New Jersey

UNIFORM APPLICATION
FY 2023 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	7/1/2021
To	6/30/2022

Block Grant Expenditure Period

From	10/1/2019
To	9/30/2021

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 use disorder treatment.

Strategies to attain the goal:

• Annual Provider Meetings: These meetings are held 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 ranging from information sharing, best practices, continuum of care, medication assisted treatment, referrals and access to services, recovery supports, Plans of Safe Care, systems collaboration, Substance Exposed Infants (SEI) and Neonatal Abstinence Syndrome (NAS), challenges, and training needs.

• Professional Development: Contracted licensed women's treatment providers that receive funding through the women's set aside block grant 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 must 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 were 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 Hub team completed a 7 COVID-19 maternal child health and OUD sessions between April and the first week of June, 2020, and MCH PPW-OUD ECHO with COVID-19 (included as a discussion topic) reconvened June 15, 2020 through December 2020. MCH PPW-OUD ECHO series is scheduled after 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.

The onset of the COVID-19 pandemic resulted in many significant safety precautions at the national and state level. The stay-at-home orders, such as closures of businesses, schools, restrictions in gatherings has had an impact on the social determinants of health (food, security, employment, income, access to medical care, etc.). Pregnant and parenting women with a history of substance use disorder could be at risk for increase in substance use or experience relapse due to feelings of isolation, lack of family supports, or social support systems. Their mental health could be adversely affected exhibiting depression during pregnancy and postpartum. State fiscal year, 2022 the MWRAP statewide initiative eligibility criteria will be expanded to include pregnant women with substance use disorder, not exclusive to opioid dependency and providers will serve a total of 50 (fifty) unduplicated women per region.

• 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 COVID19 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 COVID19 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.

• Supportive Housing: DMHAS developed a Women's Intensive Supportive Housing (WISH) Program. WISH provides permanent supportive housing for pregnant and/or parenting women with a co-existing substance abuse disorder and mental illness who are homeless or at risk of homelessness and being discharged from a licensed long-term residential substance abuse treatment and/or halfway house facility. An RFP was developed and released in January 2015 for the development of a WISH team to provide case management and supportive housing services for 10 women and their children. The RFP was awarded in 2015 to a licensed treatment provider who specializes in women's gender specific treatment, offers a continuum of care, and has a longstanding history of providing supportive housing and has demonstrated success in managing permanent supportive housing programs.

Since 2014, DMHAS has a Memorandum of Understanding (MOU) with NJ DCF, DCP&P to fund ten (10) supportive housing subsidies annually for the "Keeping Families Together" (KFT) program for parents involved with the child welfare system who are homeless or at imminent risk and in which one or more adults in the family is diagnosed with a co-occurring mental health illness and substance use disorder. DCP&P contracts with a provider for the KFT program in Essex County.

• Systems Collaboration PPW: Twelve (12) of New Jersey's 21 counties have monthly DCP&P Child Welfare Substance Use Disorder Consortia meetings which are held at the local DCP&P offices. Child welfare staff, DMHAS, Division of Family Development, Substance Use Disorder Provider Agencies, Work First New Jersey, Substance Abuse Initiative (WFNJ SAI) providers, and Boards of Social Services meet each month and plan on how to better serve families, leading to more effective policies and practices to meet the needs of infants, children and families. The Consortia also addresses ASFA timelines, Plans of Safe Care, and reunification for children in out of home placement. Through collaboration, multiple agencies working with the same family can improve communication to reduce the gaps in service delivery and improve coordination of services. The Consortia allow for cross systems collaboration with local treatment programs and other community partners who can provide the expertise needed to better serve families in the child welfare system.

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

• New Jersey was recently awarded technical assistance through the National Center on Substance Abuse and Child Welfare's (NCSACW) 2023 Policy Academy: Advancing Collaborative Practice and Policy: Promoting Healthy Development and Family Recovery for Infants, Children, Parents, and Caregivers Affected by Prenatal Substance Exposure. The Department of Health is the lead State Department and NJ Policy Academy State representatives include the Departments of Children and Families, Human Services, and the Governor's Office. The DMHAS Women's Treatment Coordinator represents the Department of Human Services. The overall goal is to increase awareness of pregnant women and SUD, through increased education and maximizing messaging through the perinatal work force; increase awareness and access to treatment, Plans of Safe Care, and improving screenings in hospitals and healthcare providers.

• Project ECHO series with new curriculums took place early Spring 2022 and concluded late Summer. The new MCH PPW-OUD ECHO series will commence 2023 with 18 sessions.

• Fall 2022, the MWRAP provided training to ReachNJ, the statewide 24/7 addictions hotline that provides screening, referral to treatment, care coordination and warm hand-offs to providers for eligible individuals. The MWRAP is another resource for pregnant women with a SUD across the state and can provide immediate case management and recovery supports.

• Sober Living: New Jersey contracts with Oxford House Inc. which has dedicated women's homes and women with children homes. The contract has been expanded to develop additional homes for special populations including women with children. Women and Children Oxford Houses are required to provide lockboxes to each for medication storage. Residents in Oxford Houses is responsible for their individual medication lock boxes. Outreach staff conduct annual training (Overdose Specific) at each Chapter meeting at the annual state workshop. Currently, there are 14 Oxford House Chapters throughout the state. This is in response to the heroin overdose epidemic in the state of New Jersey and its effects related to Oxford House. Each home is required to maintain Naloxone kits on site.

• Advertising Campaign: New Jersey continues its statewide advertising campaign centered around opioid use and bringing public awareness to call ReachNJ, the 24/7 Addiction Hotline, for treatment. New messaging, beginning in August 2022, has added pregnant women, along with student athletes and older adults, as target groups. This is a statewide campaign that utilizes television and radio advertisements, bus wraps, billboards and social media to encourage New Jerseyans to access treatment. Recently the TV ad aired on NBC during the Macy's Thanksgiving Day Parade and later that evening during an NFL football game.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Increase the number of pregnant women or women with children entering substance use disorder treatment.
Baseline Measurement:	SFY 2021: 27,210 admissions
First-year target/outcome measurement:	Increase number of pregnant women or women with children entering substance use disorder treatment in SFY 2022 by 1%.
Second-year target/outcome measurement:	Increase number of pregnant women or women with children entering substance use disorder treatment by 2% by the end of SFY 2023. The change in SFY 2023 will be measured by calculating the percent difference from SFY 2020 to SFY 2023.
New Second-year target/outcome measurement*(if needed)*:	Maintain the number of pregnant women or women with children who entered substance abuse treatment (25,694) in SFY 2022 by the end of SFY 2023.
Data Source:	

The number of pregnant women and women with children from SFY 2021 – 2023 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 use disorder 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 2021: 27,210 admissions
SFY 2022: 25,694 admissions

There were 1,516 less admissions in SFY 2022 compared to SFY 2021, a decrease of 5.57%.

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.

The MWRAP and IOT-SEI providers submit separate data to DMHAS and SUD treatment is reported. A total of 275 pregnant women were engaged in SUD treatment with the vast majority utilizing outpatient services; 392 utilized MAT at intake and 188 at the birth event. Methadone was the most commonly used at intake and at the birth event for MWRAP and buprenorphine for IOT-SEI. This includes data collected from program inception to date.

In an effort to increase the number of PPW women entering SUD treatment, DMHAS has implemented the new strategies listed above.

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

Priority #: 2

Priority Area: Persons Who Inject Drugs (PWID)

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 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:

• 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.
• 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 MAT.

• 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 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. The onset of the COVID-19 pandemic resulted in many significant safety precautions at the national and state level. The stay-at-home orders, such as closures of businesses, schools, restrictions in gatherings has had an impact on the social determinants of health (food, security, employment, income, access to medical care, etc.). Pregnant and parenting women with a history of substance use disorder could be at risk for increase in substance use or experience relapse due to feelings of isolation, lack of family supports, or social support systems. Their mental health could be adversely affected exhibiting depression during pregnancy and postpartum. State fiscal year, 2022 the MWRAP statewide initiative eligibility criteria will be expanded to include pregnant women with substance use disorder, not exclusive to opioid dependency and providers will serve a total of 50 (fifty) unduplicated women per region.
• 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 hormone (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.

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

• Telephone Recovery Support (TRS) program that calls high risk participants with an OUD, for up to four months, longer if needed, to provide encouragement, support and information.

• Long-Term Residential Incentive Payment. A new innovation is paying long term residential providers for providing MAT to clients. Effective June 1, 2020, the Long-term Residential (LTR) reimbursement rate was increased, as well as the ability to pay for Medication Assisted Treatment (MAT) and MAT related services. Beginning July 1, 2020, additional incentive payments became available for the utilization of MAT and MAT capacity in LTR. The incentive rate creates the capacity to prescribe and administer MAT, which minimally includes Buprenorphine, but also may include Naltrexone and other FDA-approved products for Opioid Use Disorder (OUD) and for Alcohol Use Disorder (AUD). The rates and incentives are divided into three (3) tiers that are structured as follows:

1) Tier 1 rate: The increased base LTR per diem rate for treatment plus Room and Board.
2) Tier 2 rate: Licensed LTR provider sites that receive Department of Health (DOH) Certificate of Need and Licensing (CN&L) approval for MAT will have the base rate raised by $5.00 per unit of service plus Room and Board. To qualify for Tier 2, providers will be required to submit the MAT certification letter that has been issued by CN&L. If the provider loses its licensed approval for MAT, they will not qualify for the Tier 2 rate and will be reimbursed for the base LTR rate.
3) When an LTR provider site has least 40% of eligible clients receiving an approved medication for treatment of an OUD or an AUD, the provider's rate will increase by $10.00 per unit of service. This incentive threshold applies to medications arranged for using an external provider (e.g., Methadone from an OTP; Buprenorphine from OBAT) and provided by the LTR Provider.

The total reimbursement rate for each per diem unit of LTR with R&B will vary between the provider that is a MAT approved site and the provider who is a non-MAT approved site but meets that 40% threshold through arranging medication. To qualify for the incentive Tier 3 rates, Medicaid and DMHAS will determine a 40% MAT utilization rate through NJSAMS reporting at client discharge. This benchmark is measured as those individuals who are medication-eligible who receive qualifying medications as reported in the NJSAMS Discharge data. The measurement will include all discharges, including duplicated and unduplicated individuals.

The medications that qualify are FDA-approved for the treatment for OUD and AUD and are inclusive of Buprenorphine, Sublocade, Methadone, Naltrexone (for OUD), and Naltrexone for Disulfiram, Acamprosate (for AUD); note that, at a minimum, Buprenorphine must be provided to receive the incentive. The benchmark will be measured by site based on the overall data, initially every three months starting July 1, 2020 for fiscal year 2021 and then every six months thereafter. The applicable incentive rate applies to all billed LTR units for the prospective period when the provider site meets the 40% benchmark incentive criteria.

4) The LTR provider can bill for medications inclusive of administration costs in addition to the new tiered rates.

• DMHAS issued a RFP to increase access to buprenorphine and other ancillary services for individuals with a SUD through current programming available at homeless shelters. It is proposed that award recipients will develop the capacity to provide medication and support services for individuals who reside or drop in at homeless shelters. The intent of the program is to provide low threshold medication services to individuals with a SUD who present in these settings.

• DMHAS finalized a MOA with the Rutgers Northern and Rowan Southern Centers of Excellence (COE) to provide technical assistance and training to the 20 county jail medical vendors and staff that participate in the County Correctional Facilities MAT and Case Management program.

• DMHAS, through a RFP process, initiated a Building Capacity in Mental Health and Substance Use Disorder initiative focusing on medications for SUD, i.e., buprenorphine, naloxone, naltrexone and methadone. The initiative enables agencies to offset the cost to create capacity to prescribe medications in licensed mental health programs as well as in licensed SUD treatment programs who provide treatment to individuals with co-occurring disorders (COD).

• DMHAS continued its statewide advertising campaign centered around opioid use and bringing public awareness that medication can support recovery and to call ReachNJ, the 24/7 Addiction Hotline. New messaging, beginning in August 2022, targeted multiple groups, such as student-athletes, pregnant women, older adults and prescribers.

• The Department of Human Services, in partnership with the Department of Health (DOH) and the State Attorney General's Office, established a Naloxone Distribution Program. The purpose of the program is to provide eligible agency participants operating in the State of New Jersey a means to furnish, distribute and administer naloxone. The program established allows eligible agencies, including police, EMS, fire departments, shelters, harm reduction programs, libraries, licensed behavioral healthcare programs, amongst others, to request direct shipments of naloxone via an online portal system.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase the number of PWID entering treatment.

Baseline Measurement: SFY 2021: 21,921 admissions

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 2023. The change in SFY 2023 will be measured by calculating the percent difference from SFY 2020 to SFY 2023.

New Second-year target/outcome measurement*(if needed)*: Maintain the number of PWID who entered treatment in SFY 2022 (20,275) by the end of SFY 2023.

Data Source:

The number of PWID in SFY 2021 through SFY 2023 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 use disorder 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 2021: 21,957 admissions
SFY 2022: 20,075 admissions

There were 1,882 less admissions in SFY 2022 compared to SFY 2021, a decrease of 8.57%.

Various options to receive medications for OUD now exist (i.e. Federally Qualified Healthcare Centers, Office Based Addiction Treatment programs, Low Threshold Programming) that are not licensed SUD treatment programs, and therefore, are not required to enter data into the NJSAMS reporting system.

DMHAS has implemented the new strategies listed above in an effort to increase the number of PWID entering SUD treatment.

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

Indicator #: 2

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

Baseline Measurement: SFY 2021: 39,771 admissions

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 2023. The change in SFY 2023 will be measured by calculating the percent difference from SFY 2021 to SFY 2023.

New Second-year target/outcome measurement*(if needed)*: Maintain the number of opiate dependent individuals entering treatment (39,523) in SFY 2022 by the end of SFY 2023.

Data Source:

The number of opiate dependent individuals from SFY 2021 - 2023 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 2021: 39, 839 admissions

SFY 2022: 39,523 admissions

There were 316 less admissions in SFY 2022 compared to SFY 2021, a slight decrease of .79%.

Various options to receive medications for OUD now exist (i.e. Federally Qualified Healthcare Centers, Office Based Addiction Treatment programs and new innovative low threshold buprenorphine programming) that are not licensed SUD treatment programs, and therefore, are not required to enter data into the NJSAMS reporting system.

DMHAS has implemented the new strategies listed above in an effort to increase the number of heroin and other opiate dependent individuals entering SUD treatment.

How first 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:

• 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.

• 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 both English, Spanish and Braille, and will include 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.

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

• Long-Term Residential Incentive Payment. A new innovation is paying long term residential providers for providing MAT to clients. Effective June 1, 2020, the Long-term Residential (LTR) reimbursement rate was increased, as well as the ability to pay for Medication Assisted Treatment (MAT) and MAT related services. Beginning July 1, 2020, additional incentive payments became available for the utilization of MAT and MAT capacity in LTR. The incentive rate creates the capacity to prescribe and administer MAT, which minimally includes Buprenorphine, but also may include Naltrexone and other FDA-approved products for Opioid Use Disorder (OUD) and for Alcohol Use Disorder (AUD). The rates and incentives are divided into three (3) tiers that are structured as follows:

1) Tier 1 rate: The increased base LTR per diem rate for treatment plus Room and Board.

2) Tier 2 rate: Licensed LTR provider sites that receive Department of Health (DOH) Certificate of Need and Licensing (CN&L) approval for MAT will have the base rate raised by $5.00 per unit of service plus Room and Board. To qualify for Tier 2, providers will be required to submit the MAT certification letter that has been issued by CN&L. If the provider loses its licensed approval for MAT, they will not qualify for the Tier 2 rate and will be reimbursed for the base LTR rate.
3) When an LTR provider site has least 40% of eligible clients receiving an approved medication for treatment of an OUD or an AUD, the provider's rate will increase by $10.00 per unit of service. This incentive threshold applies to medications arranged for using an external provider (e.g., Methadone from an OTP; Buprenorphine from OBAT) and provided by the LTR Provider.

The total reimbursement rate for each per diem unit of LTR with R&B will vary between the provider that is a MAT approved site and the provider who is a non-MAT approved site but meets that 40% threshold through arranging medication. To qualify for the incentive Tier 3 rates, Medicaid and DMHAS will determine a 40% MAT utilization rate through NJSAMS reporting at client discharge. This benchmark is measured as those individuals who are medication-eligible who receive qualifying medications as reported in the NJSAMS Discharge data. The measurement will include all discharges, including duplicated and unduplicated individuals.

The medications that qualify are FDA-approved for the treatment for OUD and AUD and are inclusive of Buprenorphine, Sublocade, Methadone, Naltrexone (for OUD), and Naltrexone for Disulfiram, Acamprosate (for AUD); note that, at a minimum, Buprenorphine must be provided to receive the incentive. The benchmark will be measured by site based on the overall data, initially every three months starting July 1, 2020 for fiscal year 2021 and then every six months thereafter. The applicable incentive rate applies to all billed LTR units for the prospective period when the provider site meets the 40% benchmark incentive criteria.

4) The LTR provider can bill for medications inclusive of administration costs in addition to the new tiered rates.

• Vital Strategies is working with the DMHAS and has developed a survey on the use of MOUD to be sent to all licensed SUD providers. The goal is to better understand the utilization of MOUD by providers, if there is reluctance to use MOUD and identify what barriers exist. This information can inform DMHAS as to actions needed to promote the use of MOUD by providers.

• DMHAS continued its statewide advertising campaign to center around opioid use and bring public awareness that "medication can support recovery" and to call ReachNJ, the 24/7 Addiction Hotline. New messaging, that began in August 2022, targeted multiple resident groups, such as student-athletes, pregnant women, older adults and prescribers.

• DMHAS finalized a Memorandum of Agreement (MOA) with the Rutgers Northern and Rowan Southern Centers of Excellence (COE) to provide technical assistance and training to the statewide county jails that participate in the County Correctional Facilities MAT and Case Management program.

• As of November 1, 2022, the DMHAS SUD Fee for Service (FFS) Initiatives will fund Buprenorphine/Suboxone medications for licensed SUD Provider Agencies that have a Certificate of Waiver for Medication Assisted Treatment issued to their sites by the Department of Health, Division of Certificate of Need and Licensing (CN&L).

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 2021: 21,227 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 2023 will be measured by calculating the percent difference from SFY 2021 to SFY 2023.

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

Data Source:

The number of heroin/other opiate admissions for whom MAT was planned from SFY 2021 - 2023 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:

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

SFY 2021: 21,284 heroin/other opiate admissions for whom MAT was planned.
SFY 2022: 23,281 heroin/other opiate admissions for whom MAT was planned.

In SFY 2022, there were 1,997 more heroin/other opiate admissions for whom MAT was planned compared to SFY 2021, an increase of 9.38%.

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 (4) 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: 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:

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 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.

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 first-year target measure.

New Second-year target/outcome measurement*(if needed)*: No change from SFY 2022 first year outcome measurement. For SFY 2023, 100% of monitored agencies will continue to be in compliance with offering every client a tuberculosis evaluation.

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)*:

According to SFY 2022 Annual Site Monitoring Reports of DMHAS' SAPT Block Grant contracted agencies, 100% of the agencies that were monitored (36 of 36 agencies) were in compliance with offering every client a tuberculosis evaluation.

Priority #: 5

Priority Area: Tobacco

Priority Type: SAP

Population(s): 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 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.

First-year target/outcome measurement: A reduction of .40% below the baseline measure.

Second-year target/outcome measurement: An additional reduction of .15% below the first year measure.

New Second-year target/outcome measurement *(if needed)*: No increase beyond 2.03 percent of the population reporting past 30-day use.

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 2018-2019 NSDUH data for New Jersey

New Data Source*(if needed)*:

Description of Data:

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

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

None

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

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

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

According to 2019-2020 NSDUH data, 2.03 percent of the target population reporting using any tobacco product during the month prior to participating in the survey.

Priority #: 6

Priority Area: Alcohol

Priority Type: SAP

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

Goal of the priority area:

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

Objective:

Decreased past month of binge drinking among persons aged 12 to 20.

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 12-20 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 12-20.

Baseline Measurement: According to 2018-2019 NSDUH data, 12.63 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 .50% 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)*: An additional reduction of .05% below the baseline measure.

Data Source:

Alcohol Use and Binge Alcohol Use in the Past Month among Individuals Aged 12 to 20, by Age Group and State: Percentages, Annual Averages Based on 2018-2019 NSDUH data for New Jersey

New Data Source*(if needed)*:

Description of Data:

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

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

None

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

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

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

According to 2019-2020 NSDUH data, 11.72 percent of the target population reporting binge drinking during the month prior to participating in the survey.

Priority #: 7

Priority Area: Marijuana

Priority Type: SAP

Population(s): 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 2018-2019 NSDUH data, 11.48 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 .05% below the baseline measure.

Second-year target/outcome measurement: An additional reduction of .05% below the baseline measure.

New Second-year target/outcome measurement*(if needed)*: No increase beyond 11.10 percent of the target population reporting marijuana use during the year prior to participating in the survey.

Data Source:

Marijuana Use in the Past Year, by Age Group and State: Percentages, Annual Averages Based on 201
8-2019 NSDUH data for New Jersey

New Data Source*(if needed)*:

Description of Data:

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

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

None

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

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

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

According to 2019-2020 NSDUH data, 11.10 percent of the target population reported marijuana use during the year prior to participating in the survey.

Priority #: 8

Priority Area: Prescription Drugs

Priority Type: SAP

Population(s): PP (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 2020, 3,637,522 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)*: An additional reduction of .50% below the baseline measure.

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:

Statewide 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 2021, 3,537,890 prescriptions for opioids were provided in New Jersey.

Priority #: 9

Priority Area: Heroin

Priority Type: SAP

Population(s): 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 2018-2019 NSDUH data, 66.82 percent of the target population reported Perceptions of Great Risk from Trying Heroin Once or Twice.

First-year target/outcome measurement: An increase of .25% above the baseline measure

Second-year target/outcome measurement: An additional increase of .10% above the first year measure

New Second-year target/outcome measurement*(if needed)*: An increase of .02% above the first year measure.

Data Source:

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

New Data Source*(if needed)*:

Description of Data:

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

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

None

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

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

According to 2019-2020 NSDUH data, 64.20 percent of the target population reported Perceptions of Great Risk from Trying Heroin Once or Twice.

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

Priority #: 10

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 Planning, Research, Evaluation, Prevention and Olmstead 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 2020 was 5535 with 651 individuals terminated. The percentage for SFY 2020 was 88.24%. The total number of clients served in CSS in SFY 2021 was 4,952 with 796 terminated. The percentage for SFY 2021 was 83.9%.
First-year target/outcome measurement:	The percentage of consumers who remain in Community Support Services during SFY 2022 will be no less than 88% 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 2023 will be no less than 88% 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.

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. In SFY 2020, 37 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)*:

Priority #: 11

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 SFY 2020, the occupancy rate (i.e., occupied CSS housing units and those units with an assignment) was 95%. COVID-19 has caused a reduction in community placement. With the pandemic situation likely persisting for the majority of SFY 2021, the situation of community placement will not likely improve. The occupancy rate for SFY 2021 was 96%.

First-year target/outcome measurement: In SFY 2022, the occupancy rate (i.e., occupied CSS housing units and those units with an assignment) is expected to be 96%.

Second-year target/outcome measurement: In SFY 2023, 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 2020 baseline value was generated from newer and slightly improved Provider Weekly Reports (PWR). The 2020 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 SFY20.

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.

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 therefore it is unlikely 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)*:

Priority #: 12

Priority Area: Early Serious Mental Illness (ESMI)

Priority Type: MHS

Population(s): ESMI

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 early serious mental illness, including 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 2021, the three CSC programs had 285 referrals and served 364 clients in their programs. New Jersey plans to continue utilizing the 10% set-aside funding in the FY 2022-23 to support the CSC teams in providing evidence-based services for individual with FEP. The CSC programs serve up to 70 clients per agency with clinical staff at 6.6 FTE levels in FY 2021.

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 ESMI treatment.

Baseline Measurement: In SFY 2020, among clients who were taking or in need of antipsychotic medication for the treatment of their psychosis at intake, 87% adhere to their medication regimen. In SFY 2021, the proposed target is that 88% of the client who are taking or in need of antipsychotic medication adhered to their psychotropic medication regimens.

First-year target/outcome measurement: In SFY 2022, 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 2023, it is anticipated that at least 88% 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 ESMI 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 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)*:

Priority #: 13

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:

The Division of Mental Health and Addiction Services (DMHAS) is committed to creating and maintaining an environment that supports "Cultural Competence" by promoting respect and understanding of diverse cultures, social groups, and individuals. To address issues of culture and diversity, DMHAS formed a Multicultural Services Advisory Committee (MSAC) in 1981. The MSAC devises strategies that are appropriate to the lifestyles, special needs, and strengths of New Jersey's diverse populations and cultural groups, and most recently, addresses challenges to ensure that BIPOC (Black, Indigenous, People of Color) receive quality equitable services in the behavioral health system of care. Additionally, MSAC makes recommendations to DMHAS regarding training content, membership eligibility, statewide Cultural competency goals, agency self-assessment processes, and in collaboration with other stakeholders, ensures that cultural competency principles are disseminated across the State and to other disciplines. MSAC membership includes broad representation from providers in the behavioral health treatment community, consumer representatives, peers, LGBTQ, administrators, and academics.

All DMHAS funded behavioral healthcare agencies are required to have a written Cultural Competency Plan describing the integration of cultural and linguistic competency throughout the organization including direct attention to issues or race, ethnicity, gender, age, religion, disability, and sexual orientation. The plan establishes culturally and linguistically appropriate goals, policies, and management accountability and infuses them throughout the organization's planning and operations adhering to Culturally and Linguistically Appropriate Services (CLAS) in their delivery of services. The CLAS standards "provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs." Additionally, the plan acts as a template for creating a workforce that improves outcomes for clients, delivers culturally responsive services, and reflects the diversity of the communities they serve. An organizational self -assessment helps prioritize the steps needed to develop those congruent behaviors and improve Culturally responsive services.

To assist agencies with preparing and maintaining a culturally and linguistically responsive delivery plan, the DMHAS contracts with two Multicultural Training and Technical Assistance Centers. The Centers provide technical assistance in the form of workshops, groups, and customized individualized support to assist agencies in the development of Cultural Competency Plans. Additionally, a statewide diversity consultant assists the two Centers with collecting, reviewing, and analyzing the plans. As a result of DMHAS commitment to Cultural Competency and the efforts of the Centers, the number of agencies that have submitted a Cultural Competency Plan has increased from less than 10% to over 50%. The remaining DMHAS agencies will submit plans by September 1, 2021. Agencies who meet cultural competency benchmarks will receive a certificate from the DMHAS Cultural Competence Training Center of Excellence that indicates their achievement in meeting this goal.

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 Competency 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 2022. The MSAC will complete the "Center for Cultural Competency Excellence" designation for agencies.

First-year target/outcome measurement: In SFY 2022, seventy-five percent (75%) 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: In SFY 2023, one hundred percent (100%) 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:

n/a

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

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

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

Priority #: 14

Priority Area: Expanding system capacity to serve youth aged 0 to 5.

Priority Type: MHS

Population(s): SED

Goal of the priority area:

To increase capacity for youth-serving agencies to support families with children ages 0 to 5.

Objective:

Implement workforce development initiative, "Zero to Five: Helping Families Thrive," which will increase community collaboration and support of families and will provide youth-serving agencies with increased capacity to serve youth aged 0 to 5.

Strategies to attain the goal:

Direct service staff at all 15 agencies providing MRSS will have 39 hours of training related to supporting very young children and their families. Additionally, clinicians will be trained in professional formation and reflective supervision methods, as well as Child Parent Psychotherapy, providing capacity to support very young children and their caregiving system with urgent, and/or complex needs.

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

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: 85% of direct service staff at all 15 agencies providing MRSS will have 39 hours of training related to supporting very young children and their families by June 30, 2022, or within one year of program implementation. The remainder of MRSS direct service staff will be trained in the second year of the initiative. Supports for ongoing capacity building will be implemented during this phase of the initiative to ensure sustainability.

Baseline Measurement: 0

First-year target/outcome measurement: 85% (approximately 408) of direct service staff in all MRSS programs will receive training.

Second-year target/outcome measurement: The remainder of MRSS direct service staff will receive training (15%, approximately 72). Additional staff will be trained, as needed, as it is assumed that some staff trained in the prior year will be lost to normal, voluntary turnover. Supports for ongoing capacity building will be implemented during this phase of the initiative to ensure sustainability.

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

Data Source:

Internal Data

New Data Source*(if needed)*:

Description of Data:

We will count MRSS direct service staff who complete the training.

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)*:

Indicator #: 2

Indicator: A cohort of 24 clinicians will be trained in professional formation and reflective supervision methods, as well as Child Parent Psychotherapy, providing capacity to support very young children and their caregiving system with urgent, and/or complex needs, by June 30, 2022, or within one year of program implementation. Additional cohorts will be trained annually.

Baseline Measurement: 0

First-year target/outcome measurement: 24 clinicians will be trained.

Second-year target/outcome measurement: an additional 24 (for a total of 48) clinicians will be trained.

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

Data Source:

Internal Data

New Data Source *(if needed)*:

Description of Data:

We will count clinicians who complete the training.

New Description of Data: *(if needed)*

Data issues/caveats that affect outcome measures:

None.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

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

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

Priority #: 15

Priority Area: Integration of community-based physical and behavioral health services for children, youth, and young adults with chronic medical conditions and mental/behavioral health and/or substance use challenges.

Priority Type: MHS

Population(s): SED

Goal of the priority area:

Plan to implement at least one expansion or enhancement of integrated health and behavioral health services.

Objective:

Increase the number of youth authorized for Behavioral Health Homes (BHH) services across the five counties (four service areas) in which this service is available. BHH services sit within the Care Management Organizations (CMO).

Strategies to attain the goal:

Strategies will be evaluated on an ongoing basis. Collaboration among partners will be essential. CSOC will engage in a quality improvement effort by working with staff at the CMOs in order to support their ability to take up a more assertive, standardized approach to identifying and engaging BHH eligible youth, including data collection around identifying eligibility, screening/engagement with youth and families, and youth engagement in or utilization of BHH services, in order to increase the percentage of eligible youth who are screened for BHH services. Youth eligibility is based on

medical and mental health diagnoses; for a list of eligible mental health diagnoses see:
https://www.state.nj.us/humanservices/dmhas/initiatives/integration/Diagnosis_Code.pdf
Continued monitoring of the Behavioral Health Homes utilization rates will inform outcomes with regard to the performance indicator.

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

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The number of eligible youth who are screened for BHH services will increase as a result of the quality improvement work done by CSOC in collaboration with the CMOs.

Baseline Measurement: To be determined through a quality improvement process, utilizing data from FY20 as FY21 is an outlier year due to the public health emergency.

First-year target/outcome measurement: 75% of eligible youth will be screened for BHH services.

Second-year target/outcome measurement: 100% of eligible youth will be screened for BHH services

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

Data Source:

To be determined by a quality improvement process.

New Data Source*(if needed)*:

Description of Data:

Data will include, for each of the four BHH programs, the number of youth eligible for BHH services and the number of youth screened for BHH services. Percentages will be formed by dividing the total number of eligible youth by number of youth screened.

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

Depending on the outcome of the quality improvement process, CMOs may be required to manually count eligible youth and screened youth, which could result in some data quality issues related to human error.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

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

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

Indicator #: 2

Indicator: The number of eligible youth provided with integrated services through the Behavioral Health Homes program will increase.

Baseline Measurement: To be determined by a quality improvement process, utilizing data from FY20 as FY21 is an outlier year due to the public health emergency.

First-year target/outcome measurement: 75% of eligible youth will engage in and utilize BHH services.

Second-year target/outcome measurement: 80% of eligible youth will engage in and utilize BHH services.

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

Data Source:

To be determined by a quality improvement process.

New Data Source*(if needed)*:

Description of Data:

Data will include, for each of the four BHH programs, the number of youth eligible for BHH services, with percentages formed by dividing the total number of eligible youth by the number of youth who engaged in or utilized BHH services.

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

Depending on the outcome of the quality improvement process, CMOs may be required to manually count eligible youth, which could result in some data quality issues related to human error.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

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

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

Priority #: 16

Priority Area: Increase access to evidence-based services and supports across the CSOC service continuum.

Priority Type: MHS

Population(s): SED

Goal of the priority area:

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

Objective:

We will enhance Intensive In-Community services providers' ability to provide healing-centered, evidence-based interventions, by collaborating with the CARES Institute to train clinicians in Trauma Focused Cognitive Behavioral Therapy (TFCBT).

Strategies to attain the goal:

A cohort of 10 clinicians who provide Intensive In-Community services to CSOC involved youth will be trained in TFCBT within one year of implementation of the training program.

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

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: A cohort of 10 clinicians who provide Intensive In-Community services to CSOC involved youth will be trained in TFCBT within one year of implementation of the training program.

Baseline Measurement: 0 clinicians trained

First-year target/outcome measurement: 10 clinicians trained

Second-year target/outcome measurement: An additional 10 clinicians trained (for a two year total of 20)

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

Data Source:

Internal Data

New Data Source*(if needed)*:

Description of Data:

Data will be a count of clinicians who completed the training program.

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)*:

0930-0168 Approved: 03/02/2022 Expires: 03/31/2025

Footnotes:

For Priority area #8: Prescription Drugs, the indicator is Opioid Prescriptions in New Jersey.

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

New Jersey SABG COVID Testing and Mitigation Program Report for October 1, 2021 - September 30, 2022

Testing i.e. Rapid Onsite Test Kits for Employees and Clients & CLIA Waiver Fee				
Vendor Name/Budget Description	**Payee Ref/Line Desc**	**Dollar Amount**	**Accept Date**	**Sub Org Name**
CATHOLIC CHARITIES DIOCESE OF	COVID-19 TESTING 04/30/2022	4,623.00	5/13/2022	COVID-19 TESTING Kits
CATHOLIC CHARITIES DIOCESE OF Total		**4,623.00**		
IRON RECOVERY AND WELLNESS CEN	COVID-19 TESTING 03/29/2022	1,925.00	4/20/2022	COVID-19 TESTING Kits
IRON RECOVERY AND WELLNESS CEN	COVID-19 TESTING 06/02/2022	860.70	6/23/2022	COVID-19 TESTING Kits
IRON RECOVERY AND WELLNESS CEN	COVID-19 TESTING 05/31/2022	3,718.00	6/23/2022	COVID-19 TESTING Kits
IRON RECOVERY AND WELLNESS CEN	COVID-19 TESTING 8/10/2022	500.00	9/9/2022	COVID-19 TESTING Kits
IRON RECOVERY AND WELLNESS CEN	COVID-19 TESTING 8/19/2022	441.00	9/9/2022	COVID-19 TESTING Kits
IRON RECOVERY AND WELLNESS CEN Total		**7,444.70**		
JOHN BROOKS RECOVERY CENTER	COVID-19 TESTING 04/29/2022	1,320.00	5/5/2022	COVID-19 TESTING Kits
JOHN BROOKS RECOVERY CENTER Total		**1,320.00**		
JSAS HEALTHCARE INC.	COVID-19 TESTING 01/27/2022	1,410.60	2/2/2022	COVID-19 TESTING Kits
JSAS HEALTHCARE INC.	COVID-19 TESTING 03/31/2022	919.08	4/6/2022	COVID-19 TESTING Kits
JSAS HEALTHCARE INC. Total		**2,329.68**		
NEW HOPE FOUNDATION	COVID-19 TESTING 7/25/2022	1,400.00	9/13/2022	COVID-19 TESTING Kits
NEW HOPE FOUNDATION Total		**1,400.00**		
OAKS INTEGRATED CARE	COVID-19 TESTING 04/29/2022	10,600.00	5/13/2022	COVID-19 TESTING Kits
OAKS INTEGRATED CARE Total		**10,600.00**		
RESCUE MISSION OF TRENTON	COVID-19 TESTING 02/07/2022	8,697.50	2/15/2022	COVID-19 TESTING Kits
RESCUE MISSION OF TRENTON	COVID-19 TESTING 07/25/2022	4,495.00	8/5/2022	COVID-19 TESTING Kits
RESCUE MISSION OF TRENTON Total		**13,192.50**		
SOMERSET TREATMENT SERVICES	COVID-19 TESTING 01/24/2022	1,634.00	1/28/2022	COVID-19 TESTING Kits
SOMERSET TREATMENT SERVICES	COVID-19 TESTING 04/29/2022	1,000.00	5/5/2022	COVID-19 TESTING Kits
SOMERSET TREATMENT SERVICES	COVID-19 TESTING 8/19/2022	1,000.00	9/9/2022	COVID-19 TESTING Kits
SOMERSET TREATMENT SERVICES Total		**3,634.00**		
TURNING POINT	COVID-19 TESTING 02/03/2022	7,182.00	2/15/2022	COVID-19 TESTING Kits
TURNING POINT	COVID-19 TESTING 07/28/2022	4,343.75	8/5/2022	COVID-19 TESTING Kits
TURNING POINT Total		**11,525.75**		
WAYNE COUNSELING CENTER INC.	COVID-19 TESTING 01/31/2022	225.90	2/3/2022	COVID-19 TESTING Kits
WAYNE COUNSELING CENTER INC. Total		**225.90**		
Grand Total		**$56,296**		

Prevention / Mitigation i.e. Services/Activities to: Prevent spread of COVID-19, Maintain healthy environments, Address consumer hesitancy				
N/A				
PPE Supplies				
N/A				
Education i.e. Development and printing of posters and fact sheets				
N/A				
Administration i.e. DMHAS contract staff time				
N/A				
Consultant to provide training and TA to providers regarding testing				
N/A				

III: Expenditure Reports

Table 2a - State Agency Expenditure Report

Expenditure Period Start Date: 7/1/2021 Expenditure Period End Date: 6/30/2022

Activity (See instructions for entering expenses in Row 1)	A. SA Block Grant	B. MH Block Grant	C. Medicaid (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	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]	I. ARP[2]
1. Substance Abuse Prevention (Other than Primary Prevention) and Treatment[3]	$34,724,303.00		$217,684,988.00	$30,139,936.00	$101,029,154.00	$0.00	$0.00	$809,452.00	$0.00
a. Pregnant Women and Women with Dependent Children	$6,111,285.00		$0.00	$0.00	$1,401,000.00	$0.00	$0.00	$0.00	$0.00
b. All Other	$28,613,018.00		$217,684,988.00	$30,139,936.00	$99,628,154.00	$0.00	$0.00	$809,452.00	$0.00
2. Substance Use Disorder Primary Prevention	$9,588,802.00		$0.00	$9,683,803.00	$1,963,054.00	$0.00	$0.00	$3,725,620.00	$0.00
3. Tuberculosis Services	$0.00		$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)[4]	$0.00		$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)	$1,426,252.00		$0.00	$2,071,411.00	$1,405,327.00	$0.00	$0.00	$440,608.00	$0.00
11. Total	**$45,739,357.00**	**$0.00**	**$217,684,988.00**	**$41,895,150.00**	**$104,397,535.00**	**$0.00**	**$0.00**	**$4,975,680.00**	**$0.00**

[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 planned expenditure period of July 1, 2021 - June 30, 2023, for most states.

[2] The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" MHBG/SABG. Per the instructions, the planning period for the standard MHBG/SABG expenditures is July 1, 2021 - June 30, 2023.

[3] Prevention other than primary prevetion

[4] 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

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Footnotes:
The State Substance Abuse Authority spent zero dollars on TB services in the state for SFY22 (whether SABG or state funds).

III: Expenditure Reports

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

Expenditure Period Start Date 10/1/2021 Expenditure Period End Date 9/30/2022

Service	COVID-19 Expenditures
Healthcare Home/Physical Health	**$0**
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)	**$0**
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)	
Primary Substance Use Disorder Prevention (Education)	
Primary Substance Use Disorder Prevention (Alternatives)	
Employee Assistance Programs (Problem Identification and Referral)	
Primary Substance Use Disorder Prevention (Community-Based Processes)	

Primary Substance Use Disorder Prevention (Environmental)	
Intervention Services	**$0**
Fentanyl Strips	
Syringe Services Program	
Naloxone	
Overdose Kits/Dissemination of Overdose Kits	
Engagement Services	**$0**
Assessment	
Specialized Evaluations (Psychological and Neurological)	
Services Planning (including crisis planning)	
Consumer/Family Education	
Outreach (including hiring of outreach workers)	
Outpatient Services	**$0**
Evidence-based Therapies	
Group Therapy	
Family Therapy	
Multi-family Therapy	
Consultation to Caregivers	
Medication Services	**$0**
Medication Management	
Pharmacotherapy (including MAT)	
Laboratory Services	
Community Support (Rehabilitative)	**$0**
Parent/Caregiver Support	
Case Management	
Behavior Management	

Supported Employment	
Permanent Supported Housing	
Recovery Housing	
Recovery Supports	**$0**
Peer Support	
Recovery Support Coaching	
Recovery Support Center Services	
Supports For Self-Directed Care	
Supports (Habilitative)	**$0**
Personal Care	
Respite	
Supported Education	
Acute Intensive Services	**$0**
Mobile Crisis	
Peer-based Crisis Services	
Urgent Care	
23-hour Observation Bed	
Medically Monitored Intensive Inpatient for SUD	
24/7 Crisis Hotline	
Other	**$0**
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: 07/01/2021 Expenditure End Date: 06/30/2022

Syringe Services Program SSP Agency Name	Main Address of SSP	Dollar Amount of SABG Funds Expended for SSP	Dollar Amount of COVID-19[1] Funds Expended for SSP	Dollar Amount of ARP[2] Funds Expended for SSP	SUD Treatment Provider (Yes or No)	# Of locations (Include any mobile locations)	Narcan Provider (Yes or No)	Fentanyl Strips (Yes or No)
No Data Available								

[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] The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" MHBG/SABG. Per the instructions, the planning period for standard MHBG/SABG expenditures is July 1, 2021 – June 30, 2023.

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Footnotes:

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

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Table 3b SABG - Syringe Services Program

Expenditure Start Date: Expenditure End Date:

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

ARP							
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

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: 10/1/2019 Expenditure Period End Date: 9/30/2021

Expenditure Category	FY 2020 SA Block Grant Award
1. Substance Abuse Prevention[1] and Treatment	$33,306,986.75
2. Primary Prevention	$11,715,792.32
3. HIV Early Intervention Services[2]	$0.00
4. Early Intervention Services Regarding the Human Immunodeficiency Virus (EIS/HIV)	$0.00
5. Administration (excluding program/provider level)	$1,108,336.93
Total	**$46,131,116.00**

[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:

III: Expenditure Reports

Table 5a - SABG Primary Prevention Expenditures

The state or jurisdiction must complete SABG Table 5a. 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 plans to use strategies not covered by these six categories or the state is unable to calculate expenditures by strategy, please report them under "Other" in Table 5a.

Expenditure Period Start Date: 10/1/2019 Expenditure Period End Date: 9/30/2021

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 (Synar)-Tobacco	Selective					
Section 1926 (Synar)-Tobacco	Indicated					
Section 1926 (Synar)-Tobacco	Universal					
Section 1926 (Synar)-Tobacco	Unspecified					
Section 1926 (Synar)-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 (Synar)-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:

III: Expenditure Reports

Table 5b - SABG Primary Prevention Targeted Priorities (Required)

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 2020 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: 10/1/2019 Expenditure Period End Date: 9/30/2021

	SABG Award
Targeted Substances	
Alcohol	☑
Tobacco	☑
Marijuana	☑
Prescription Drugs	☑
Cocaine	☑
Heroin	☑
Inhalants	☑
Methamphetamine	☑
Synthetic Drugs (i.e. 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 - Non Direct Services/System Development

Expenditure Period Start Date: 10/1/2019 Expenditure Period End Date: 9/30/2021

Activity	A. SABG Treatment	B. SABG Prevention	C. SABG Integrated[1]
1. Information Systems	$2,071,196.00	$0.00	$0.00
2. Infrastructure Support	$431,697.00	$0.00	$0.00
3. Partnerships, community outreach, and needs assessment	$65,584.00	$29,233.00	$0.00
4. Planning Council Activities (MHBG required, SABG optional)	$0.00	$0.00	$0.00
5. Quality Assurance and Improvement	$27,701.00	$0.00	$0.00
6. Research and Evaluation	$2,053,334.00	$1,585,366.02	$0.00
7. Training and Education	$176,326.00	$0.00	$0.00
8. Total	**$4,825,838.00**	**$1,614,599.02**	**$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 system development/non-direct service expenditures.

Expenditure Period Start Date: 10/1/2019 Expenditure Period End Date: 9/30/2021

										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
	2000840	NJ103071	✗	99	Acenda, Inc- 2000840	340 WEST HANOVER AVENUE	MORRISTOWN	NJ	07960	$7,579.00	$7,579.00	$0.00	$0.00	$0.00	$0.00
	2000841	NJ103071	✗	99	Acenda, Inc- 2000841	6 GAUNTT PLACE, BLDG #2	FLEMINGTON	NJ	08822	$7,596.00	$7,596.00	$0.00	$0.00	$0.00	$0.00
	2000842	NJ103071	✗	99	Acenda, Inc- 2000842	399 NORTH MAIN STREET	MANAHAWKIN	NJ	08050	$5,142.00	$5,142.00	$0.00	$0.00	$0.00	$0.00
	2000843	NJ103071	✗	99	Acenda, Inc- 2000843	9 HARDING HIGHWAY	PITTSGROVE	NJ	08319	$5,704.00	$5,704.00	$0.00	$0.00	$0.00	$0.00
	1000088	NJ103071	✗	99	Acenda, Inc. - 1000155	42 Delsea Drive South	Glassboro	NJ	08028 -2621	$497,271.00	$497,271.00	$0.00	$0.00	$0.00	$0.00
	2000813	NJ103071	✗	99	Acenda, Inc. - 2000813	128 CREST HAVEN ROAD	CAPE MAY COURT HOUSE	NJ	08210	$4,610.00	$4,610.00	$0.00	$0.00	$0.00	$0.00
	2000693	NJ102946	✗	99	Adult Family Health Services - 2000693	53 Orchard Street	Clifton	NJ	07013	$1,107.00	$1,107.00	$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	$204,979.00	$204,979.00	$0.00	$0.00	$0.00	$0.00
	2000074	NJ902437	✗	99	Alfre, Inc. d.b.a. Mrs. Wilson's - 2000074	56 Mount Kemble Avenue	Morristown	NJ	07960	$1,125.00	$1,125.00	$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	$319,603.00	$319,603.00	$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	$100,019.00	$100,019.00	$35,055.00	$0.00	$0.00	$0.00
	2000615	NJ101970	✗	99	Behavioral Crossroads Recovery - 2000615	205 West Parkway Drive	Egg Harbor Township	NJ	08234	$118.00	$118.00	$0.00	$0.00	$0.00	$0.00
	2000071	NJ101656	✗	99	C-LINE COMMUNITY OUTREACH - 2000071	110 MARTIN LUTHER KING DRIVE	JERSEY CITY	NJ	07305	$4,106.00	$4,106.00	$0.00	$0.00	$0.00	$0.00
	2000511	NJ100774	✗	99	C-Line Counseling Center - 2000511	680 BROADWAY	PATERSON	NJ	07509	$511.00	$511.00	$0.00	$0.00	$0.00	$0.00
	306175	NJ101797	✗	04	CAMDEN COUNTY COUNCIL ON	1 Alpha Avenue Suite 22	Voorhees	NJ	08043	$535,000.00	$0.00	$0.00	$535,000.00	$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
	1024030	NJ102403	✗	05	Cape Regional Medical Center	2 Stone Harbor Boulevard	CAPE MAY COURT HOUSE	NJ	08210	$44,000.00	$44,000.00	$0.00	$0.00	$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	NJ102684	✗	99	Catholic Charities Alcoholism/Addictions Program - 2000313	10 SOUTHARD STREET	TRENTON	NJ	08609	$630.00	$630.00	$0.00	$0.00	$0.00	$0.00
	2000312	NJ102684	✗	99	Catholic Charities, Diocese of Trenton, Project Free/New Choices - 2000312	10 SOUTHARD STREET	TRENTON	NJ	08609	$26,308.00	$26,308.00	$0.00	$0.00	$0.00	$0.00
	2000041	NJ100603	✗	99	Center for Family Services, Inc. - 2000041	601 SOUTH BLACKHORSE PIKE	WILLIAMSTOWN	NJ	08094	$11,233.00	$11,233.00	$0.00	$0.00	$0.00	$0.00
	2000241	NJ000121	✗	99	Center for Family Services, Inc. - 2000241	108 SOMERDALE ROAD	VOORHEES	NJ	08043	$7,175.00	$7,175.00	$0.00	$0.00	$0.00	$0.00

	2000243	NJ101537	✗	99	Center for Family Services, Inc. - 2000243	594 BENSON STREET	CAMDEN	NJ	08103	$4,223.00	$4,223.00	$0.00	$0.00	$0.00	$0.00
	100853	NJ100853	✗	Sussex County	Center for Prevention and Counseling	61 Spring Street	Newton	NJ	07860	$423,686.00	$94,986.00	$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	$4,753.00	$4,753.00	$0.00	$0.00	$0.00	$0.00
	2000182	NJ300715	✗	99	Corner House - 2000182	One Monument Drive	Princeton	NJ	08540	$21,199.00	$21,199.00	$0.00	$0.00	$0.00	$0.00
	2000651	NJ102779	✗	99	CPC Aberdeen Counseling Center - 2000651	1088 HIGHWAY 34	ABERDEEN	NJ	07747	$1,162.00	$1,162.00	$0.00	$0.00	$0.00	$0.00
	2000332	NJ100392	✗	99	CPC Behavioral Healthcare, Inc. - 2000332	270 Route 35	RED BANK	NJ	07701	$34,997.00	$34,997.00	$0.00	$0.00	$0.00	$0.00
	2000806	NJ103191	✗	99	CPC Behavioral Healthcare, Neptune City Counseling Center - 2000806	72 MORRIS AVENUE	NEPTUNE CITY	NJ	07753	$10,050.00	$10,050.00	$0.00	$0.00	$0.00	$0.00
	2000659	NJ102886	✗	99	CPC Freehold Counseling Center - 2000659	22 COURT STREET	FREEHOLD	NJ	07728	$1,188.00	$1,188.00	$0.00	$0.00	$0.00	$0.00
	2000679	NJ102895	✗	99	CPC Howell Counseling Center - 2000679	4539 US HIGHWAY 9	HOWELL	NJ	07731	$13,220.00	$13,220.00	$0.00	$0.00	$0.00	$0.00
	305300	NJ100756	✗	07	CURA INCORPORATED	35 Lincoln Park, P.O. Box 180	Newark	NJ	07101 -0180	$308,376.00	$308,376.00	$185,046.00	$0.00	$0.00	$0.00
	1000085	NJ100868	✗	99	CURA, Inc. - 1000085	595 COUNTY AVENUE	SECAUCUS	NJ	07094	$279,123.00	$279,123.00	$0.00	$0.00	$0.00	$0.00
	2000208	NJ107532	✗	99	CURA, Inc. - 2000208	729 E LANDIS AVENUE	VINELAND	NJ	08360	$46,659.00	$46,659.00	$0.00	$0.00	$0.00	$0.00
	2000263	NJ107870	✗	99	CURA, Inc. - 2000263	61 LINCOLN PARK	NEWARK	NJ	07101	$75,587.00	$75,587.00	$0.00	$0.00	$0.00	$0.00
	1000050	NJ306159	✗	99	Damon House, Inc. - 1000050	105 JOYCE KILMER AVE	NEW BRUNSWICK	NJ	08901	$15,911.00	$15,911.00	$0.00	$0.00	$0.00	$0.00
	2000084	NJ100936	✗	99	Delaware Valley Medical	7980 S CRESCENT BLVD	PENNSAUKEN	NJ	08109	$35,058.00	$35,058.00	$0.00	$0.00	$0.00	$0.00
	2000037	NJ105551	✗	99	Discovery Institute for Addictive Disorder - 2000037	81 CONOVER ROAD	Marlboro	NJ	07746	$22,258.00	$22,258.00	$0.00	$0.00	$0.00	$0.00
	1000051	NJ100477	✗	99	Discovery Institute for Addictive Disorders, Inc. - 1000051	80 CONOVER ROAD	MARLBORO	NJ	07746	$243,962.00	$243,962.00	$0.00	$0.00	$0.00	$0.00
	1000063	NJ301028	✗	99	Dismas House for Drug Rehabilitation - 1000063	396 STRAIGHT ST	PATERSON	NJ	07501	$264,725.00	$264,725.00	$0.00	$0.00	$0.00	$0.00
	2000136	NJ300806	✗	99	East Orange Substance Abuse Treatment Program - 2000136	110 South Grove Street	East Orange	NJ	07018 -2693	$86,756.00	$86,756.00	$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	$100,117.00	$100,117.00	$0.00	$0.00	$0.00	$0.00
	1000105	NJ103193	✗	99	Epiphany House, Inc.-Long Branch - 1000105	373 BRIGHTON AVENUE	LONG BRANCH	NJ	07740	$231,297.00	$231,297.00	$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	$2,322,193.00	$2,322,193.00	$542,566.00	$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	$189.00	$189.00	$0.00	$0.00	$0.00	$0.00
	902635	NJ902635	✗	Warren County	Family Guidance Center of Warren Cnty	492 Route 57 West	Washington	NJ	07882	$11,750.00	$11,750.00	$0.00	$0.00	$0.00	$0.00
	2000005	NJ107359	✗	99	Family Guidance Center of Warren County - 2000005	370 MEMORIAL PARKWAY	PHILLIPSBURG	NJ	08865	$1,864.00	$1,864.00	$0.00	$0.00	$0.00	$0.00
	2000411	NJ902635	✗	99	Family Guidance Center of Warren County - 2000411	492 RT 57 WEST	WASHINGTON	NJ	07882	$4,582.00	$4,582.00	$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	$1,030,015.00	$1,030,015.00	$0.00	$0.00	$0.00	$0.00
	2000518	NJ100516		99	Freedom House - 2000518	2004 ROUTE 31, NORTH	CLINTON	NJ	08809	$189,763.00	$189,763.00	$0.00	$0.00	$0.00	$0.00
	2000650	NJ103267		99	Freedom House Outpatient Services - 2000650	427-429 SOUTH MAIN STREET	PHILLIPSBURG	NJ	08865	$24,165.00	$24,165.00	$0.00	$0.00	$0.00	$0.00
	2000153	NJ101478		99	Genesis Counseling Center - 2000153	1000 ATLANTIC AVENUE	CAMDEN	NJ	08105	$3,224.00	$3,224.00	$0.00	$0.00	$0.00	$0.00
	2000146	NJ101899		99	Genesis Counseling Center, Inc. - 2000146	566 Haddon Avenue	Collingswood	NJ	08108	$9,562.00	$9,562.00	$0.00	$0.00	$0.00	$0.00
	2000171	NJ101573		99	Genesis Counseling Center, Marlton - 2000171	2003 LINCOLN DRIVE WEST	MARLTON	NJ	08053	$9,851.00	$9,851.00	$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
	2000133	NJ104612		99	Guided Life Structures - 2000133	286 East Main Street	Somerville	NJ	08876	$3,175.00	$3,175.00	$0.00	$0.00	$0.00	$0.00
	2000490	NJ102027		99	Habit Opco - 2000490	111 HIGHWAY 35, SUITE 7	CLIFFWOOD	NJ	07721	$9,560.00	$9,560.00	$0.00	$0.00	$0.00	$0.00
	1000003	NJ101677		01	Hansen House	411 Aloe Street	Egg Harbor City	NJ	08215	$647,859.00	$647,859.00	$0.00	$0.00	$0.00	$0.00
	1000007	NJ105270		99	Hendricks House, Inc. - 1000007	542 N West Blvd	Vineland	NJ	08360	$454,649.00	$454,649.00	$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	$900.00	$900.00	$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 Street	Flemington	NJ	08822	$49,976.00	$49,976.00	$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	$24,565.00	$24,565.00	$0.00	$0.00	$0.00	$0.00
	100420	NJ100420		07	Integrity House Inc - Mens Facility	105 Lincoln Park	Newark	NJ	07102	$377,409.00	$377,409.00	$0.00	$0.00	$0.00	$0.00
	1000022	NJ107706		99	Integrity, Inc. - 1000022	99 LINCOLN PARK	NEWARK	NJ	07102	$80,103.00	$80,103.00	$0.00	$0.00	$0.00	$0.00
	1000036	NJ103390		99	Integrity, Inc. - 1000036	595 COUNTY AVENUE, BUILDING #6	SECAUCUS	NJ	07094	$284,328.00	$284,328.00	$0.00	$0.00	$0.00	$0.00
	1000070	NJ107722		99	Integrity, Inc. - 1000070	43 LINCOLN PARK	NEWARK	NJ	07102	$72,889.00	$72,889.00	$0.00	$0.00	$0.00	$0.00
	1000072	NJ000163		99	Integrity, Inc. - 1000072	101 LINCOLN PARK	NEWARK	NJ	07102	$163,779.00	$163,779.00	$0.00	$0.00	$0.00	$0.00
	1000081	NJ100420		99	Integrity, Inc. - 1000081	105 LINCOLN PARK	NEWARK	NJ	07102	$16,311.00	$16,311.00	$0.00	$0.00	$0.00	$0.00
	1000123	NJ103556		99	Integrity, Inc. - 1000123	595 COUNTY AVENUE, BUILDING 7	SECAUCUS	NJ	07094	$80,511.00	$80,511.00	$0.00	$0.00	$0.00	$0.00
	1000146	NJ103556		99	Integrity, Inc. - 1000146	97 LINCOLN PARK	NEWARK	NJ	07102	$229,437.00	$229,437.00	$0.00	$0.00	$0.00	$0.00
	2000154	NJ103556		99	Integrity, Inc. - 2000154	595 COUNTY AVENUE	SECAUCUS	NJ	07094	$30,101.00	$30,101.00	$0.00	$0.00	$0.00	$0.00
	2000333	NJ107821		99	Integrity, Inc. - 2000333	26-28 LONGWORTH STREET	NEWARK	NJ	07102	$85,223.00	$85,223.00	$0.00	$0.00	$0.00	$0.00
	2000530	NJ103518		99	Integrity, Inc. - 2000530	360-398 MARTIN LUTHER KING Boulevard	JERSEY CITY	NJ	07305	$471.00	$471.00	$0.00	$0.00	$0.00	$0.00
	2000613	NJ103519		99	Integrity, Inc. - 2000613	30-32 CENTRAL AVENUE	JERSEY CITY	NJ	07306	$7,398.00	$7,398.00	$0.00	$0.00	$0.00	$0.00
	2000635	NJ103556		99	Integrity, Inc. - 2000635	415 SPEEDWELL AVENUE	MORRIS PLAINS	NJ	07950	$22,862.00	$22,862.00	$0.00	$0.00	$0.00	$0.00
	1000119	NJ103556		99	Integrity, Inc., Halfway House - 1000119	595 COUNTY AVENUE	SECAUCUS	NJ	07094	$269,766.00	$269,766.00	$0.00	$0.00	$0.00	$0.00

	2000435	NJ100594	✗	99	Inter County Council on Drug and Alcohol Abuse - 2000435	480 KEARNY AVENUE	KEARNY	NJ	07032	$145,781.00	$145,781.00	$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	$21,591.00	$21,591.00	$21,591.00	$0.00	$0.00	$0.00
	100461	NJ100461	✗	Mercer County	IRON RECOVERY AND WELLNESS CEN	132 Perry Street	Trenton	NJ	08618	$66,353.00	$66,353.00	$30,081.00	$0.00	$0.00	$0.00
	2000519	NJ102035	✗	99	Jewish Family and Children's Service of Greater Monmouth County - 2000519	705 SUMMERFIELD AVENUE	ASBURY PARK	NJ	07712	$23,183.00	$23,183.00	$0.00	$0.00	$0.00	$0.00
	300103	NJ300103	✗	01	JOHN BROOKS RECOVERY CENTER	1315 Pacific Avenue	Atlantic City	NJ	08401	$38,862.00	$38,862.00	$38,862.00	$0.00	$0.00	$0.00
	1000044	NJ101989	✗	99	John Brooks Recovery Center - 1000044	20 S TENNESSEE AVE	ATLANTIC CITY	NJ	08401	$5,423.00	$5,423.00	$0.00	$0.00	$0.00	$0.00
	1000048	NJ000081	✗	99	John Brooks Recovery Center - 1000048	1455 PINEWOOD BOULEVARD	MAYS LANDING	NJ	08330	$53,122.00	$53,122.00	$0.00	$0.00	$0.00	$0.00
	2000275	NJ101038	✗	99	John Brooks Recovery Center - 2000275	660 Black Horse Pike	Pleasantville	NJ	08232	$536,025.00	$536,025.00	$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	$137,732.00	$137,732.00	$0.00	$0.00	$0.00	$0.00
	100156	NJ100156	✗	Monmouth County	JSAS HEALTHCARE INC.	685 Neptune Boulevard Suite 101	Neptune	NJ	07753	$73,406.00	$73,406.00	$73,406.00	$0.00	$0.00	$0.00
	2000316	NJ100156	✗	99	JSAS Healthcare, Inc. - 2000316	685 NEPTUNE Boulevard	NEPTUNE	NJ	07754	$1,048,557.00	$1,048,557.00	$0.00	$0.00	$0.00	$0.00
	100404	NJ100404	✗	07	LENNARD CLINIC INC.	164 Blanchard Street	Newark	NJ	07105	$181,356.00	$181,356.00	$181,356.00	$0.00	$0.00	$0.00
	1000140	NJ103431	✗	99	MARYVILLE, INC - 1000140	610 PEMBERTONTON BROWNS MILLS ROAD	PEMBERTON	NJ	08068	$34,908.00	$34,908.00	$0.00	$0.00	$0.00	$0.00
	2000680	NJ103109	✗	99	MARYVILLE, INC - 2000680	1907 NEW ROAD	NORTHFIELD	NJ	08225	$2,996.00	$2,996.00	$0.00	$0.00	$0.00	$0.00
	1000028	NJ106237	✗	99	Maryville, Inc. - 1000028	1903 Grant Avenue	Williamstown	NJ	08094	$163,683.00	$163,683.00	$0.00	$0.00	$0.00	$0.00
	2000132	NJ100817	✗	99	Maryville, Inc. - 2000132	129 JOHNSON ROAD	TURNERSVILLE	NJ	08012	$39,138.00	$39,138.00	$0.00	$0.00	$0.00	$0.00
	2000300	NJ107813	✗	99	Maryville, Inc. - 2000300	1173 EAST LANDIS AVENUE	VINELAND	NJ	08360	$10,830.00	$10,830.00	$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	$356,150.00	$0.00	$0.00	$356,150.00	$0.00	$0.00
	2000404	NJ101983	✗	99	Middletown Medical, LLC - 2000404	600 State Route 35	Middletown	NJ	07748	$110,292.00	$110,292.00	$0.00	$0.00	$0.00	$0.00
	2000423	NJ100651	✗	99	Morris County Aftercare Center - 2000423	273 East Main Street	Denville	NJ	07834	$640,100.00	$640,100.00	$0.00	$0.00	$0.00	$0.00
	101818	NJ101818	✗	Morris County	Morris County Prevention is Key	25 West Main Street	Rockaway	NJ	07866	$451,166.00	$43,166.00	$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	$56,134.00	$56,134.00	$56,134.00	$0.00	$0.00	$0.00
	2000164	NJ101581	✗	99	New Brunswick Counseling Center - 2000164	320 Suydam Street	New Brunswick	NJ	08901 -2417	$587,661.00	$587,661.00	$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 STREET	MOUNT HOLLY	NJ	08060	$253,983.00	$253,983.00	$0.00	$0.00	$0.00	$0.00
	1000053	NJ103194	✗	99	New Hope Foundation, Inc. - 1000053	82 CONOVER ROAD	Marlboro	NJ	07746	$334,407.00	$334,407.00	$0.00	$0.00	$0.00	$0.00
					New Hope										

	1000058	NJ108183	✗	99	Foundation, Inc., Epiphany House, Inc. - 1000058	300 FOURTH AVENUE	ASBURY PARK	NJ	07712	$77,334.00	$77,334.00	$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	$154,120.00	$154,120.00	$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	$75,248.00	$75,248.00	$0.00	$0.00	$0.00	$0.00
	1000020	NJ107003	✗	99	New Hope Integrated Behavioral Health - 1000020	190 CHELSEA AVENUE	LONG BRANCH	NJ	07740	$177,233.00	$177,233.00	$0.00	$0.00	$0.00	$0.00
	2000307	NJ106260	✗	99	New Hope Outpatient Services - 2000307	2 MONMOUTH AVE	FREEHOLD	NJ	07728	$16,473.00	$16,473.00	$0.00	$0.00	$0.00	$0.00
	2000345	NJ100461	✗	99	New Horizon Treatment Services, Inc. - 2000345	132 PERRY STREET	TRENTON	NJ	08618	$201,092.00	$201,092.00	$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	$1,528.00	$1,528.00	$0.00	$0.00	$0.00	$0.00
	759802	NJ100858	✗	Ocean County	NEW JERSEY PREVENTION NETWORK	150 AIRPORT ROAD	LAKEWOOD	NJ	08701	$2,327,500.00	$1,802,500.00	$0.00	$525,000.00	$0.00	$0.00
	2000281	NJ101635	✗	99	New Life Program - 2000281	331 White Horse Pike	Atco	NJ	08004	$6,324.00	$6,324.00	$0.00	$0.00	$0.00	$0.00
	306092	NJ306092	✗	07	Newark Renaissance House Inc	50 Norfolk Street	Newark	NJ	07103	$58,268.00	$58,268.00	$58,268.00	$0.00	$0.00	$0.00
	101821	NJ101821	✗	07	North Jersey Community Research Initiative	393 Central Ave	Newark	NJ	07103	$225,000.00	$0.00	$0.00	$225,000.00	$0.00	$0.00
	2000320	NJ100487	✗	99	Northeast Life Skills Associates, Inc. - 2000320	121 Howe Avenue	Passaic	NJ	07055	$160,650.00	$160,650.00	$0.00	$0.00	$0.00	$0.00
	2000597	NJ101236	✗	99	Oaks Integrated Care - 2000597	770 Woodlane Road	Mount Holly	NJ	08060-1056	$26,034.00	$26,034.00	$0.00	$0.00	$0.00	$0.00
	2000451	NJ101900	✗	99	Ocean Monmouth Care, LLC - 2000451	150 BRICKBoulevard	BRICK	NJ	08723	$36,957.00	$36,957.00	$0.00	$0.00	$0.00	$0.00
	1000145	NJ102948	✗	99	Onward Behavioral Health - 1000145	600 South White Horse Pike	Hammonton	NJ	08037	$3,648.00	$3,648.00	$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	$550,413.00	$550,413.00	$0.00	$0.00	$0.00	$0.00
	100495	NJ100495	✓	Passaic County	Paterson Counseling Center Inc	319-321 Main Street	Paterson	NJ	07505	$99,315.00	$99,315.00	$99,315.00	$0.00	$0.00	$0.00
	2000108	NJ100495	✗	99	Paterson Counseling Center, Inc. - 2000108	319-321 Main Street	Paterson	NJ	07505-1805	$248,752.00	$248,752.00	$0.00	$0.00	$0.00	$0.00
	2000330	NJ102454	✗	99	Preferred Behavioral Health of N.J., Inc. - 2000330	848 W BAY AVENUE	BARNEGAT	NJ	08005	$26,350.00	$26,350.00	$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	$32,661.00	$32,661.00	$0.00	$0.00	$0.00	$0.00
	2000152	NJ101295	✗	99	Preferred Behavioral Health of New Jersey, Inc. - 2000152	700 AIRPORT RoaD	LAKEWOOD	NJ	08701	$77,184.00	$77,184.00	$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 Route 35	OCEAN	NJ	07712	$21,304.00	$21,304.00	$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	$34,138.00	$34,138.00	$0.00	$0.00	$0.00	$0.00
	1000082	NJ750687	✗	99	Rescue Mission of Trenton - 1000082	96 CARROLL STREET	TRENTON	NJ	08609	$251,927.00	$251,927.00	$0.00	$0.00	$0.00	$0.00

	2000107	NJ101115	✗	99	Rescue Mission of Trenton - 2000107	72 EWING STREET	TRENTON	NJ	08609	$27,066.00	$27,066.00	$0.00	$0.00	$0.00	$0.00
	2000829	NJ103253	✗	99	Resource Center for the Chemically Dependent, Inc., d/b/a Sussex County Aftercare Center - 2000829	124 HAMPTON HOUSE ROAD	NEWTON	NJ	07860	$2,208.00	$2,208.00	$0.00	$0.00	$0.00	$0.00
	104315	NJ102934	✗	Middlesex County	RUTGERS THE STATE UNIVERSITY OF NJ	33 Knightsbridge Road 2nd Fl East Wing	Piscataway	NJ	08854	$28,279.00	$0.00	$0.00	$28,279.00	$0.00	$0.00
	100164	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	$20,714.00	$20,714.00	$0.00	$0.00	$0.00	$0.00
	2000331	NJ108068	✗	99	SODAT of NJ, Inc. - 2000331	75 MARKET STREET	SALEM	NJ	08079 -1108	$15,137.00	$15,137.00	$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	$16,453.00	$16,453.00	$0.00	$0.00	$0.00	$0.00
	2000210	NJ108076	✗	99	SODAT of NJ, Inc. Mount Holly Office - 2000210	60 HIGH STREET	MOUNT HOLLY	NJ	08060	$3,997.00	$3,997.00	$0.00	$0.00	$0.00	$0.00
	2000040	NJ101237	✗	99	SODAT of NJ, Inc., Cumberland - 2000040	92 VINE STREET	BRIDGETON	NJ	08302	$10,043.00	$10,043.00	$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	$196,350.00	$0.00	$0.00	$196,350.00	$0.00	$0.00
	100693	NJ100693	✓	Somerset County	Somerset Treatment Services	118 West End Avenue	Somerville	NJ	08876	$21,590.00	$21,590.00	$21,590.00	$0.00	$0.00	$0.00
	2000200	NJ100693	✗	99	Somerset Treatment Services - 2000200	118 West End Avenue	Somerville	NJ	08876	$228,768.00	$228,768.00	$0.00	$0.00	$0.00	$0.00
	2000355	NJ100677	✗	99	South Jersey Drug Treatment Center - 2000355	162 Sunny Slope Dr	Bridgeton	NJ	08302	$81,326.00	$81,326.00	$0.00	$0.00	$0.00	$0.00
	109876	NJ109876	✗	04	Southern New Jersey Perinatal Cooperative	2500 McClellan Ave	Pennsauken	NJ	08109	$485,149.00	$485,149.00	$485,149.00	$0.00	$0.00	$0.00
	2000142	NJ306316	✗	99	Spectrum Health Care, Inc. - 2000142	74-80 Pacific AveNUE	Jersey City	NJ	07304 -3216	$1,094,252.00	$1,094,252.00	$0.00	$0.00	$0.00	$0.00
	306316	NJ306316	✗	09	Spectrum Healthcare Inc	74-80 Pacific Avenue	Jersey City	NJ	07304	$120,904.00	$120,904.00	$120,904.00	$0.00	$0.00	$0.00
	105072	NJ100095	✗	01	St. Barnabas Health Care Inst. for Prevention	1695 US HIGHWAY 9	TOMS RIVER	NJ	08754	$2,811,811.00	$1,806,931.00	$0.00	$1,004,880.00	$0.00	$0.00
	2000491	NJ101996	✗	99	STAND4RECOVERY PROGRAM - 2000491	316 HADDON AVENUE	COLLINGSWOOD	NJ	08108	$61,715.00	$61,715.00	$0.00	$0.00	$0.00	$0.00
	999074	NJ102679	✗	Passaic County	STRAIGHT & NARROW INC	P.O. Box 2738	Paterson	NJ	07501	$1,696,669.00	$1,696,669.00	$1,696,666.00	$0.00	$0.00	$0.00
	2000176	NJ306258	✗	99	Straight & Narrow, Inc. - 2000176	230 E RIDGEWOOD AVE	PARAMUS	NJ	07652	$304,662.00	$304,662.00	$0.00	$0.00	$0.00	$0.00
	1000143	NJ102682	✗	99	Straight & Narrow, Inc. - Alpha House I - 1000143	396 STRAIGHT STREET	PATERSON	NJ	07501	$7,826.00	$7,826.00	$0.00	$0.00	$0.00	$0.00
	2000308	NJ102679	✗	99	Straight and Narrow Outpatient Clinic - 2000308	508 Straight St	Paterson	NJ	07503 -3044	$5,971.00	$5,971.00	$0.00	$0.00	$0.00	$0.00
	2000321	NJ100720	✗	99	Team Management 2000, Inc. - 2000321	84 MAIN STREET	HACKENSACK	NJ	07601	$46,461.00	$46,461.00	$0.00	$0.00	$0.00	$0.00
	2000054	NJ101716	✗	99	Team Management 2000, Inc. CBO - 2000054	744 BROAD STREET	NEWARK	NJ	07102	$1,648.00	$1,648.00	$0.00	$0.00	$0.00	$0.00
	2000061	NJ100457	✗	99	The Bridge, Inc. - 2000061	50 UNION AVE	IRVINGTON	NJ	07111	$3,594.00	$3,594.00	$0.00	$0.00	$0.00	$0.00
	2000144	NJ370700	✗	99	The Bridge, Inc. - 2000144	860 Bloomfield Avenue	West Caldwell	NJ	07006	$5,162.00	$5,162.00	$0.00	$0.00	$0.00	$0.00
	101830	NJ101830	✗	02	The Center for Alcohol and - Drug Resource	241 Main Street	PARAMUS	NJ	07652	$689,350.00	$197,650.00	$163,900.00	$491,700.00	$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 STREET	NEW BRUNSWICK	NJ	08901	$3,353.00	$3,353.00	$0.00	$0.00	$0.00	$0.00

	2000196	NJ306449	X	99	The Lennard Clinic, Inc. - 2000196	461 Frelinghuysen Avenue	Newark	NJ	07114	$731,439.00	$731,439.00	$0.00	$0.00	$0.00	$0.00
	2000417	NJ101215	X	99	The Lennard Clinic, Inc. - 2000417	850 WOODRUFF LANE	ELIZABETH	NJ	07201	$300,614.00	$300,614.00	$0.00	$0.00	$0.00	$0.00
	102467	NJ102467	X	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	X	06	THE SOUTHWEST COUNCIL INC.	1405 North Delsea Drive	Vineland	NJ	08360	$1,395,498.00	$63,264.00	$0.00	$1,332,234.00	$0.00	$0.00
	2000249	NJ103520	X	99	The Wise Program - 2000249	659 MARTIN LUTHER KING Boulevard	NEWARK	NJ	07102 -1119	$20,902.00	$20,902.00	$0.00	$0.00	$0.00	$0.00
	1000062	NJ101851	X	99	Turning Point, Inc. - 1000062	680 BROADWAY	PATERSON	NJ	07514	$258,821.00	$258,821.00	$0.00	$0.00	$0.00	$0.00
	2000642	NJ102456	X	99	Turning Point, Inc. - 2000642	680 Broadway, Suite 104	Paterson	NJ	07514	$2,652.00	$2,652.00	$0.00	$0.00	$0.00	$0.00
	2000702	NJ100641	X	99	Turning Point, Inc. - 2000702	101 PROSPECT STREET	LAKEWOOD	NJ	08701	$13,409.00	$13,409.00	$0.00	$0.00	$0.00	$0.00
	100939	NJ100939	X	04	Urban Renewal Corp Sussex House	224 Sussex Avenue	CAMDEN	NJ	08102	$21,590.00	$21,590.00	$21,590.00	$0.00	$0.00	$0.00
	2000459	NJ000281	X	99	Urban Treatment Associates, Inc. - 2000459	508 Atlantic Avenue	Camden	NJ	08104	$358,468.00	$358,468.00	$0.00	$0.00	$0.00	$0.00
	103147	NJ103147	X	Middlesex County	VERITAS RECOVERY CENTER, LLC	540 Bordentown Ave	South Amboy	NJ	08879	$17,899.00	$17,899.00	$0.00	$0.00	$0.00	$0.00
	2000082	NJ108019	X	99	Warren Medical Services - 2000082	590 MARSHALL STEET	PHILLIPSBURG	NJ	08865	$19,538.00	$19,538.00	$0.00	$0.00	$0.00	$0.00
	2000322	NJ102452	X	99	Wayne Counseling and Family Services - 2000322	1022 Hamburg Turnpike	Wayne	NJ	07470 -3209	$4,513.00	$4,513.00	$0.00	$0.00	$0.00	$0.00
	371203	NJ102452	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	$150,000.00	$0.00	$0.00	$150,000.00	$0.00	$0.00
Total										$38,582,342.00	$28,481,149.00	$5,819,275.00	$10,101,193.00	$0.00	$0.00

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

0930-0168 Approved: 03/02/2022 Expires: 03/31/2025

Footnotes:

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: 07/01/2021 Expenditure Period End Date: 06/30/2022

Total Single State Agency (SSA) Expenditures for Substance Abuse Prevention and Treatment		
Period **(A)**	**Expenditures** **(B)**	**B1(2020) + B2(2021)** **2** **(C)**
SFY 2020 (1)	$155,469,198.00	
SFY 2021 (2)	$152,686,955.00	$154,078,076.50
SFY 2022 (3)	$144,339,519.00	

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

SFY 2020 Yes **X** No ____

SFY 2021 Yes **X** No ____

SFY 2022 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.
See Attached file

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Footnotes:

The $144,339,519 SFY 2022 Amount reported is the sum of $104,397,535 reported in Table 2, Column E. State Funds and $39,941,984 of the $217,684,988 Medicaid funds included in Table 2 Column D.

MAINTENANCE OF EFFORT (MOE) CALCULATIONS FOR SFY 2022
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 to 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
100-054-7700-231, Supportive Housing Subsidies
100-054-7700-232, Recovery Housing
100-054-7700-238, HOPE ONE -ST AID GRTS
100-054-7700-241, Opioid Reduction Options
100-054-7700-242, Jail MAT Reentry Initiative
100-054-7700-244, IME Addiction Call Center
100-054-7700-246, Media Campaign
100-054-7700-247, Substance Exposed Infants
760-054-7700-001, (4290-001) AEREF; funding for the Local Alcohol Authorities Expansion Program

Some State MOE expenditures occur within DMHAS with funding from other State agencies via interagency Memoranda of Agreements (MOA). These include expenditures for the Recovery Court program with funding from the New Jersey Administrative Office of the Court (AOC), i.e., the NJ Judiciary, posted to 100-054-7700-158. In addition, included in the MOE expenditures are costs incurred for the Mutual Agreement Parolee (MAP) program, which is funded through a combination of DMHA appropriations and transfers from the State Parole Board (SPB); these are record in account 100-054-7700-165.

The MOE expenditures also include the **State** share of applicable costs in Medicaid for qualifying Substance Use Disorder services. These are incurred within the accounts of the Division of Medical Assistance and Health Services (DMAHS), which is a sister division to DMHAS within the NJ Department of Human Services. The primary account is 100-054-7540-378.

In addition, MOE expenditures include State-funded costs incurred within several DMHAS accounts for Room and Board with respect to Medicaid-eligible clients. Since the Room and Board costs for Long-Term Residential, Short-Term Residential and Withdrawal Management (Detoxification) residential services are not covered by Medicaid, DMHAS transfers funds to DMAHS to reimburse providers for Room and Board.

Expenditures related to the Intoxicated Driver Resources Center Fund (100-054-7700-002), the Compulsive Gambling fund (100-054-7700-164), the Racing Commission Fees (100-054-7700-173) and Internet Gambling (100-054-7700-193) 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 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 2022, it totals $7,512,285 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 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: 07/01/2021 Expenditure Period End Date: 06/30/2022

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 2020		$ 7,662,799.00	
SFY 2021		$ 8,171,204.00	
SFY 2022		$ 7,512,285.00	(•) Actual ( ) Estimated
Enter the amount the State plans to expend in SFY 2023 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)): $ 7600000.00			

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).
See attached file

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Footnotes:

MAINTENANCE OF EFFORT (MOE) CALCULATIONS FOR SFY 2022
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 to 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
100-054-7700-231, Supportive Housing Subsidies
100-054-7700-232, Recovery Housing
100-054-7700-238, HOPE ONE -ST AID GRTS
100-054-7700-241, Opioid Reduction Options
100-054-7700-242, Jail MAT Reentry Initiative
100-054-7700-244, IME Addiction Call Center
100-054-7700-246, Media Campaign
100-054-7700-247, Substance Exposed Infants
760-054-7700-001, (4290-001) AEREF; funding for the Local Alcohol Authorities Expansion Program

Some State MOE expenditures occur within DMHAS with funding from other State agencies via interagency Memoranda of Agreements (MOA). These include expenditures for the Recovery Court program with funding from the New Jersey Administrative Office of the Court (AOC), i.e., the NJ Judiciary, posted to 100-054-7700-158. In addition, included in the MOE expenditures are costs incurred for the Mutual Agreement Parolee (MAP) program, which is funded through a combination of DMHA appropriations and transfers from the State Parole Board (SPB); these are record in account 100-054-7700-165.

The MOE expenditures also include the **State** share of applicable costs in Medicaid for qualifying Substance Use Disorder services. These are incurred within the accounts of the Division of Medical Assistance and Health Services (DMAHS), which is a sister division to DMHAS within the NJ Department of Human Services. The primary account is 100-054-7540-378.

In addition, MOE expenditures include State-funded costs incurred within several DMHAS accounts for Room and Board with respect to Medicaid-eligible clients. Since the Room and Board costs for Long-Term Residential, Short-Term Residential and Withdrawal Management (Detoxification) residential services are not covered by Medicaid, DMHAS transfers funds to DMAHS to reimburse providers for Room and Board.

Expenditures related to the Intoxicated Driver Resources Center Fund (100-054-7700-002), the Compulsive Gambling fund (100-054-7700-164), the Racing Commission Fees (100-054-7700-173) and Internet Gambling (100-054-7700-193) 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 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 2022, it totals $7,512,285 as documented in Row B on Table 8d in Web BGAS.

IV: Population and Services Reports

Table 9 - Prevention Strategy Report

Expenditure Period Start Date: 10/1/2019 Expenditure Period End Date: 9/30/2021

Column A (Risks)	Column B (Strategies)	Column C (Providers)
Children of Persons with Substance Use Disorders	**2. Education**	
	1. Parenting and family management	18
	2. Ongoing classroom and/or small group sessions	12
	3. Peer leader/helper programs	5
	4. Education programs for youth groups	6
	5. Mentors	24
	3. Alternatives	
	1. Drug free dances and parties	10
	2. Youth/adult leadership activities	4
	3. Community drop-in centers	3
	6. Environmental	
	1. Promoting the establishment or review of alcohol, tobacco, and drug use policies in schools	3
	2. Guidance and technical assistance on monitoring enforcement governing availability and distribution of alcohol, tobacco, and other drugs	7
Pregnant women/teens	**2. Education**	
	1. Parenting and family management	5
	2. Ongoing classroom and/or small group sessions	5
Drop-outs	**1. Information Dissemination**	
	2. Resources directories	1
	2. Education	
	2. Ongoing classroom and/or small group sessions	1
	5. Mentors	1
Violent and delinquent behavior	**2. Education**	
	1. Parenting and family management	2
Mental health	**1. Information Dissemination**	

problems	1. Clearinghouse/information resources centers	21
	2. Resources directories	21
	4. Brochures	1
	8. Information lines/Hot lines	21
	5. Community-Based Process	
	3. Multi-agency coordination and collaboration/coalition	6
Economically disadvantaged	**1. Information Dissemination**	
	1. Clearinghouse/information resources centers	16
	5. Community-Based Process	
	2. Systematic planning	16
Physically disabled	**2. Education**	
	5. Mentors	4
	4. Problem Identification and Referral	
	2. Student Assistance Programs	3
Abuse victims	**1. Information Dissemination**	
	1. Clearinghouse/information resources centers	3
	8. Information lines/Hot lines	3
	2. Education	
	2. Ongoing classroom and/or small group sessions	7
Already using substances	**2. Education**	
	1. Parenting and family management	12
	2. Ongoing classroom and/or small group sessions	14
	5. Mentors	8
	3. Alternatives	
	1. Drug free dances and parties	5
	3. Community drop-in centers	3
Homeless and/or runaway youth	**2. Education**	
	2. Ongoing classroom and/or small group sessions	2
	3. Alternatives	
	3. Community drop-in centers	3

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Footnotes:

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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: 7/1/2021 Expenditure Period End Date: 6/30/2022

Level of Care	SABG Number of Admissions ≥ Number of Persons Served		COVID-19 Number of Admissions ≥ Number of Persons Served		SABG Costs per Person			COVID-19 Costs per Person[1]			ARP Costs per Person[2]		
	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)	Mean Cost of Services (C)	Median Cost of Services (D)	Standard Deviation of Cost (E)
DETOXIFICATION (24-HOUR CARE)													
1. Hospital Inpatient	23	23											
2. Free-Standing Residential	13,366	8,895											
REHABILITATION/RESIDENTIAL													
3. Hospital Inpatient	448	411											
4. Short-term (up to 30 days)	8,346	6,685											
5. Long-term (over 30 days)	5,275	4,249											
AMBULATORY (OUTPATIENT)													
6. Outpatient	23,987	20,544											
7. Intensive Outpatient	15,485	12,898											
8. Detoxification	237	207											
OUD MEDICATION ASSISTED TREATMENT													
9. OUD Medication-Assisted Detoxification[3]	5,157	3,903											
10. OUD Medication-Assisted Treatment Outpatient[4]	11,406	8,803											

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]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 planned expenditure period of July 1, 2021 – June 30, 2023, for most states.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" MHBG/SABG. Per the instructions, the planning period for standard MHBG/SABG expenditures is July 1, 2021 – June 30, 2023.

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

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

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Footnotes:

IV: Population and Services Reports

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: 7/1/2021 Expenditure Period End Date: 6/30/2022

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	379	189	90	52	32	1	1	2	0	3	1	6	2			93	159	51	75
2. 18 - 24	2,278	823	606	557	177	22	5	24	6	15	3	26	14			965	480	440	167
3. 25 - 44	23,460	9,530	7,206	4,248	1,681	154	51	138	40	115	41	155	101			11,081	3,086	6,013	1,148
4. 45 - 64	13,220	4,622	3,382	3,555	1,382	63	18	46	15	65	10	45	17			6,815	1,465	3,033	320
5. 65 and Over	1,076	351	280	316	104	6	2	0	2	6	2	1	6			584	94	257	19
6. Total	**40,413**	**15,515**	**11,564**	**8,728**	**3,376**	**246**	**77**	**210**	**63**	**204**	**57**	**233**	**140**	**0**	**0**	**19,538**	**5,284**	**9,794**	**1,729**
7. Pregnant Women	426		307		104		1		3		3		8				339		85

Number of persons served who were admitted in a period prior to the 12 month reporting period	29,405
Number of persons served outside of the levels of care described on Table 10	114

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	Gender Identity (GI): "Do you think of yourself as:"						Sexual Orientation (SO): "Do you think of yourself as:"				
	Cisgender Male	Cisgender Female	Transgender Man/Trans Man/Female-To-Male	Transgender Woman/Trans Woman/Male-To-Female	Genderqueer/Gender Non-Conforming/Neither Exclusively Male Nor Female	Additional Gender Category (or Other)	Straight or Heterosexual	Lesbian or Gay	Bisexual	Queer, Pansexual, and/or Questioning	Something Else; Please Specify:
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:

Due to lack of information to separate clients served by COVID-19 supplemental funds from other funding sources, we do not have data to complete table 11b.

IV: Population and Services Reports

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

Expenditure Period Start Date: 7/1/2021 Expenditure Period End Date: 6/30/2022

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: 7/1/2021 Expenditure Period End Date: 6/30/2022

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 2022. 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 2022.

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Footnotes:

V: Performance Data and Outcomes

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]	628	436
Total number of clients with non-missing values on employment/student status [denominator]	6,738	6,738
Percent of clients employed or student (full-time and part-time)	9.3 %	6.5 %

Notes (for this level of care):	
Number of CY 2021 admissions submitted:	10,019
Number of CY 2021 discharges submitted:	10,024
Number of CY 2021 discharges linked to an admission:	8,226
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	6,794
Number of CY 2021 linked discharges eligible for this calculation (non-missing values):	6,738

Source: SAMHSA/CBHSQ TEDS CY 2021 admissions file and CY 2021 linked discharge file
[Records received through 2/1/2023]

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]	1,618	2,128
Total number of clients with non-missing values on employment/student status [denominator]	5,666	5,666
Percent of clients employed or student (full-time and part-time)	28.6 %	37.6 %

Notes (for this level of care):	
Number of CY 2021 admissions submitted:	7,668
Number of CY 2021 discharges submitted:	7,595
Number of CY 2021 discharges linked to an admission:	6,962
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	5,713

Number of CY 2021 linked discharges eligible for this calculation (non-missing values):	5,666

Source: SAMHSA/CBHSQ TEDS CY 2021 admissions file and CY 2021 linked discharge file
[Records received through 2/1/2023]

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]	7,026	8,609
Total number of clients with non-missing values on employment/student status [denominator]	13,991	13,991
Percent of clients employed or student (full-time and part-time)	50.2 %	61.5 %
Notes (for this level of care):		
Number of CY 2021 admissions submitted:		28,206
Number of CY 2021 discharges submitted:		28,305
Number of CY 2021 discharges linked to an admission:		23,408
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):		14,292
Number of CY 2021 linked discharges eligible for this calculation (non-missing values):		13,991

Source: SAMHSA/CBHSQ TEDS CY 2021 admissions file and CY 2021 linked discharge file
[Records received through 2/1/2023]

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]	4,566	5,977
Total number of clients with non-missing values on employment/student status [denominator]	13,073	13,073
Percent of clients employed or student (full-time and part-time)	34.9 %	45.7 %
Notes (for this level of care):		
Number of CY 2021 admissions submitted:		22,123
Number of CY 2021 discharges submitted:		21,684
Number of CY 2021 discharges linked to an admission:		18,243
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):		13,500

Number of CY 2021 linked discharges eligible for this calculation (non-missing values):	13,073

Source: SAMHSA/CBHSQ TEDS CY 2021 admissions file and CY 2021 linked discharge file
[Records received through 2/1/2023]

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Footnotes:

V: Performance Data and Outcomes

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]	5,237	6,353
Total number of clients with non-missing values on living arrangements [denominator]	6,737	6,737
Percent of clients in stable living situation	77.7 %	94.3 %

Notes (for this level of care):	
Number of CY 2021 admissions submitted:	10,019
Number of CY 2021 discharges submitted:	10,024
Number of CY 2021 discharges linked to an admission:	8,226
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	6,794
Number of CY 2021 linked discharges eligible for this calculation (non-missing values):	6,737

Source: SAMHSA/CBHSQ TEDS CY 2021 admissions file and CY 2021 linked discharge file
[Records received through 2/1/2023]

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]	4,955	5,110
Total number of clients with non-missing values on living arrangements [denominator]	5,665	5,665
Percent of clients in stable living situation	87.5 %	90.2 %

Notes (for this level of care):	
Number of CY 2021 admissions submitted:	7,668
Number of CY 2021 discharges submitted:	7,595
Number of CY 2021 discharges linked to an admission:	6,962
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	5,713
Number of CY 2021 linked discharges eligible for this calculation (non-missing values):	5,665

Source: SAMHSA/CBHSQ TEDS CY 2021 admissions file and CY 2021 linked discharge file
[Records received through 2/1/2023]

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]	13,575	13,690
Total number of clients with non-missing values on living arrangements [denominator]	13,984	13,984
Percent of clients in stable living situation	97.1 %	97.9 %

Notes (for this level of care):	
Number of CY 2021 admissions submitted:	28,206
Number of CY 2021 discharges submitted:	28,305
Number of CY 2021 discharges linked to an admission:	23,408
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	14,292
Number of CY 2021 linked discharges eligible for this calculation (non-missing values):	13,984

Source: SAMHSA/CBHSQ TEDS CY 2021 admissions file and CY 2021 linked discharge file
[Records received through 2/1/2023]

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]	12,120	12,399
Total number of clients with non-missing values on living arrangements [denominator]	13,067	13,067
Percent of clients in stable living situation	92.8 %	94.9 %

Notes (for this level of care):	
Number of CY 2021 admissions submitted:	22,123
Number of CY 2021 discharges submitted:	21,684
Number of CY 2021 discharges linked to an admission:	18,243
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	13,500
Number of CY 2021 linked discharges eligible for this calculation (non-missing values):	13,067

Source: SAMHSA/CBHSQ TEDS CY 2021 admissions file and CY 2021 linked discharge file
[Records received through 2/1/2023]

Footnotes:

V: Performance Data and Outcomes

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]	6,476	6,677
Total number of Admission and Discharge clients with non-missing values on arrests [denominator]	6,741	6,741
Percent of clients without arrests	96.1 %	99.1 %

Notes (for this level of care):	
Number of CY 2021 admissions submitted:	10,019
Number of CY 2021 discharges submitted:	10,024
Number of CY 2021 discharges linked to an admission:	8,226
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	6,797
Number of CY 2021 linked discharges eligible for this calculation (non-missing values):	6,741

Source: SAMHSA/CBHSQ TEDS CY 2021 admissions file and CY 2021 linked discharge file
[Records received through 2/1/2023]

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]	5,370	5,615
Total number of Admission and Discharge clients with non-missing values on arrests [denominator]	5,717	5,717
Percent of clients without arrests	93.9 %	98.2 %

Notes (for this level of care):	
Number of CY 2021 admissions submitted:	7,668
Number of CY 2021 discharges submitted:	7,595
Number of CY 2021 discharges linked to an admission:	6,962
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	5,763

Number of CY 2021 linked discharges eligible for this calculation (non-missing values):	5,717

Source: SAMHSA/CBHSQ TEDS CY 2021 admissions file and CY 2021 linked discharge file
[Records received through 2/1/2023]

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]	13,876	13,914
Total number of Admission and Discharge clients with non-missing values on arrests [denominator]	14,234	14,234
Percent of clients without arrests	97.5 %	97.8 %

Notes (for this level of care):	
Number of CY 2021 admissions submitted:	28,206
Number of CY 2021 discharges submitted:	28,305
Number of CY 2021 discharges linked to an admission:	23,408
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	14,535
Number of CY 2021 linked discharges eligible for this calculation (non-missing values):	14,234

Source: SAMHSA/CBHSQ TEDS CY 2021 admissions file and CY 2021 linked discharge file
[Records received through 2/1/2023]

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]	12,867	12,980
Total number of Admission and Discharge clients with non-missing values on arrests [denominator]	13,352	13,352
Percent of clients without arrests	96.4 %	97.2 %

Notes (for this level of care):	
Number of CY 2021 admissions submitted:	22,123
Number of CY 2021 discharges submitted:	21,684
Number of CY 2021 discharges linked to an admission:	18,243
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	13,780

Number of CY 2021 linked discharges eligible for this calculation (non-missing values):	13,352

Source: SAMHSA/CBHSQ TEDS CY 2021 admissions file and CY 2021 linked discharge file
[Records received through 2/1/2023]

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Footnotes:

V: Performance Data and Outcomes

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]	3,460	6,455
All clients with non-missing values on at least one substance/frequency of use [denominator]	6,471	6,471
Percent of clients abstinent from alcohol	53.5 %	99.8 %

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

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

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		2,998
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	3,011	
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T2 / #T1 x 100]		99.6 %

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]		3,457
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	3,460	
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 2021 admissions submitted:	10,019
Number of CY 2021 discharges submitted:	10,024
Number of CY 2021 discharges linked to an admission:	8,226
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	6,797
Number of CY 2021 linked discharges eligible for this calculation (non-missing values):	6,471

Source: SAMHSA/CBHSQ TEDS CY 2021 admissions file and CY 2021 linked discharge file
[Records received through 2/1/2023]

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]	2,982	5,184
All clients with non-missing values on at least one substance/frequency of use [denominator]	5,220	5,220
Percent of clients abstinent from alcohol	57.1 %	99.3 %

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

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

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		2,224
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	2,238	
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T2 / #T1 x 100]		99.4 %

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

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

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		2,960
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	2,982	
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T2 / #T1 x 100]		99.3 %

Notes (for this level of care):	
Number of CY 2021 admissions submitted:	7,668
Number of CY 2021 discharges submitted:	7,595
Number of CY 2021 discharges linked to an admission:	6,962
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	5,763
Number of CY 2021 linked discharges eligible for this calculation (non-missing values):	5,220

Source: SAMHSA/CBHSQ TEDS CY 2021 admissions file and CY 2021 linked discharge file
[Records received through 2/1/2023]

Outpatient (OP)

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

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

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol [numerator]	7,357	9,207
All clients with non-missing values on at least one substance/frequency of use [denominator]	10,286	10,286
Percent of clients abstinent from alcohol	71.5 %	89.5 %

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

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

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		2,354
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	2,929	
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T2 / #T1 x 100]		80.4 %

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

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

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		6,853
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	7,357	
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T2 / #T1 x 100]		93.1 %

Notes (for this level of care):	
Number of CY 2021 admissions submitted:	28,206
Number of CY 2021 discharges submitted:	28,305
Number of CY 2021 discharges linked to an admission:	23,408
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	14,535
Number of CY 2021 linked discharges eligible for this calculation (non-missing values):	10,286

Source: SAMHSA/CBHSQ TEDS CY 2021 admissions file and CY 2021 linked discharge file
[Records received through 2/1/2023]

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]	5,556	7,812
All clients with non-missing values on at least one substance/frequency of use [denominator]	8,950	8,950
Percent of clients abstinent from alcohol	62.1 %	87.3 %

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

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

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		2,628
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	3,394	
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T2 / #T1 x 100]		77.4 %

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

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

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		5,184
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	5,556	
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T2 / #T1 x 100]		93.3 %

Notes (for this level of care):	
Number of CY 2021 admissions submitted:	22,123
Number of CY 2021 discharges submitted:	21,684
Number of CY 2021 discharges linked to an admission:	18,243
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	13,780
Number of CY 2021 linked discharges eligible for this calculation (non-missing values):	8,950

Source: SAMHSA/CBHSQ TEDS CY 2021 admissions file and CY 2021 linked discharge file
[Records received through 2/1/2023]

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Footnotes:

V: Performance Data and Outcomes

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]	1,849	6,438
All clients with non-missing values on at least one substance/frequency of use [denominator]	6,471	6,471
Percent of clients abstinent from drugs	28.6 %	99.5 %

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

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

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator]		4,595
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	4,622	
Percent of clients abstinent from drugs at discharge among clients using Drug at admission [#T2 / #T1 x 100]		99.4 %

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]		1,843
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	1,849	
Percent of clients abstinent from drugs at discharge among clients abstinent from Drug at admission [#T2 / #T1 x 100]		99.7 %

Notes (for this level of care):	
Number of CY 2021 admissions submitted:	10,019
Number of CY 2021 discharges submitted:	10,024
Number of CY 2021 discharges linked to an admission:	8,226
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	6,797
Number of CY 2021 linked discharges eligible for this calculation (non-missing values):	6,471

Source: SAMHSA/CBHSQ TEDS CY 2021 admissions file and CY 2021 linked discharge file
[Records received through 2/1/2023]

Long-term Residential(LR)

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

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

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs [numerator]	2,633	5,087
All clients with non-missing values on at least one substance/frequency of use [denominator]	5,220	5,220
Percent of clients abstinent from drugs	50.4 %	97.5 %

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

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

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator]		2,508
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	2,587	
Percent of clients abstinent from drugs at discharge among clients using Drug at admission [#T2 / #T1 x 100]		96.9 %

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]		2,579
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	2,633	
Percent of clients abstinent from drugs at discharge among clients abstinent from Drug at admission [#T2 / #T1 x 100]		97.9 %

Notes (for this level of care):	
Number of CY 2021 admissions submitted:	7,668
Number of CY 2021 discharges submitted:	7,595
Number of CY 2021 discharges linked to an admission:	6,962
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	5,763
Number of CY 2021 linked discharges eligible for this calculation (non-missing values):	5,220

Source: SAMHSA/CBHSQ TEDS CY 2021 admissions file and CY 2021 linked discharge file
[Records received through 2/1/2023]

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]	7,036	8,360
All clients with non-missing values on at least one substance/frequency of use [denominator]	10,286	10,286
Percent of clients abstinent from drugs	68.4 %	81.3 %

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]		2,102
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	3,250	
Percent of clients abstinent from drugs at discharge among clients using Drug at admission [#T2 / #T1 x 100]		64.7 %

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]		6,258
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	7,036	
Percent of clients abstinent from drugs at discharge among clients abstinent from Drug at admission [#T2 / #T1 x 100]		88.9 %

Notes (for this level of care):	
Number of CY 2021 admissions submitted:	28,206
Number of CY 2021 discharges submitted:	28,305
Number of CY 2021 discharges linked to an admission:	23,408
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	14,535
Number of CY 2021 linked discharges eligible for this calculation (non-missing values):	10,286

Source: SAMHSA/CBHSQ TEDS CY 2021 admissions file and CY 2021 linked discharge file
[Records received through 2/1/2023]

Intensive Outpatient (IO)

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

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

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs [numerator]	4,731	6,814
All clients with non-missing values on at least one substance/frequency of use [denominator]	8,950	8,950
Percent of clients abstinent from drugs	52.9 %	76.1 %

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]		2,654
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	4,219	
Percent of clients abstinent from drugs at discharge among clients using Drug at admission [#T2 / #T1 x 100]		62.9 %

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]		4,160
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	4,731	
Percent of clients abstinent from drugs at discharge among clients abstinent from Drug at admission [#T2 / #T1 x 100]		87.9 %

Notes (for this level of care):	
Number of CY 2021 admissions submitted:	22,123
Number of CY 2021 discharges submitted:	21,684
Number of CY 2021 discharges linked to an admission:	18,243
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	13,780
Number of CY 2021 linked discharges eligible for this calculation (non-missing values):	8,950

Source: SAMHSA/CBHSQ TEDS CY 2021 admissions file and CY 2021 linked discharge file
[Records received through 2/1/2023]

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Footnotes:

V: Performance Data and Outcomes

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]	1,223	4,738
Total number of Admission and Discharge clients with non-missing values on participation in self-help groups [denominator]	6,797	6,797
Percent of clients participating in self-help groups	18.0 %	69.7 %
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]	51.7 %	
Notes (for this level of care):		
Number of CY 2021 admissions submitted:	10,019	
Number of CY 2021 discharges submitted:	10,024	
Number of CY 2021 discharges linked to an admission:	8,226	
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	6,797	
Number of CY 2021 linked discharges eligible for this calculation (non-missing values):	6,797	

Source: SAMHSA/CBHSQ TEDS CY 2021 admissions file and CY 2021 linked discharge file
[Records received through 2/1/2023]

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]	1,370	4,240
Total number of Admission and Discharge clients with non-missing values on participation in self-help groups [denominator]	5,750	5,750
Percent of clients participating in self-help groups	23.8 %	73.7 %
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]	49.9 %	
Notes (for this level of care):		
Number of CY 2021 admissions submitted:	7,668	
Number of CY 2021 discharges submitted:	7,595	

Number of CY 2021 discharges linked to an admission:	6,962
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	5,763
Number of CY 2021 linked discharges eligible for this calculation (non-missing values):	5,750

Source: SAMHSA/CBHSQ TEDS CY 2021 admissions file and CY 2021 linked discharge file
[Records received through 2/1/2023]

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]	2,739	3,295
Total number of Admission and Discharge clients with non-missing values on participation in self-help groups [denominator]	14,320	14,320
Percent of clients participating in self-help groups	19.1 %	23.0 %
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]	3.9 %	

Notes (for this level of care):	
Number of CY 2021 admissions submitted:	28,206
Number of CY 2021 discharges submitted:	28,305
Number of CY 2021 discharges linked to an admission:	23,408
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	14,535
Number of CY 2021 linked discharges eligible for this calculation (non-missing values):	14,320

Source: SAMHSA/CBHSQ TEDS CY 2021 admissions file and CY 2021 linked discharge file
[Records received through 2/1/2023]

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]	3,275	4,334
Total number of Admission and Discharge clients with non-missing values on participation in self-help groups [denominator]	13,700	13,700
Percent of clients participating in self-help groups	23.9 %	31.6 %
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]	7.7 %	

Notes (for this level of care):	
Number of CY 2021 admissions submitted:	22,123

Number of CY 2021 discharges submitted:	21,684
Number of CY 2021 discharges linked to an admission:	18,243
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	13,780
Number of CY 2021 linked discharges eligible for this calculation (non-missing values):	13,700

Source: SAMHSA/CBHSQ TEDS CY 2021 admissions file and CY 2021 linked discharge file
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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	19	4	4	5
2. Free-Standing Residential	6	4	5	7
REHABILITATION/RESIDENTIAL				
3. Hospital Inpatient	56	6	7	106
4. Short-term (up to 30 days)	21	12	22	28
5. Long-term (over 30 days)	72	22	35	114
AMBULATORY (OUTPATIENT)				
6. Outpatient	121	47	88	148
7. Intensive Outpatient	81	28	57	104
8. Detoxification	54	15	31	47
OUD MEDICATION ASSISTED TREATMENT				
9. OUD Medication-Assisted Detoxification[1]	6	4	5	8
10. OUD Medication-Assisted Treatment Outpatient[2]	186	42	103	254

Level of Care	2022 TEDS discharge record count	
	Discharges submitted	Discharges linked to an admission
DETOXIFICATION (24-HOUR CARE)		
1. Hospital Inpatient	39	30
2. Free-Standing Residential	12887	8558
REHABILITATION/RESIDENTIAL		
3. Hospital Inpatient	51	4
4. Short-term (up to 30 days)	7720	6422

5. Long-term (over 30 days)	5918	5537
AMBULATORY (OUTPATIENT)		
6. Outpatient	20289	10438
7. Intensive Outpatient	15818	13257
8. Detoxification	189	97
OUD MEDICATION ASSISTED TREATMENT		
9. OUD Medication-Assisted Detoxification[1]		3110
10. OUD Medication-Assisted Treatment Outpatient[2]		7265

Source: SAMHSA/CBHSQ TEDS CY 2022 admissions file and CY 2022 linked discharge file
[Records received through 2/1/2023]

[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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Table 21 - Primary Substance Abuse Use Disorder 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. Supplemental Data, if any
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		
	Age 21+ - CY 2019 - 2020		
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		
	Age 18+ - CY 2019 - 2020		
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		
	Age 18+ - CY 2019 - 2020		
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		
	Age 18+ - CY 2019 - 2020		
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		

	Age 18+ - CY 2019 - 2020		

[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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Table 22 - Primary Substance Abuse Use Disorder 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. Supplemental Data, if any
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		
	Age 21+ - CY 2019 - 2020		
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		
	Age 18+ - CY 2019 - 2020		
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		
	Age 18+ - CY 2019 - 2020		

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Table 23 - Primary Substance Abuse Use Disorder 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. Supplemental Data, if any
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		☐
	Age 18+ - CY 2019 - 2020		☐
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		☐
	Age 18+ - CY 2019 - 2020		☐
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		☐
	Age 18+ - CY 2019 - 2020		☐
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		☐
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		

[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 - Primary Substance Abuse Use Disorder 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. Supplemental Data, if any
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		
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		
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		
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		
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 - Primary Substance Abuse Use Disorder Prevention NOMs Domain: Reduced Morbidity – Abstinence from Drug Use/Alcohol Use Measure: Perception of Workplace Policy

A. Measure	B. Question/Response	C. Pre-populated Data	D. Supplemental Data, if any
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		

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Table 26 - Primary Substance Abuse Use Disorder Prevention NOMs Domain: Reduced Morbidity – Abstinence from Drug Use/Alcohol Use Measure: Average Daily School Attendance Rate

A. Measure	B. Question/Response	C. Pre-populated Data	D. Supplemental Data, if any
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 2019		

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Table 27 - Primary Substance Abuse Use Disorder Prevention NOMs Domain: Crime and Criminal Justice Measure: Alcohol Related Fatalities

A. Measure	B. Question/Response	C. Pre-populated Data	D. Supplemental Data, if any
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 2020		

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Table 28 - Primary Substance Abuse Use Disorder Prevention NOMs Domain: Crime and Criminal Justice Measure: Alcohol and Drug-Related Arrests

A. Measure	B. Question/Response	C. Pre-populated Data	D. Supplemental Data, if any
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 2020		

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Table 29 - Primary Substance Abuse Use Disorder Prevention NOMs Domain: Social Connectedness Measure: Family Communications Around Drug and Alcohol Use

A. Measure	B. Question/Response	C. Pre-populated Data	D. Supplemental Data, if any
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		
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		

[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 - Primary Substance Abuse Use Disorder Prevention NOMs Domain: Retention Measure: Percentage of Youth Seeing, or Listening to a Prevention Message

A. Measure	B. Question/Response	C. Pre-populated Data	D. Supplemental Data, if any
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		

[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 - Primary Substance Use Disorder Prevention Individual-Based Programs and Strategies – Number of Persons Served by Age, Gender, Race, and Ethnicity	1/1/2020	12/31/2020
2. Table 32 - Primary Substance Use Disorder Prevention Population-Based Programs and Strategies – Number of Persons Served by Age, Gender, Race, and Ethnicity	1/1/2020	12/31/2020
3. Table 33 (Optional) - Primary Substance Use Disorder Prevention Number of Persons Served by Type of Intervention	1/1/2020	12/31/2020
4. Table 34 - Primary Substance Use Disorder Prevention Evidence-Based Programs and Strategies by Type of Intervention	1/1/2020	12/31/2020
5. Table 35 - Total Primary Substance Use Disorder Prevention Number of Evidence Based Programs/Strategies and Total SABG Dollars Spent on Primary Substance Use Disorder Prevention Evidence-Based Programs/Strategies	10/1/2019	9/30/2022

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 - Primary Substance Use Disorder Prevention Individual-Based Programs and Strategies – Number of Persons Served by Age, Gender, Race, and Ethnicity

Category	Total
A. Age	**161,630**
0-4	7,700
5-11	64,500
12-14	23,700
15-17	18,000
18-20	7,325
21-24	4,330
25-44	19,000
45-64	6,200
65 and over	6,775
Age Not Known	4,100
B. Gender	**161,630**
Male	85,664
Female	75,966
Gender Unknown	0
C. Race	**161,630**
White	63,036
Black or African American	46,872
Native Hawaiian/Other Pacific Islander	1,225
Asian	8,170
American Indian/Alaska Native	475
More Than One Race (not OMB required)	12,445

Race Not Known or Other (not OMB required)	29,407
D. Ethnicity	**161,630**
Hispanic or Latino	46,873
Not Hispanic or Latino	101,827
Ethnicity Unknown	12,930

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Table 32 - Primary Substance Use Disorder Prevention Population-Based Programs and Strategies – Number of Persons Served by Age, Gender, Race, and Ethnicity

Category	Total
A. Age	**526925**
0-4	7050
5-11	43700
12-14	103050
15-17	68300
18-20	43875
21-24	37000
25-44	105500
45-64	48900
65 and over	31000
Age Not Known	38550
B. Gender	**526925**
Male	254001
Female	231924
Gender Unknown	41000
C. Race	**526925**
White	283000
Black or African American	134500
Native Hawaiian/Other Pacific Islander	6000
Asian	62700
American Indian/Alaska Native	775
More Than One Race (not OMB required)	19000

Race Not Known or Other (not OMB required)	20950
D. Ethnicity	**526925**
Hispanic or Latino	177000
Not Hispanic or Latino	288925
Ethnicity Unknown	61000

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Table 33 (Optional) - Primary Substance Use Disorder 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	129,000	N/A
2. Universal Indirect	N/A	$526,925.00
3. Selective	17,500	N/A
4. Indicated	15,130	N/A
5. Total	**161,630**	**$526,925.00**
Number of Persons Served[1]	**161,630**	**526,925**

[1]Number of Persons Served is populated from Table 31 - Primary Substance Use Disorder Prevention Individual-Based Programs and Strategies - Number of Persons Served by Age, Gender, Race, and Ethnicity and Table 32 - Primary Substance Use Disorder Prevention Population-Based Programs and Strategies - Number of Persons Served by Age, Gender, Race, and Ethnicity

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Table 34 - Primary Substance Use Disorder 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 above criteria.

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

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

Table 34 - SUBSTANCE ABUSE PREVENTION **Number of 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 Primary Substance Use Disorder Prevention Number of Evidence Based Programs/Strategies and Total SABG Dollars Spent on Primary Substance Use Disorder 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	$2,354,876.00
Universal Indirect	Total # 6	$3,749,053.00
Selective	Total # 13	$3,503,021.00
Indicated	Total # 6	$2,108,842.00
Unspecified	Total # 0	
	Total EBPs: 37	Total Dollars Spent: $11,715,792.00
Primary Prevention Total[1]	**$11,715,792.32**	

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

0930-0168 Approved: 03/02/2022 Expires: 03/31/2025

Footnotes:

V: Performance Data and Outcomes

Prevention Attachments

Submission Uploads

FFY 2023 Prevention Attachment Category A:

File	Version	Date Added

FFY 2023 Prevention Attachment Category B:

File	Version	Date Added

FFY 2023 Prevention Attachment Category C:

File	Version	Date Added

FFY 2023 Prevention Attachment Category D:

File	Version	Date Added

0930-0168 Approved: 03/02/2022 Expires: 03/31/2025

Footnotes: