINO	
		Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
1. 17 and Under	174	97	44	21	7							3	2			59	150	51	55
2. 18 - 24	2,769	919	816	648	277	16	4	24	3	20	4	25	13			1,153	627	762	249
3. 25 - 44	23,534	9,675	7,364	4,007	1,666	143	64	158	48	135	41	144	89			11,240	3,279	6,819	1,299
4. 45 - 64	12,215	4,322	3,209	3,119	1,293	61	15	47	15	65	10	42	17			6,242	1,440	3,252	339
5. 65 and Over	813	284	190	248	76	7		1	1	4		2				468	65	156	9
6. Total	**39,505**	**15,297**	**11,623**	**8,043**	**3,319**	**227**	**83**	**230**	**67**	**224**	**55**	**216**	**121**	**0**	**0**	**19,162**	**5,561**	**11,040**	**1,951**
7. Pregnant Women	469		324		132		1		3		3		6				385		84

Number of persons served who were admitted in a period prior to the 12 month reporting period	29,406
Number of persons served outside of the levels of care described on Table 10	57

Are the values reported in this table generated from a client based system with unique client identifiers? (•) Yes ( ) No

TABLE 11B – COVID-19 Unduplicated Count of Persons Served for Alcohol and Other Drug Use

Age	A. Total	B. WHITE		C. BLACK OR AFRICAN AMERICAN		D. NATIVE HAWAIIAN / OTHER PACIFIC ISLANDER		E. ASIAN		F. AMERICAN INDIAN / ALASKAN NATIVE		G. MORE THAN ONE RACE REPORTED		H. Unknown		I. NOT HISPANIC OR LATINO		J. HISPANIC OR LATINO	
		Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
1. 17 and Under	0																		
2. 18 - 24	0																		
3. 25 - 44	0																		
4. 45 - 64	0																		
5. 65 and Over	0																		
6. Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
7. Pregnant Women	0																		

TABLE 11C – SABG Unduplicated Count of Person Served for Alcohol and Other Drug Use by Sex, Gender Identity, and Sexual Orientation (Requested)

Age	Cisgender Male	Cisgender Female	Transgender Man /Transman /Female -To-Man	Transgender Woman/ Transwoman/ Male-To-Female	Genderqueer/ Gender Non-Conforming/ Neither Exclusively Male nor Female	Additional Gender Category (or Other)	Straight or Heterosexual	Gay or Lesbian	Bisexual	Queer, Pansexual, and/or Questioning	Something Else? Please Specify Under Footnotes
1. 17 and Under											
2. 18 - 24						3					
3. 25 - 44						23					
4. 45 - 64						13					
5. 65 and Over						1					
6. Total	**0**	**0**	**0**	**0**	**0**	**40**	**0**	**0**	**0**	**0**	**0**

Footnotes:
Table 11B: There were no services purchased with SABG COVID-19 supplemental funds in SFY 2021.

Table 11C: Other Gender is a combination of all genders other than Male and Female.

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Table 12 - SABG Early Intervention Services Regarding the Human Immunodeficiency Virus (EIS/HIV) in Designated States

Expenditure Period Start Date: 7/1/2020 Expenditure Period End Date: 6/30/2021

Early Intervention Services for Human Immunodeficiency Virus (HIV)		
1. Number of SAPT HIV EIS programs funded in the State	Statewide: _____	Rural: _____
2. Total number of individuals tested through SAPT HIV EIS funded programs		
3. Total number of HIV tests conducted with SAPT HIV EIS funds		
4. Total number of tests that were positive for HIV		
5. Total number of individuals who prior to the 12-month reporting period were unaware of their HIV infection		
6. Total number of HIV-infected individuals who were diagnosed and referred into treatment and care during the 12-month reporting period		
Identify barriers, including State laws and regulations, that exist in carrying out HIV testing services:		

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Footnotes:

New Jersey is not a HIV designated state.

IV: Population and Services Reports

Table 13 - Charitable Choice

Under Charitable Choice Provisions; Final Rule (42 CFR Part 54), states, local governments, and religious organizations, such as SAMHSA grant recipients, must: (1) ensure that religious organizations that are providers provide to all potential and actual program beneficiaries (services recipients) notice of their right to alternative services; (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 this table is to document how the state is complying with these provisions.

Expenditure Period Start Date: 7/1/2020 Expenditure Period End Date: 6/30/2021

Notice to Program Beneficiaries - Check all that apply:

- [x] Used model notice provided in final regulation.
- [ ] Used notice developed by State (please attach a copy to the Report).
- [x] State has disseminated notice to religious organizations that are providers.
- [x] 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 Behavioral Health Treatment Locator is used to help identify providers.
- [ ] Other networks and information systems are used to help identify providers.
- [x] State maintains record of referrals made by religious organizations that are providers.

0 Enter the total number of referrals to other substance abuse providers ("alternative providers") necessitated by religious objection, as defined above, made during the State fiscal year immediately preceding the federal fiscal year for which the state is applying for funds. Provide the total only. No information on specific referrals is required. If no alternative referrals were made, enter zero.

Provide a brief description (one paragraph) of any training for local governments and/or faith-based and/or community organizations that are providers on these requirements.

There were no additional trainings provided to local government and faith-based and community organizations on these requirements for SFY 2021. In January 2020, all DMHAS addictions providers received correspondence indicating the Division's intent to monitor the provisions of the Charitable Choice Act. The correspondence included the model notice and the Charitable Choice law. In addition to the questionnaire portion of the annual site visit monitoring form (the form is sent to the agency prior to the review period and requires the agency to identify if they are, or are not faith-based in their approach to substance abuse treatment), all providers are required to submit quarterly referral logs to the Program Management Officers of the Contract Monitoring Unit in the event the agency receives a referral or request for transfer. In addition, the Program Management Officers of the Contract Monitoring Unit are required to complete an annual site visit to all of the contracted agencies. During the annual site visit, the Program Management Officers ask direct questions to executive staff members present at the opening interview pertaining to Charitable Choice referrals. The responses are recorded and documented in the annual site visit report. There were 0 Charitable Choice referrals for SFY 2021.

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Footnotes:

V: Performance Indicators and Accomplishments

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

Short-term Residential(SR)

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

	At Admission(T1)	At Discharge(T2)
Number of clients employed or student (full-time and part-time) [numerator]	1,152	1,144
Total number of clients with non-missing values on employment/student status [denominator]	6,710	6,710
Percent of clients employed or student (full-time and part-time)	17.2 %	17.0 %

Notes (for this level of care):	
Number of CY 2020 admissions submitted:	10,804
Number of CY 2020 discharges submitted:	10,830
Number of CY 2020 discharges linked to an admission:	7,775
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	6,771
Number of CY 2020 linked discharges eligible for this calculation (non-missing values):	6,710

Source: SAMHSA/CBHSQ TEDS CY 2020 admissions file and CY 2020 linked discharge file
[Records received through 2/1/2022]

Long-term Residential(LR)

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

	At Admission(T1)	At Discharge(T2)
Number of clients employed or student (full-time and part-time) [numerator]	1,162	1,549
Total number of clients with non-missing values on employment/student status [denominator]	4,418	4,418
Percent of clients employed or student (full-time and part-time)	26.3 %	35.1 %

Notes (for this level of care):	
Number of CY 2020 admissions submitted:	7,092
Number of CY 2020 discharges submitted:	7,599
Number of CY 2020 discharges linked to an admission:	5,180
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	4,460

Number of CY 2020 linked discharges eligible for this calculation (non-missing values):	4,418

Source: SAMHSA/CBHSQ TEDS CY 2020 admissions file and CY 2020 linked discharge file
[Records received through 2/1/2022]

Outpatient (OP)

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

	At Admission(T1)	At Discharge(T2)
Number of clients employed or student (full-time and part-time) [numerator]	4,904	5,733
Total number of clients with non-missing values on employment/student status [denominator]	10,083	10,083
Percent of clients employed or student (full-time and part-time)	48.6 %	56.9 %
Notes (for this level of care):		
Number of CY 2020 admissions submitted:		27,955
Number of CY 2020 discharges submitted:		28,110
Number of CY 2020 discharges linked to an admission:		15,050
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):		10,267
Number of CY 2020 linked discharges eligible for this calculation (non-missing values):		10,083

Source: SAMHSA/CBHSQ TEDS CY 2020 admissions file and CY 2020 linked discharge file
[Records received through 2/1/2022]

Intensive Outpatient (IO)

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

	At Admission(T1)	At Discharge(T2)
Number of clients employed or student (full-time and part-time) [numerator]	3,165	4,188
Total number of clients with non-missing values on employment/student status [denominator]	10,524	10,524
Percent of clients employed or student (full-time and part-time)	30.1 %	39.8 %
Notes (for this level of care):		
Number of CY 2020 admissions submitted:		22,321
Number of CY 2020 discharges submitted:		23,312
Number of CY 2020 discharges linked to an admission:		14,090
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):		10,836

Number of CY 2020 linked discharges eligible for this calculation (non-missing values):	10,524

Source: SAMHSA/CBHSQ TEDS CY 2020 admissions file and CY 2020 linked discharge file
[Records received through 2/1/2022]

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Footnotes:

V: Performance Indicators and Accomplishments

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

Short-term Residential(SR)

Clients living in a stable living situation (prior 30 days) at admission vs. discharge

	At Admission (T1)	At Discharge (T2)
Number of clients living in a stable situation [numerator]	5,402	6,426
Total number of clients with non-missing values on living arrangements [denominator]	6,708	6,708
Percent of clients in stable living situation	80.5 %	95.8 %

Notes (for this level of care):	
Number of CY 2020 admissions submitted:	10,804
Number of CY 2020 discharges submitted:	10,830
Number of CY 2020 discharges linked to an admission:	7,775
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	6,771
Number of CY 2020 linked discharges eligible for this calculation (non-missing values):	6,708

Source: SAMHSA/CBHSQ TEDS CY 2020 admissions file and CY 2020 linked discharge file
[Records received through 2/1/2022]

Long-term Residential(LR)

Clients living in a stable living situation (prior 30 days) at admission vs. discharge

	At Admission (T1)	At Discharge (T2)
Number of clients living in a stable situation [numerator]	3,734	3,962
Total number of clients with non-missing values on living arrangements [denominator]	4,420	4,420
Percent of clients in stable living situation	84.5 %	89.6 %

Notes (for this level of care):	
Number of CY 2020 admissions submitted:	7,092
Number of CY 2020 discharges submitted:	7,599
Number of CY 2020 discharges linked to an admission:	5,180
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	4,460
Number of CY 2020 linked discharges eligible for this calculation (non-missing values):	4,420

Source: SAMHSA/CBHSQ TEDS CY 2020 admissions file and CY 2020 linked discharge file
[Records received through 2/1/2022]

Outpatient (OP)

Clients living in a stable living situation (prior 30 days) at admission vs. discharge

	At Admission (T1)	At Discharge (T2)
Number of clients living in a stable situation [numerator]	9,793	9,879
Total number of clients with non-missing values on living arrangements [denominator]	10,074	10,074
Percent of clients in stable living situation	97.2 %	98.1 %

Notes (for this level of care):	
Number of CY 2020 admissions submitted:	27,955
Number of CY 2020 discharges submitted:	28,110
Number of CY 2020 discharges linked to an admission:	15,050
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	10,267
Number of CY 2020 linked discharges eligible for this calculation (non-missing values):	10,074

Source: SAMHSA/CBHSQ TEDS CY 2020 admissions file and CY 2020 linked discharge file
[Records received through 2/1/2022]

Intensive Outpatient (IO)

Clients living in a stable living situation (prior 30 days) at admission vs. discharge

	At Admission (T1)	At Discharge (T2)
Number of clients living in a stable situation [numerator]	9,794	10,058
Total number of clients with non-missing values on living arrangements [denominator]	10,521	10,521
Percent of clients in stable living situation	93.1 %	95.6 %

Notes (for this level of care):	
Number of CY 2020 admissions submitted:	22,321
Number of CY 2020 discharges submitted:	23,312
Number of CY 2020 discharges linked to an admission:	14,090
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	10,836
Number of CY 2020 linked discharges eligible for this calculation (non-missing values):	10,521

Source: SAMHSA/CBHSQ TEDS CY 2020 admissions file and CY 2020 linked discharge file
[Records received through 2/1/2022]

Footnotes:

V: Performance Indicators and Accomplishments

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

Short-term Residential(SR)

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

	At Admission(T1)	At Discharge(T2)
Number of Clients without arrests [numerator]	6,180	6,595
Total number of Admission and Discharge clients with non-missing values on arrests [denominator]	6,712	6,712
Percent of clients without arrests	92.1 %	98.3 %

Notes (for this level of care):	
Number of CY 2020 admissions submitted:	10,804
Number of CY 2020 discharges submitted:	10,830
Number of CY 2020 discharges linked to an admission:	7,775
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	6,773
Number of CY 2020 linked discharges eligible for this calculation (non-missing values):	6,712

Source: SAMHSA/CBHSQ TEDS CY 2020 admissions file and CY 2020 linked discharge file
[Records received through 2/1/2022]

Long-term Residential(LR)

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

	At Admission(T1)	At Discharge(T2)
Number of Clients without arrests [numerator]	4,077	4,348
Total number of Admission and Discharge clients with non-missing values on arrests [denominator]	4,443	4,443
Percent of clients without arrests	91.8 %	97.9 %

Notes (for this level of care):	
Number of CY 2020 admissions submitted:	7,092
Number of CY 2020 discharges submitted:	7,599
Number of CY 2020 discharges linked to an admission:	5,180
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	4,483

Number of CY 2020 linked discharges eligible for this calculation (non-missing values):	4,443

Source: SAMHSA/CBHSQ TEDS CY 2020 admissions file and CY 2020 linked discharge file
[Records received through 2/1/2022]

Outpatient (OP)

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

	At Admission(T1)	At Discharge(T2)
Number of Clients without arrests [numerator]	9,935	9,980
Total number of Admission and Discharge clients with non-missing values on arrests [denominator]	10,222	10,222
Percent of clients without arrests	97.2 %	97.6 %

Notes (for this level of care):	
Number of CY 2020 admissions submitted:	27,955
Number of CY 2020 discharges submitted:	28,110
Number of CY 2020 discharges linked to an admission:	15,050
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	10,415
Number of CY 2020 linked discharges eligible for this calculation (non-missing values):	10,222

Source: SAMHSA/CBHSQ TEDS CY 2020 admissions file and CY 2020 linked discharge file
[Records received through 2/1/2022]

Intensive Outpatient (IO)

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

	At Admission(T1)	At Discharge(T2)
Number of Clients without arrests [numerator]	10,206	10,393
Total number of Admission and Discharge clients with non-missing values on arrests [denominator]	10,743	10,743
Percent of clients without arrests	95.0 %	96.7 %

Notes (for this level of care):	
Number of CY 2020 admissions submitted:	22,321
Number of CY 2020 discharges submitted:	23,312
Number of CY 2020 discharges linked to an admission:	14,090
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	11,055

Number of CY 2020 linked discharges eligible for this calculation (non-missing values):	10,743

Source: SAMHSA/CBHSQ TEDS CY 2020 admissions file and CY 2020 linked discharge file
[Records received through 2/1/2022]

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Footnotes:

V: Performance Indicators and Accomplishments

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

Short-term Residential(SR)

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

Alcohol Abstinence – Clients with no alcohol use at admission vs. discharge, as a percent of all clients (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol [numerator]	3,273	6,371
All clients with non-missing values on at least one substance/frequency of use [denominator]	6,399	6,399
Percent of clients abstinent from alcohol	51.1 %	99.6 %

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

Clients abstinent from alcohol at discharge among clients using alcohol at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		3,100
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	3,126	
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T2 / #T1 x 100]		99.2 %

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

Clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		3,271
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	3,273	
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T2 / #T1 x 100]		99.9 %

Notes (for this level of care):	
Number of CY 2020 admissions submitted:	10,804
Number of CY 2020 discharges submitted:	10,830
Number of CY 2020 discharges linked to an admission:	7,775
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	6,773
Number of CY 2020 linked discharges eligible for this calculation (non-missing values):	6,399

Source: SAMHSA/CBHSQ TEDS CY 2020 admissions file and CY 2020 linked discharge file
[Records received through 2/1/2022]

Long-term Residential(LR)

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

Alcohol Abstinence – Clients with no alcohol use at admission vs. discharge, as a percent of all clients (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol [numerator]	2,295	4,021
All clients with non-missing values on at least one substance/frequency of use [denominator]	4,047	4,047
Percent of clients abstinent from alcohol	56.7 %	99.4 %

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

Clients abstinent from alcohol at discharge among clients using alcohol at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		1,737
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	1,752	
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T2 / #T1 x 100]		99.1 %

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

Clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		2,284
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	2,295	
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T2 / #T1 x 100]		99.5 %

Notes (for this level of care):	
Number of CY 2020 admissions submitted:	7,092
Number of CY 2020 discharges submitted:	7,599
Number of CY 2020 discharges linked to an admission:	5,180
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	4,483
Number of CY 2020 linked discharges eligible for this calculation (non-missing values):	4,047

Source: SAMHSA/CBHSQ TEDS CY 2020 admissions file and CY 2020 linked discharge file
[Records received through 2/1/2022]

Outpatient (OP)

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

Alcohol Abstinence – Clients with no alcohol use at admission vs. discharge, as a percent of all clients (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol [numerator]	5,202	6,309
All clients with non-missing values on at least one substance/frequency of use [denominator]	7,081	7,081
Percent of clients abstinent from alcohol	73.5 %	89.1 %

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

Clients abstinent from alcohol at discharge among clients using alcohol at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		1,460
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	1,879	
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T2 / #T1 x 100]		77.7 %

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

Clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		4,849
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	5,202	
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T2 / #T1 x 100]		93.2 %

Notes (for this level of care):	
Number of CY 2020 admissions submitted:	27,955
Number of CY 2020 discharges submitted:	28,110
Number of CY 2020 discharges linked to an admission:	15,050
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	10,415
Number of CY 2020 linked discharges eligible for this calculation (non-missing values):	7,081

Source: SAMHSA/CBHSQ TEDS CY 2020 admissions file and CY 2020 linked discharge file
[Records received through 2/1/2022]

Intensive Outpatient (IO)

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

Alcohol Abstinence – Clients with no alcohol use at admission vs. discharge, as a percent of all clients (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol [numerator]	4,517	5,784
All clients with non-missing values on at least one substance/frequency of use [denominator]	6,713	6,713
Percent of clients abstinent from alcohol	67.3 %	86.2 %

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

Clients abstinent from alcohol at discharge among clients using alcohol at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		1,586
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	2,196	
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T2 / #T1 x 100]		72.2 %

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

Clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		4,198
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	4,517	
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T2 / #T1 x 100]		92.9 %

Notes (for this level of care):	
Number of CY 2020 admissions submitted:	22,321
Number of CY 2020 discharges submitted:	23,312
Number of CY 2020 discharges linked to an admission:	14,090
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	11,055
Number of CY 2020 linked discharges eligible for this calculation (non-missing values):	6,713

Source: SAMHSA/CBHSQ TEDS CY 2020 admissions file and CY 2020 linked discharge file
[Records received through 2/1/2022]

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Footnotes:

V: Performance Indicators and Accomplishments

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

Short-term Residential(SR)

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

Drug Abstinence – Clients with no Drug use at admission vs. discharge, as a percent of all clients (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs [numerator]	1,906	6,360
All clients with non-missing values on at least one substance/frequency of use [denominator]	6,399	6,399
Percent of clients abstinent from drugs	29.8 %	99.4 %

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

Clients abstinent from Drug at discharge among clients using Drug at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator]		4,455
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	4,493	
Percent of clients abstinent from drugs at discharge among clients using Drug at admission [#T2 / #T1 x 100]		99.2 %

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

Clients abstinent from Drug at discharge among clients abstinent from Drug at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [numerator]		1,905
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	1,906	
Percent of clients abstinent from drugs at discharge among clients abstinent from Drug at admission [#T2 / #T1 x 100]		99.9 %

Notes (for this level of care):	
Number of CY 2020 admissions submitted:	10,804
Number of CY 2020 discharges submitted:	10,830
Number of CY 2020 discharges linked to an admission:	7,775
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	6,773
Number of CY 2020 linked discharges eligible for this calculation (non-missing values):	6,399

Source: SAMHSA/CBHSQ TEDS CY 2020 admissions file and CY 2020 linked discharge file
[Records received through 2/1/2022]

Long-term Residential(LR)

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

Drug Abstinence – Clients with no Drug use at admission vs. discharge, as a percent of all clients (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs [numerator]	1,945	3,924
All clients with non-missing values on at least one substance/frequency of use [denominator]	4,047	4,047
Percent of clients abstinent from drugs	48.1 %	97.0 %

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

Clients abstinent from Drug at discharge among clients using Drug at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator]		2,032
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	2,102	
Percent of clients abstinent from drugs at discharge among clients using Drug at admission [#T2 / #T1 x 100]		96.7 %

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

Clients abstinent from Drug at discharge among clients abstinent from Drug at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [numerator]		1,892
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	1,945	
Percent of clients abstinent from drugs at discharge among clients abstinent from Drug at admission [#T2 / #T1 x 100]		97.3 %

Notes (for this level of care):	
Number of CY 2020 admissions submitted:	7,092
Number of CY 2020 discharges submitted:	7,599
Number of CY 2020 discharges linked to an admission:	5,180
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	4,483
Number of CY 2020 linked discharges eligible for this calculation (non-missing values):	4,047

Source: SAMHSA/CBHSQ TEDS CY 2020 admissions file and CY 2020 linked discharge file
[Records received through 2/1/2022]

Outpatient (OP)

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

Drug Abstinence – Clients with no Drug use at admission vs. discharge, as a percent of all clients (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs [numerator]	4,953	5,601
All clients with non-missing values on at least one substance/frequency of use [denominator]	7,081	7,081
Percent of clients abstinent from drugs	69.9 %	79.1 %

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

Clients abstinent from Drug at discharge among clients using Drug at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator]		1,271
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	2,128	
Percent of clients abstinent from drugs at discharge among clients using Drug at admission [#T2 / #T1 x 100]		59.7 %

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

Clients abstinent from Drug at discharge among clients abstinent from Drug at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [numerator]		4,330
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	4,953	
Percent of clients abstinent from drugs at discharge among clients abstinent from Drug at admission [#T2 / #T1 x 100]		87.4 %

Notes (for this level of care):	
Number of CY 2020 admissions submitted:	27,955
Number of CY 2020 discharges submitted:	28,110
Number of CY 2020 discharges linked to an admission:	15,050
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	10,415
Number of CY 2020 linked discharges eligible for this calculation (non-missing values):	7,081

Source: SAMHSA/CBHSQ TEDS CY 2020 admissions file and CY 2020 linked discharge file
[Records received through 2/1/2022]

Intensive Outpatient (IO)

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

Drug Abstinence – Clients with no Drug use at admission vs. discharge, as a percent of all clients (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs [numerator]	3,392	4,769
All clients with non-missing values on at least one substance/frequency of use [denominator]	6,713	6,713
Percent of clients abstinent from drugs	50.5 %	71.0 %

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

Clients abstinent from Drug at discharge among clients using Drug at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator]		1,894
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	3,321	
Percent of clients abstinent from drugs at discharge among clients using Drug at admission [#T2 / #T1 x 100]		57.0 %

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

Clients abstinent from Drug at discharge among clients abstinent from Drug at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [numerator]		2,875
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	3,392	
Percent of clients abstinent from drugs at discharge among clients abstinent from Drug at admission [#T2 / #T1 x 100]		84.8 %

Notes (for this level of care):	
Number of CY 2020 admissions submitted:	22,321
Number of CY 2020 discharges submitted:	23,312
Number of CY 2020 discharges linked to an admission:	14,090
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	11,055
Number of CY 2020 linked discharges eligible for this calculation (non-missing values):	6,713

Source: SAMHSA/CBHSQ TEDS CY 2020 admissions file and CY 2020 linked discharge file
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V: Performance Indicators and Accomplishments

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

Short-term Residential(SR)

Social Support of Recovery - Clients participating in self-help groups (e.g., AA, NA, etc.) (prior 30 days) at admission vs. discharge

	At Admission (T1)	At Discharge (T2)
Number of clients participating in self-help groups (AA NA meetings attended, etc.) [numerator]	1,028	3,406
Total number of Admission and Discharge clients with non-missing values on participation in self-help groups [denominator]	4,685	4,685
Percent of clients participating in self-help groups	21.9 %	72.7 %
Percent of clients with participation in self-help groups at discharge minus percent of clients with self-help attendance at admission Absolute Change [%T2-%T1]	50.8 %	
Notes (for this level of care):		
Number of CY 2020 admissions submitted:		10,804
Number of CY 2020 discharges submitted:		10,830
Number of CY 2020 discharges linked to an admission:		7,775
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):		6,773
Number of CY 2020 linked discharges eligible for this calculation (non-missing values):		4,685

Source: SAMHSA/CBHSQ TEDS CY 2020 admissions file and CY 2020 linked discharge file
[Records received through 2/1/2022]

Long-term Residential(LR)

Social Support of Recovery - Clients participating in self-help groups (e.g., AA, NA, etc.) (prior 30 days) at admission vs. discharge

	At Admission (T1)	At Discharge (T2)
Number of clients participating in self-help groups (AA NA meetings attended, etc.) [numerator]	1,130	2,743
Total number of Admission and Discharge clients with non-missing values on participation in self-help groups [denominator]	3,386	3,386
Percent of clients participating in self-help groups	33.4 %	81.0 %
Percent of clients with participation in self-help groups at discharge minus percent of clients with self-help attendance at admission Absolute Change [%T2-%T1]	47.6 %	
Notes (for this level of care):		
Number of CY 2020 admissions submitted:		7,092
Number of CY 2020 discharges submitted:		7,599

Number of CY 2020 discharges linked to an admission:	5,180
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	4,483
Number of CY 2020 linked discharges eligible for this calculation (non-missing values):	3,386

Source: SAMHSA/CBHSQ TEDS CY 2020 admissions file and CY 2020 linked discharge file
[Records received through 2/1/2022]

Outpatient (OP)

Social Support of Recovery - Clients participating in self-help groups (e.g., AA, NA, etc.) (prior 30 days) at admission vs. discharge

	At Admission (T1)	At Discharge (T2)
Number of clients participating in self-help groups (AA NA meetings attended, etc.) [numerator]	2,088	2,017
Total number of Admission and Discharge clients with non-missing values on participation in self-help groups [denominator]	7,596	7,596
Percent of clients participating in self-help groups	27.5 %	26.6 %
Percent of clients with participation in self-help groups at discharge minus percent of clients with self-help attendance at admission Absolute Change [%T2-%T1]	-0.9 %	

Notes (for this level of care):	
Number of CY 2020 admissions submitted:	27,955
Number of CY 2020 discharges submitted:	28,110
Number of CY 2020 discharges linked to an admission:	15,050
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	10,415
Number of CY 2020 linked discharges eligible for this calculation (non-missing values):	7,596

Source: SAMHSA/CBHSQ TEDS CY 2020 admissions file and CY 2020 linked discharge file
[Records received through 2/1/2022]

Intensive Outpatient (IO)

Social Support of Recovery - Clients participating in self-help groups (e.g., AA, NA, etc.) (prior 30 days) at admission vs. discharge

	At Admission (T1)	At Discharge (T2)
Number of clients participating in self-help groups (AA NA meetings attended, etc.) [numerator]	2,294	2,590
Total number of Admission and Discharge clients with non-missing values on participation in self-help groups [denominator]	7,848	7,848
Percent of clients participating in self-help groups	29.2 %	33.0 %
Percent of clients with participation in self-help groups at discharge minus percent of clients with self-help attendance at admission Absolute Change [%T2-%T1]	3.8 %	

Notes (for this level of care):	
Number of CY 2020 admissions submitted:	22,321

Number of CY 2020 discharges submitted:	23,312
Number of CY 2020 discharges linked to an admission:	14,090
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	11,055
Number of CY 2020 linked discharges eligible for this calculation (non-missing values):	7,848

Source: SAMHSA/CBHSQ TEDS CY 2020 admissions file and CY 2020 linked discharge file
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V: Performance Indicators and Accomplishments

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

Level of Care	Average (Mean)	25th Percentile	50th Percentile (Median)	75th Percentile
DETOXIFICATION (24-HOUR CARE)				
1. Hospital Inpatient	4	3	3	4
2. Free-Standing Residential	5	4	5	6
REHABILITATION/RESIDENTIAL				
3. Hospital Inpatient	13	4	7	28
4. Short-term (up to 30 days)	16	7	14	22
5. Long-term (over 30 days)	55	17	28	89
AMBULATORY (OUTPATIENT)				
6. Outpatient	86	37	72	120
7. Intensive Outpatient	64	23	49	90
8. Detoxification	16	10	15	16
OUD MEDICATION ASSISTED TREATMENT				
9. OUD Medication-Assisted Detoxification[1]	7	4	5	7
10. OUD Medication-Assisted Treatment Outpatient[2]	86	32	66	123

Level of Care	2020 TEDS discharge record count	
	Discharges submitted	Discharges linked to an admission
DETOXIFICATION (24-HOUR CARE)		
1. Hospital Inpatient	190	175
2. Free-Standing Residential	12492	8891
REHABILITATION/RESIDENTIAL		
3. Hospital Inpatient	9	3
4. Short-term (up to 30 days)	10830	7775

5. Long-term (over 30 days)	7599	5180
AMBULATORY (OUTPATIENT)		
6. Outpatient	28110	10456
7. Intensive Outpatient	23312	14090
8. Detoxification	494	284
OUD MEDICATION ASSISTED TREATMENT		
9. OUD Medication-Assisted Detoxification[1]	0	2503
10. OUD Medication-Assisted Treatment Outpatient[2]	0	4594

Source: SAMHSA/CBHSQ TEDS CY 2020 admissions file and CY 2020 linked discharge file
[Records received through 2/1/2022]

[1] OUD Medication-Assisted Treatment Detoxification includes hospital detoxification, residential detoxification, or ambulatory detoxification services/settings AND Opioid Medication-Assisted Treatment.

[2] OUD Medication-Assisted Treatment Outpatient includes outpatient services/settings AND Opioid Medication-Assisted Treatment.

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V: Performance Indicators and Accomplishments

TABLE 21 - SUBSTANCE ABUSE PREVENTION 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.		
	Age 12 - 20 - CY 2019 - 2020	21.3	
	Age 21+ - CY 2019 - 2020	56.9	
2. 30-day Cigarette Use	**Source Survey Item:** NSDUH Questionnaire: "During the past 30 days, that is, since **[DATEFILL]**, on how many days did you smoke part or all of a cigarette?[Response option: Write in a number between 0 and 30.] **Outcome Reported:** Percent who reported having smoked a cigarette during the past 30 days.		
	Age 12 - 17 - CY 2019 - 2020	0.2	
	Age 18+ - CY 2019 - 2020	13.2	
3. 30-day Use of Other Tobacco Products	**Survey Item: NSDUH Questionnaire:** "During the past 30 days, that is, since **[DATEFILL]**, on how many days did you use [other tobacco products][1]?[Response option: Write in a number between 0 and 30.] **Outcome Reported:** Percent who reported having used a tobacco product other than cigarettes during the past 30 days, calculated by combining responses to questions about individual tobacco products (cigars, smokeless tobacco, pipe tobacco).		
	Age 12 - 17 - CY 2019 - 2020	0.7	
	Age 18+ - CY 2019 - 2020	5.2	
4. 30-day Use of Marijuana	**Source Survey Item: NSDUH Questionnaire:** "Think specifically about the past 30 days, from **[DATEFILL]** up to and including today. During the past 30 days, on how many days did you use marijuana or hashish?[Response option: Write in a number between 0 and 30.] **Outcome Reported:** Percent who reported having used marijuana or hashish during the past 30 days.		
	Age 12 - 17 - CY 2019 - 2020	7.7	
	Age 18+ - CY 2019 - 2020	8.8	
5. 30-day Use of Illegal Drugs Other Than Marijuana	**Source Survey Item: NSDUH Questionnaire:** "Think specifically about the past 30 days, from **[DATEFILL]** up to and including today. During the past 30 days, on how many days did you use [any other illegal drug]?[2] **Outcome Reported:** Percent who reported having used illegal drugs other than marijuana or hashish during the past 30 days, calculated by combining responses to questions about individual drugs (heroin, cocaine, hallucinogens, inhalants, methamphetamine, and misuse of prescription drugs).		
	Age 12 - 17 - CY 2019 - 2020	1.1	

	Age 18+ - CY 2019 - 2020	2.0	

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

Table 22 - SUBSTANCE ABUSE PREVENTION 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.		
	Age 12 - 20 - CY 2019 - 2020	79.3	
	Age 21+ - CY 2019 - 2020	83.0	
2. Perception of Risk From Cigarettes	**Source Survey Item: NSDUH Questionnaire:** "How much do people risk harming themselves physically and in other ways when they smoke one or more packs of cigarettes per day?[Response options: No risk, slight risk, moderate risk, great risk] **Outcome Reported:** Percent reporting moderate or great risk.		
	Age 12 - 17 - CY 2019 - 2020	92.4	
	Age 18+ - CY 2019 - 2020	94.4	
3. Perception of Risk From Marijuana	**Source Survey Item:** NSDUH Questionnaire: "How much do people risk harming themselves physically and in other ways when they smoke marijuana once or twice a week?[Response options: No risk, slight risk, moderate risk, great risk] **Outcome Reported:** Percent reporting moderate or great risk.		
	Age 12 - 17 - CY 2019 - 2020	65.9	
	Age 18+ - CY 2019 - 2020	57.9	

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V: Performance Indicators and Accomplishments

Table 23 - SUBSTANCE ABUSE PREVENTION 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.		
	Age 12 - 20 - CY 2019 - 2020		
	Age 21+ - CY 2019 - 2020		
2. Age at First Use of Cigarettes	**Source Survey Item:** NSDUH Questionnaire: "How old were you the first time you smoked part or all of a cigarette?[Response option: Write in age at first use.] **Outcome Reported:** Average age at first use of cigarettes.		
	Age 12 - 17 - CY 2019 - 2020	12.8	
	Age 18+ - CY 2019 - 2020	16.6	
3. Age at First Use of Tobacco Products Other Than Cigarettes	**Source Survey Item:** NSDUH Questionnaire: "How old were you the first time you used [any other tobacco product][1]?[Response option: Write in age at first use.] **Outcome Reported:** Average age at first use of tobacco products other than cigarettes.		
	Age 12 - 17 - CY 2019 - 2020	15.1	
	Age 18+ - CY 2019 - 2020	21.5	
4. Age at First Use of Marijuana or Hashish	**Source Survey Item:** NSDUH Questionnaire: "How old were you the first time you used marijuana or hashish?[Response option: Write in age at first use.] **Outcome Reported:** Average age at first use of marijuana or hashish.		
	Age 12 - 17 - CY 2019 - 2020	14.7	
	Age 18+ - CY 2019 - 2020	18.1	
5. Age at First Use Heroin	**Source Survey Item:** NSDUH Questionnaire: "How old were you the first time you used heroin? [Response option: Write in age at first use.] **Outcome Reported:** Average age at first use of heroin.		
	Age 12 - 17 - CY 2019 - 2020		
	Age 18+ - CY 2019 - 2020	25.4	
6. Age at First Misuse of Prescription Pain Relievers Among Past Year Initiates	**Source Survey Item:** NSDUH Questionnaire: "How old were you the first time you used [specific pain reliever][2] in a way a doctor did not direct you to use it?"[Response option: Write in age at first use.] **Outcome Reported:** Average age at first misuse of prescription pain relievers among those who first misused prescription pain relievers in the last 12 months.		

	Age 12 - 17 - CY 2019 - 2020		
	Age 18+ - CY 2019 - 2020	19.6	

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

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Table 24 - SUBSTANCE ABUSE PREVENTION 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.		
	Age 12 - 17 - CY 2019 - 2020	95.8	
2. Perception of Peer Disapproval of Cigarettes	**Source Survey Item: NSDUH Questionnaire:** "How do you think your close friends would feel about you smoking one or more packs of cigarettes a day?[Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove] **Outcome Reported:** Percent reporting that their friends would somewhat or strongly disapprove.		
	Age 12 - 17 - CY 2019 - 2020	96.9	
3. Disapproval of Using Marijuana Experimentally	**Source Survey Item:** NSDUH Questionnaire: "How do you feel about someone your age trying marijuana or hashish once or twice?[Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove] **Outcome Reported:** Percent somewhat or strongly disapproving.		
	Age 12 - 17 - CY 2019 - 2020	78.3	
4. Disapproval of Using Marijuana Regularly	**Source Survey Item: NSDUH Questionnaire:** "How do you feel about someone your age using marijuana once a month or more?[Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove] **Outcome Reported:** Percent somewhat or strongly disapproving.		
	Age 12 - 17 - CY 2019 - 2020	79.5	
5. Disapproval of Alcohol	**Source Survey Item:** NSDUH Questionnaire: "How do you feel about someone your age having one or two drinks of an alcoholic beverage nearly every day?[Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove] **Outcome Reported:** Percent somewhat or strongly disapproving.		
	Age 12 - 20 - CY 2019 - 2020		

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Table 25 - SUBSTANCE ABUSE PREVENTION 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.		
	Age 15 - 17 - CY 2019 - 2020		
	Age 18+ - CY 2019 - 2020	23.7	

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Table 26 - SUBSTANCE ABUSE PREVENTION 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.		
	School Year 2018	94.6	

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Table 27 - SUBSTANCE ABUSE PREVENTION 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 2019	30.0	

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Table 28 - SUBSTANCE ABUSE PREVENTION 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 2019	3.3	

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Table 29 - SUBSTANCE ABUSE PREVENTION 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.		
	Age 12 - 17 - CY 2019 - 2020	62.5	
2. Family Communications Around Drug and Alcohol Use (Parents of children aged 12-17)	**Source Survey Item:** NSDUH Questionnaire: "During the past 12 months, how many times have you talked with your child about the dangers or problems associated with the use of tobacco, alcohol, or other drugs?[1][Response options: 0 times, 1 to 2 times, a few times, many times] **Outcome Reported:** Percent of parents reporting that they have talked to their child.		
	Age 18+ - CY 2019 - 2020	84.2	

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

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Table 30 - SUBSTANCE ABUSE PREVENTION 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][1]? **Outcome Reported:** Percent reporting having been exposed to prevention message.		
	Age 12 - 17 - CY 2019 - 2020	92.2	

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

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

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

Please indicate the reporting period for each of the following NOMS.

Tables	A. Reporting Period Start Date	B. Reporting Period End Date
1. Table 31 - SUBSTANCE ABUSE PREVENTION - Individual-Based Programs and Strategies: Number of Persons Served by Age, Gender, Race, and Ethnicity	1/1/2019	12/31/2019
2. Table 32 - SUBSTANCE ABUSE PREVENTION - Population-Based Programs and Strategies, Number of Persons Served by Age, Gender, Race, and Ethnicity	1/1/2019	12/31/2019
3. Table 33 (Optional) - SUBSTANCE ABUSE PREVENTION - Number of Persons Served by Type of Intervention	1/1/2019	12/31/2019
4. Table 34 - Substance Abuse Prevention - Evidence-Based Programs and Strategies by Type of Intervention	1/1/2019	12/31/2019
5. Table 35 - Total SUBSTANCE ABUSE PREVENTION Number of Evidence Based Programs/Strategies and Total SABG Dollars Spent on SUBSTANCE ABUSE PREVENTION Evidence-Based Programs/Strategies	10/1/2018	9/30/2020

General Questions Regarding Prevention NOMS Reporting

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

New Jersey's web-based Prevention Outcomes Management System (POMS) and manual process

Question 2: Describe how your State's data collection and reporting processes record a participant's race, specifically for participants who are more than one race.

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

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

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Table 31 - SUBSTANCE ABUSE PREVENTION - Individual-Based Programs and Strategies: Number of Persons Served by Age, Gender, Race, and Ethnicity

Category	Total
A. Age	**142,839**
0-4	8,200
5-11	59,500
12-14	20,150
15-17	16,002
18-20	6,112
21-24	3,600
25-44	18,300
45-64	4,100
65 and over	4,675
Age Not Known	2,200
B. Gender	**142,839**
Male	69,352
Female	69,637
Gender Unknown	3,850
C. Race	**142,839**
White	54,279
Black or African American	37,138
Native Hawaiian/Other Pacific Islander	
Asian	6,367
American Indian/Alaska Native	200
More Than One Race (not OMB required)	13,855

Race Not Known or Other (not OMB required)	31,000
D. Ethnicity	**142,839**
Hispanic or Latino	38,650
Not Hispanic or Latino	94,189
Ethnicity Unknown	10,000

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Table 32 - SUBSTANCE ABUSE PREVENTION - Population-Based Programs and Strategies, Number of Persons Served by Age, Gender, Race, and Ethnicity

Category	Total
A. Age	**484550**
0-4	6300
5-11	41500
12-14	97000
15-17	76750
18-20	40000
21-24	28500
25-44	117000
45-64	39500
65 and over	21000
Age Not Known	17000
B. Gender	**484550**
Male	222790
Female	223760
Gender Unknown	38000
C. Race	**484550**
White	266503
Black or African American	116292
Native Hawaiian/Other Pacific Islander	0
Asian	43610
American Indian/Alaska Native	425
More Than One Race (not OMB required)	24228

Race Not Known or Other (not OMB required)	33492
D. Ethnicity	**484550**
Hispanic or Latino	167000
Not Hispanic or Latino	278550
Ethnicity Unknown	39000

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Table 33 (Optional) - SUBSTANCE ABUSE PREVENTION - Number of Persons Served by Type of Intervention

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

Intervention Type	A. Individual-Based Programs and Strategies	B. Population-Based Programs and Strategies
1. Universal Direct	102,845	N/A
2. Universal Indirect	N/A	$484,550.00
3. Selective	22,854	N/A
4. Indicated	17,140	N/A
5. Total	**142,839**	**$484,550.00**
Number of Persons Served[1]	**142,839**	**484,550**

[1]Number of Persons Served is populated from Table 31 - SUBSTANCE ABUSE PREVENTION - Individual-Based Programs and Strategies: Number of Persons Served by Age, Gender, Race, and Ethnicity and Table 32 - SUSTANCE ABUSE PREVENTION - Population-Based Programs and Strategies: Number of Persons Served By Age, Gender, Race, and Ethnicity

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Table 34 - Substance Abuse Prevention - Evidence-Based Programs and Strategies by Type of Intervention

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.

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

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

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

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

	A. Universal Direct	B. Universal Indirect	C. Universal Total	D. Selective	E. Indicated	F. Total
1. Number of Evidence-Based Programs and Strategies Funded	12	6	18	13	6	37
2. Total number of Programs and Strategies Funded	12	6	18	13	6	37
3. Percent of Evidence-Based Programs and Strategies	100.00 %	100.00 %	100.00 %	100.00 %	100.00 %	100.00 %

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Table 35 - Total SUBSTANCE ABUSE PREVENTION Number of Evidence Based Programs/Strategies and Total SABG Dollars Spent on SUBSTANCE ABUSE PREVENTION Evidence-Based Programs/Strategies

	Total Number of Evidence-Based Programs/Strategies for IOM Category Below	Total SAPT Block Grant Dollars Spent on evidence-based Programs/Strategies
Universal Direct	Total # 12	
Universal Indirect	Total # 6	
Selective	Total # 13	
Indicated	Total # 6	
	Total EBPs: 37	Total Dollars Spent: $0.00
Primary Prevention Total[1]	**$11,411,474.00**	

[1]Primary Prevention Total is populated from Table 4 - State Agency SABG Expenditure Compliance Report, Row 2 Primary Prevention.

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Prevention Attachments

Submission Uploads

FFY 2022 Prevention Attachment Category A:

File	Version	Date Added

FFY 2022 Prevention Attachment Category B:

File	Version	Date Added

FFY 2022 Prevention Attachment Category C:

File	Version	Date Added

FFY 2022 Prevention Attachment Category D:

File	Version	Date Added

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