Substance Abuse and Mental Health Services Administration

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Substance Abuse Prevention and Synar System Review Report

New Jersey

Federal Fiscal Year 2012

May 1–3, 2012

Strategic Prevention Framework

Advancement & Support

Center for Substance Abuse Prevention

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

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System Review Summary

The Alcohol, Drug Abuse, and Mental Health Administration Reorganization Act (P.L. 102-321) enacted by Congress in July 1992 authorized the Substance Abuse Prevention and Treatment Block Grant (SABG) administered by the Substance Abuse and Mental Health Services Administration (SAMHSA). SAMHSA's Center for Substance Abuse Prevention (CSAP) is charged with providing policy and program guidance to help States[1] use and report on the 20-percent primary prevention set-aside of the SABG. CSAP is committed to providing support and guidance for advancing Single State Authority (SSA) substance abuse prevention systems through technical assistance (TA), expert panel meetings, national and regional conferences, training, videos, guidance documents, and other products.

CSAP also supports States by conducting thorough substance abuse prevention system reviews to examine how a State's substance abuse prevention system is addressing State needs. This report is a summary of the most recent CSAP system review for New Jersey.

The system review conducted on May 1–3, 2012, examined the progress of the New Jersey substance abuse prevention system and Synar program in improving the substance abuse indicators and outcomes measured by SAMHSA's National Outcome Measures (NOMs), as well as other State-specific goals and objectives. The system review also involved detailed discussions with State participants concerning the State's current capacity for using performance management processes to achieve and sustain outcomes measured by the NOMs and other State-specific outcomes. The System Review Report will help guide New Jersey in enhancing its infrastructure and State prevention system capacity to implement the five steps of the Strategic Prevention Framework (SPF) or other equivalent planning process and to achieve population-level reductions in the incidence and prevalence of substance abuse and related problems and consequences.

The review included an analysis of the system review findings (appendix A). The findings identify potential areas of capacity and infrastructure development that could further enhance the New Jersey prevention system and Synar program, either through State-supported efforts or through TA requested from CSAP.

In addition to appendix A, which details New Jersey's successes and challenges and maps out next steps, the System Review Report contains:

- A list of participants from the system review (appendix B)
- A list of New Jersey's prevention and Synar documents that were consulted in preparation for the system review (appendix C)
- A summary of the State's estimated Federal fiscal year (FFY) 2011 and planned FFY 2012 prevention and Synar budgets (appendix D)
- The SSA organizational charts (appendix E)
- The abbreviations used in the System Review Report (appendix F).

Prevention System Elements

Prevention System Organization

Organization of State Prevention System

SSA Prevention System

The Division of Mental Health and Addiction Services (DMHAS) in the Department of Human Services (DHS) serves as the SSA for substance abuse as well as the State Mental Health Authority for mental health services in New Jersey. DHS also serves as the umbrella organization to the Commission for the Blind and Visually Impaired and the Divisions of the Deaf and Hard of Hearing, Developmental Disabilities, Disability Services, Family Development, Medical Assistance and Health Services, and the newly transferred Division of Aging Services. The Commissioner of DHS reports directly to the Governor. The newly appointed Assistant Commissioner of DMHAS, who is the designated SSA, reports to the Commissioner of DHS. A Deputy Director, who oversees offices responsible for

[1] In this document, the word *State* refers to the 50 States and the District of Columbia and to the Territories, Pacific jurisdictions, and Native American tribe that receive SABG funds.

STRENGTHS

- *The restructured DMHAS provides a venue for coordinated planning and implementation of substance abuse and mental health services across the lifespan at both the State and the county levels.*
- *DMHAS is funding services that cover the State.*
- *Prevention staff within DMHAS are providing committed leadership for State substance abuse prevention efforts.*

substance abuse prevention and treatment, reports to the Assistant Commissioner.

DMHAS was created July 1, 2010, through a merger of the former Divisions of Mental Health Services (DMHS) and Addiction Services (DAS). The restructured DMHAS provides a venue for coordinated planning and implementation of substance abuse and mental health services across the lifespan at both the State and the county levels. The former SSA Director for substance abuse now serves as the Deputy Director of DMHAS.

As part of the restructure, addiction services for adolescents up to age 18 and persons ages 18 to 21, as well as mental health services for persons ages 18 to 21, will be transferred to the oversight of the Department of Children and Families (DCF) during State fiscal year (SFY) 2013. Other changes to the operation of the SSA include increases in community options for the mentally ill to comply with the 2009 Olmstead Act and a recent transfer of responsibility for children with developmental disabilities, substance abuse, and mental illness—and all associated funds—to DCF. During the system review, DMHAS staff reported they were attending the first-ever joint meeting between a Local Advisory Committee on Alcoholism and Drug Abuse (LACADA) and a county mental health board to show their support for service integration at the county level.

DMHAS has a budget of nearly $1 billion and more than 1,400 employees. It is charged with coordination and management responsibilities for State psychiatric institutions and community mental health services. DMHAS also is charged with planning for and supporting a statewide network of community addictions services to prevent, treat, and support the recovery of people with addiction disorders. In addition, DMHAS is responsible for coordinating with other mental health programs and providing counseling programs for compulsive gamblers. DMHAS Office of State Hospital Management manages the State psychiatric hospitals.

DMHAS is organized into multiple units. Reporting directly to the Assistant Commissioner are the Offices of State Hospital Management, Legal Liaison, Quality Management, Information Technology, Medical Director, Human Resources, Fiscal Management and Operations, and the Deputy Director. The Office of the Deputy Director oversees the Offices of Prevention, Early Intervention, and Community Services (OPEICS), Treatment and Recovery Supports (OTRS), Care Management, and Research, Planning, and Evaluation (ORPE). The Deputy Director's purview is to oversee the State's publicly funded, community-based system of mental health and addiction services. Its policy and supervisory functions include:

- Overseeing the transition of the system of care to a managed behavioral health care approach and integrating addiction and mental health services in primary health care settings
- Supervising DMHAS supportive housing opportunities, which includes expanding community housing opportunities, enabling many people with mental illness and substance abuse to live in settings that are less restrictive than State psychiatric hospitals, and administering Federal Block Grants for substance abuse and mental health
- Directing all programmatic aspects of DMHAS, including research, planning, and evaluation; workforce development; care management; mental health and addiction prevention, early intervention, treatment, and recovery support services; criminal justice; and adolescent and women's services.

DMHAS carries out its responsibilities with the advice and counsel of a number of advisory bodies. A Professional Advisory Committee, whose members serve at the pleasure of the Commissioner of DHS, makes recommendations relative to substance use disorders and addictions to the Commissioner through DMHAS. Membership on the Professional Advisory Committee ranges from 15 to 30 members who have exhibited leadership and expertise on services and/or advocacy issues related to substance use disorders and addictions. A separate Advisory Committee on the Alcohol and Drug Abuse Program for the Deaf, Hard of Hearing, and Disabled advises DMHAS on the operation of an alcohol and drug abuse program for persons who are deaf, hard of hearing, and disabled with a specific funding source that is legislated.

A Citizens Advisory Council focused on addiction issues serves as a resource to DMHAS as it consists of consumers of addiction services and individuals in recovery from substance abuse in fulfillment of DMHAS goal to develop and sustain a system of client-centered care. DMHAS also has a stakeholder steering committee that was created to guide health care reform and the transition to a managed behavioral health system, which includes an emphasis on prevention. DMHAS also hosts the Mental Health Planning Council (MHPC), which is federally and State legislated. Prior to the merger of the divisions, the SSA had a seat on the council to advise on substance abuse-related topics. As part of the merger, in February 2012 the MHPC issued a call for members to add more members with addiction experience. As a result, addiction representation from substance abuse providers and persons in recovery has increased. The MHPC committee also partners with the New Jersey Mental Health Stigma Council, which was created by Executive Order in 2004, to take a leadership and advisory role on mental health promotion and mental illness prevention. Their efforts include cosponsoring a public awareness campaign called "A Community Effort."

DMHAS also supports the planning efforts of other advisory bodies. Most recently, it responded to a February 2012 call for members by New Jersey's Mental Health Planning Council, which was interested in adding more members with experience and expertise in addiction. As a result, DMHAS now has a seat on the Planning Council and will represent substance abuse addiction and prevention in the council's efforts.

OPEICS comprises one statewide and three regional offices that are primarily responsible for oversight of the community behavioral health system of care. OPEICS negotiates contracts with community providers for the provision of prevention and early intervention services, as well as ambulatory outpatient and inpatient behavioral health care. OPEICS also participates in agency reviews and assists consumers in navigating the service system.

The State's representative to the National Prevention Network (NPN) reports to the Assistant Division Director of OPEICS, who reports to the Deputy Director of DMHAS. The NPN representative currently supervises six staff: an administrative assistant; three program officers; and two consumer advocate positions, one for mental health and one for addiction services. The NPN representative is responsible for oversight of the primary prevention set-aside from the SABG, early intervention services, a Strategic Prevention Framework State Incentive Grant (SPF SIG), and a State Prevention Enhancement (SPE) grant from SAMHSA; both grants will end in September 2012. New Jersey was awarded a SPF SIG in October 2006 and received a 1-year no-cost extension from CSAP to extend funding an additional year.

The prevention unit monitors more than $14 million in funding to 52 contracted provider agencies and 17 coalitions that offer prevention programming and facilitate environmental change in all 21 counties of the State. The State representative to the NPN also serves as the County Liaison for DMHAS, and in this role collaborates with 21 County Alcohol and Drug Abuse Directors and other county and local government

entities in the administration of prevention and early intervention services. A strength noted by the CSAP system review team was the stable leadership displayed for substance abuse prevention and treatment efforts during a time of agency restructuring. Positioning the previous SSA Director to maintain an active role and keeping the NPN representative within DMHAS prevention unit and the Synar Coordinator in the Deputy Director's office allowed for stable and consistent leadership with regard to SABG administration.

ORPE is responsible for updating New Jersey's Epidemiological Profiles in conjunction with the State Epidemiological Outcomes Work Group (SEOW). ORPE's responsibilities include overseeing the administration of New Jersey's Middle and High School Risk and Protective Factors Surveys, New Jersey's Household Survey on Drug Use and Health, and individual and family program-level evaluations. ORPE contracts out certain data collection and survey functions to Rutgers University, the State University of New Jersey.

DMHAS partners with the Department of Law and Public Safety (DLPS) on efforts to reduce underage drinking and promote responsible drinking among adults. Among these efforts are public service announcements, training, driving under the influence (DUI) programs, and college and high school programs. DLPS is the administering agency for New Jersey's Enforcing Underage Drinking Laws (EUDL) Block Grant funds from the Federal Office of Juvenile Justice and Delinquency Prevention (OJJDP). This partnership is new since the 2009 CSAP system review. DMHAS also works with the Office of the Attorney General to support a gang awareness initiative.

DMHAS partners with the Department of Health and Senior Services (DHSS) and Medicaid. The partnership with DHSS supports programming for AIDS and tuberculosis prevention, family health services, and fetal alcohol spectrum disorders (FASD). DMHAS partners with Medicaid on waiver programs and strategies to assist health maintenance organizations and others in establishing health homes (long-term care facilities). In addition, DMHAS has assisted programs funded by SAMHSA grants and public–private partnerships to establish health homes and federally qualified health centers. DMHAS further participates on a task force developed by the New Jersey Association of Mental Health and Addiction Agencies and the New Jersey Primary Care Association to work on integration across discipline issues.

DMHAS formed the Primary Care and Behavioral Health Care Task Force to examine the specific causative factors for early mortality, most of which are related to potentially preventable risk factors that shorten life expectancy (e.g., smoking, lack of exercise, poor nutrition, substance use, exposure to communicable diseases). The main goal of this task force is to increase access to primary care and improve collaboration between mental health agencies and health care providers.

SSA Approach to Prevention

At the time of the 2009 system review, New Jersey's SABG funds were primarily supporting individually focused strategies targeted at indicated populations (i.e., groups of individuals identified as exhibiting early warning signs of problems, such as experimentation with substance abuse or instances of intense use). The CSAP review team encouraged DMHAS to adopt a more comprehensive approach and broaden its focus to include not only other populations but also environmental strategies in order to achieve desired outcomes at the population level. The 2012 system review team found that DMHAS has since demonstrated its commitment to a more comprehensive prevention approach by significantly reallocating SABG funds to support environmental as well as individual strategies.

In addition, the 2009 system review team noted that although DMHAS was using data for prevention planning, the division had not fully operationalized SAMHSA's SPF to infuse performance management principles throughout its prevention system operations. During the 2012 system review, team members noted that New Jersey has since fully adopted the

SPF and is using it to guide prevention efforts at both the State and the county levels. DMHAS used the SPF as an organizing framework for the most recent request for proposals (RFP) it issued to allocate the majority of SABG funds. During the system review, the Deputy Director remarked that DMHAS also intends to adopt the SPF to guide mental health and treatment planning as well.

According to the mission and vision statements that DMHAS staff discussed during the system review, DMHAS "seeks to institutionalize a systematic approach to prevention that synthesizes and strengthens knowledge from multiple disciplines and addresses substance abuse and its related societal concerns based upon the following tenants:

- Health is more than healthcare or the absence of injury or disease.
- The environment in which we live profoundly shapes our health and wellbeing.
- Prevention requires commitment and dedication.
- Prevention offers hope by saving lives and money."

In accordance with its mission, DMHAS works in partnership with consumers, family members, providers, and other stakeholders to promote wellness and recovery for individuals with mental illness, substance use disorders, or co-occurring disorders through a continuum of prevention, early intervention, treatment, and recovery services delivered by a culturally competent and well-trained workforce.

DMHAS vision, as presented by SSA staff, is "an integrated mental health and substance abuse service system that provides a continuum of prevention, treatment, and recovery supports to residents of New Jersey who have, or are at risk of, mental health, addictions or co-occurring disorders. At any point of entry the service system will provide prompt and easy access to appropriate and effective person-centered, culturally competent services delivered by a welcoming and well trained work force. Consumers will be given the tools to achieve wellness and recovery, a sense of personal responsibility and a meaningful role in the community."

STRENGTHS

- *DMHAS has demonstrated its commitment to a more comprehensive prevention approach by significantly reallocating SABG funds to support environmental as well as individual strategies.*
- *New Jersey has fully adopted the SPF and is using it to guide prevention efforts at both the State and the county levels.*

CHALLENGES

- *The CSAP system review team was unable to find a written definition of primary prevention that has been adopted by DMHAS to guide the SABG prevention system.*

DMHAS staff also noted that the agency's work is "driven by the following values shared by Division staff and partner agencies: person-centered and person-directed services; the strength of consumers, their families and friends as a foundation for recovery; the commitment of its partner agencies to professionalism, diversity, hope and positive outcomes; evidence-based practices that are consumer-informed and peer-led; and effective and efficient services."

DMHAS prevention framework, which is outlined in a 2011 strategic plan, specifies that DMHAS "seeks to fund programs and strategies that:

- Apply a comprehensive strategy across diverse disciplines, populations, and issues
- Respond to and address national priorities and directives as identified by Federal funders
- Advance changes in social norms and systems
- Advocate for solutions that concurrently have an impact on multiple problems
- Research, synthesize, and disseminate information that builds on successes
- Inspire a broad vision and fresh approach that incorporates a variety of strategies

- Are responsive to, and reflective of, community needs, including culturally diverse communities and individuals with special needs
- Acknowledge the importance of a comprehensive approach to prevention that includes both individual and family-focused, evidence-based curricula as well as environmental approaches
- Integrate a community and policy orientation into prevention practice that utilizes a multidimensional approach to risk and protective factors to have an impact on multiple problems and communities
- Expand the field by encouraging new participants, dialogue, and explorations."

The CSAP system review team was unable to find a written definition of primary prevention that has been adopted by DMHAS to guide the SABG prevention system. Although references to the risk and protective factor framework and the Institute of Medicine (IOM) model appear in State documents, the lack of a formal State definition of prevention appears to contribute to a lack of clarity for some subrecipients as to what constitutes primary substance abuse prevention. DMHAS recent restructure and emphasis on the integration of substance abuse and mental health services might add to a lack of clarity at both the State and the subrecipient levels as to where the boundaries for primary prevention services are drawn.

DMHAS might benefit from developing a conceptual framework for prevention that can consistently guide SABG-funded primary prevention services within an integrated behavioral health system. The framework should include a written definition for primary prevention that can clearly distinguish activities intended to prevent or delay onset of substance abuse from those that are intended for early intervention, treatment, or relapse prevention purposes.

Multiagency/State Prevention System

During the 2006 and 2009 system reviews, CSAP documented New Jersey's struggle to establish unified direction and leadership for the State's many substance abuse prevention programs and authorities. The 2012 CSAP review team noted, however, that DMHAS has made significant progress in strengthening and expanding its partnerships at the State level to better unify prevention efforts. In addition to the new partnership with DLPS, other accomplishments in this area are 1) coordinating with the Governor's Council on Alcoholism and Drug Abuse (GCADA), 2) forming a multiagency Prevention Unification committee to streamline and coordinate needs assessment processes at the local level and reduce duplication and facilitate coordination, and 3) expanding the membership of the SEOW.

GCADA was established by the New Jersey Legislature as an independent body charged with conducting research and generating public awareness of substance abuse. Also, GCADA is charged with reviewing, coordinating, and evaluating the State's efforts to prevent and treat alcoholism and drug abuse. The council is further responsible for preparing a State plan on substance abuse, advising the Governor on substance abuse funding, supporting employee assistance and other programs, collecting data as necessary to carry out its responsibilities, and reviewing and coordinating all State departments' efforts in regard to substance abuse. Accordingly, GCADA has broad powers to administer and set policy for substance abuse programs.

GCADA has 26 members, 14 of whom are public members appointed by the Governor or legislative leadership. The remaining members represent State departments, including DMHAS. The council maintains the following standing subcommittees: Planning, Interdepartmental Advisory Panel, Veterans and Military Families, Municipal Alliance Prevention, Criminal Juvenile Justice, Legislative, and Treatment.

GCADA has undergone some changes in leadership recently. The Governor appointed a new executive director and several new public members in January 2010, and a new staffing pattern resulted in the hiring of two more staff. In addition, an Advisory Panel of national experts, including a representative from the Community Anti-Drug Coalitions of

America (CADCA), is being convened to assist the council carry out its duties.

GCADA also administers the State funds earmarked for the Municipal Alliance Network, a volunteer-driven network of 402 grassroots coalitions encompassing more than 560 municipalities in New Jersey. Municipal Alliance Network members—many of whom have been trained in the SPF—design and implement local, public prevention public activities and mobilize for environmental prevention approaches.

The Municipal Alliance Network also helps advance GCADA advocacy objective by educating legislators about the benefits of using evidence-based strategies to prevent alcohol, tobacco, and other drug (ATOD) problems among the residents of New Jersey. The authority of GCADA, combined with the coverage and active advocacy of the Municipal Alliance Network, positions New Jersey well to leverage funds across sectors and advance positive public policies at the State and municipal levels.

The Partnership for a Drug-Free New Jersey (PDFNJ) is funded by DMHAS and was founded in 1992 as "a state anti-drug alliance to localize, strengthen, and deepen drug-prevention media efforts." PDFNJ has gained $10,000 in donated media and coordinates its campaign efforts with the municipal alliances, regional coalitions, and County Alcohol and Drug Coordinators. DMHAS contracts with the PDFNJ for its work in environmental strategies.

At the time of the 2009 system review, the CSAP review team noted the roles of GCADA, the Municipal Alliance Network, the Prevention Coordinating Council (a subcommittee of the Governor's Oversight Committee for Safe Streets and Neighborhoods), the SPF-SIG Advisory Council, and the SSA were not clear, and coordination was sporadic. Complicating matters, DMHAS's relationship with GCADA was strained. Since this time, the Prevention Coordinating Council and SPF-SIG Advisory Council are no longer active and DMHAS and GCADA both reported working together to unify prevention efforts.

STRENGTHS

- *DMHAS has made significant progress in strengthening and expanding its partnerships at the State level to better unify prevention efforts.*
- *New Jersey's GCADA and Municipal Alliance provide a means of leveraging funds and advancing policies at the State and municipal levels.*
- *New Jersey's GCADA funds a Municipal Alliance Network to implement prevention efforts using the SPF.*
- *The State uses a process it calls Prevention Unification to improve coordination of substance abuse prevention across agencies at all levels.*
- *DMHAS has been able to broaden the mission of the SEOW and integrate it into existing State infrastructure.*
- *The widespread adoption of the SPF, along with Prevention Unification, in New Jersey has created an avenue for DMHAS and its diverse partners to use a common language when working toward shared goals.*

During the 2012 system review, a representative from GCADA noted the council's intent to model coordinated planning at the State level before expecting this at the county and municipal levels. Both DMHAS and GCADA require coordination between the regional coalitions and the municipal alliances in their service areas to maximize prevention efforts and promote coordination across the continuum of services. Additionally, GCADA has adopted the SPF and is now using it as the planning framework for the Municipal Alliance Network. To this end, it appears the widespread adoption of the SPF, along with Prevention Unification, in New Jersey has created an avenue for DMHAS and its diverse partners to use a common language when working toward shared goals.

The State uses a process it calls Prevention Unification to improve coordination of substance abuse

prevention across agencies at all levels. Prevention Unification is a needs assessment process historically carried out in New Jersey every 4 to 5 years by county and municipal authorities to identify local and countywide priorities. Prevention Unification also occurs at the State level simultaneously to planning efforts at the local level. The priorities identified then inform the development of a subsequent RFP to award SABG funding for county-based prevention programming. The entire process is designed to be a comprehensive, integrated, and cohesive planning strategy for community-based prevention services and is now another avenue to advance the SPF. To enhance the process, DMHAS has formed a Prevention Unification committee that comprises a representative from DMHAS, GCADA, the LACADAs, the regional coalitions, and the Municipal Alliance Network; a County Alcohol and Other Drug (AOD) Coordinator; and others.

At the time of the 2012 system review, the committee had met once and was identifying the different needs assessment processes used at the municipal and county levels to identify where they can be streamlined. The committee also was identifying the level of support needed at the State level to reduce duplication and facilitate coordination. Although the committee had just met once, future meetings were scheduled and all committee members present during the system review appeared to be engaged, committed, and optimistic about the results.

New Jersey's SEOW, which was created in December 2006, comprises 35 members representing a broad array of agencies that have access to data at the State, county, and municipal levels. Membership includes representatives from DHSS, GCADA, the Departments of Education and Labor, Princeton House Behavioral Health, the Hospital Association, the New Jersey Prevention Network (NJPN), Rutgers University, the New Jersey Poison Information and Education System, and county alliance coordinators, among others. The New York/New Jersey High Intensity Drug Trafficking Area agency is also an active member of the group. The mission of this federally funded agency is to significantly reduce illegal drug use through collaborative, measurable initiatives that include enforcement, prosecution, and prevention.

In 2006, a charter was developed to outline the following goals and objectives to be accomplished by the SEOW:

- Create a State Epidemiological Profile
- Develop a SEOW work plan and goal statement
- Collect National Outcome Measures and performance measurement data
- Analyze data
- Conduct ongoing surveillance
- Distribute the Epidemiological Profile and other substance abuse prevention data.

Initially, the SEOW's efforts were primarily focused on fulfilling SPF-SIG requirements for analyzing the prevalence and patterns of substance abuse-related problems and contributing factors. During the system review, however, DMHAS staff expressed the division's commitment to sustain the group beyond the expiration of SPF-SIG funds and expand its mission. The SEOW's efforts would include the collection and analysis of data on mental health indicators to better inform policy development and the continuum of services for the New Jersey health care system.

Although there are no federally recognized tribes in New Jersey, there are three State-recognized tribes: the Nanticoke Lenni-Lenape, the Powhatan Renape Nation, and the Ramapough Lenape Nation. The State also recognizes the Inter-Tribal American Indians of New Jersey, an organization created circa 1980 to meet the needs of American Indians from across North and South America now living in New Jersey. This recognition includes giving the organization membership on the Commission on American Indian Affairs.

The New Jersey Commission on American Indian Affairs serves as a liaison between the tribal, State, and Federal governments. It is empowered to develop programs and projects to further the understanding of New Jersey's American Indian history and culture. The commission has nine members: the Secretary of State,

serving ex officio, and eight public members. The public members consist of two members from each of the following: Nanticoke Lenni-Lenape Indians, Powhatan Renape Indians, Ramapough Lenape Indian Nation, and Inter-Tribal American Indians of New Jersey. The system review team found no evidence of collaboration between the SSA and the commission or the tribes.

Substate Prevention System

New Jersey's substate prevention system is comprehensive and is composed of county and municipal authorities charged with providing a continuum of AOD services, including prevention, across the lifespan.

Each of New Jersey's 21 counties (see map below) has a statutorily designated County Alcoholism and Drug Abuse Authority (CADAA) that is the agency designated by the County Board of Chosen Freeholders to plan, develop, and establish alcoholism and drug abuse programs for county residents. Each CADAA designates an AOD coordinator to prepare the County Alcoholism and Drug Abuse Plan, and to coordinate the development of alcoholism and drug abuse services in cooperation with the LACADA for that area.

Each county has grassroots municipal level coalitions that compose the Municipal Alliance Network. The municipal alliances are established by municipal ordinances and are funded by GCADA through moneys from mandatory penalties on drug offenders. These funds are funneled through the CADAAs to the member municipalities to support appropriate county and municipal alcohol and drug abuse education and public awareness activities. In some counties, county AOD Coordinators also serve as the Municipal Alliance Coordinator for their county. In this role, they monitor each of the county's local Municipal Alliance organizations through monthly reports and quarterly meetings.

Each of the 21 established LACADAs is responsible for identifying local needs and developing service plans and funding priorities for the county. They may also provide rehabilitation services for abusers of alcohol and drugs. Once a county plan is developed and approved, funds may be subcontracted to agencies within the county to help implement planned services. During the system review, DMHAS indicated that many agencies that receive a prevention contract from DMHAS also receive a subcontract from a CADAA to implement prevention services in their approved plan.

Many of the Municipal Alliance Network members participate on LACADAs and are also members of regional coalitions funded by DMHAS. GCADA indicated that the network provides the infrastructure for advocacy efforts at the local and State levels. In total, the Municipal Alliance Network reportedly engages more than 7,000 volunteers in efforts to prevent alcoholism and drug abuse in approximately 560 communities throughout New Jersey. Examples of volunteers are youth, parents, residents, and local government and law enforcement officials and individuals from schools, nonprofit organizations, and the faith community. New Jersey received a

STRENGTHS

- *New Jersey's substate prevention system is comprehensive and is composed of a continuum of AOD services, including prevention, across the lifespan.*
- *DMHAS funds 17 regional coalitions—many of which have been or are current grantees of the Drug Free Communities (DFC) grant program—to use the SPF to select and implement environmental strategies in all of New Jersey's 21 counties.*
- *DMHAS requires that the membership of the regional coalitions includes representatives from the local Municipal Alliance(s), AOD County Coordinators, and LACADAs in order to minimize duplication and coordinate prevention efforts.*

CHALLENGES

- *Prevention efforts in some counties are not well coordinated.*

State Recognition award from CADCA in February 2012 for having one of the largest antidrug coalition networks in the Nation due to the work of the Municipal Alliance Network.

Historically, DMHAS has supported a statewide network of resource centers that provided AOD-related information and educational materials. In January 2012, the SABG funds used to support this network were redirected toward regional coalitions. DMHAS now funds 17 regional coalitions—many of which have been or are current grantees of the Office of National Drug Control Policy's (ONDCP's) Drug Free Communities (DFC) grant program—to use the SPF to select and implement environmental strategies in all of New Jersey's 21 counties. Because of variations in county size and population density, some coalitions are funded to serve two counties. DMHAS requires that the membership of the regional coalitions includes representatives from the local Municipal Alliance(s), AOD County Coordinators, and LACADAs in order to minimize duplication and coordinate prevention efforts at the county level.

In addition to the 17 regional coalitions, DMHAS also awards 52 contracts to community-based agencies to implement evidence-based programs targeting individuals and families. One contract is awarded to the North Jersey Community Research Initiative to deliver prevention, early intervention, social marking, and structured recreational activities targeting the gay/lesbian/bisexual/transgender/questioning (GLBTQ) youth in Newark, New Jersey. A second special contract is with NJPN for work with military families. A third special contract is with PROCEED, Inc., a not-for-profit service agency, for cultural competence promotion among DMHAS-funded prevention providers.

The many groups charged with planning and implementing AOD services in New Jersey contribute to the complexity of its substate system. More than 30 people representing regional coalitions, LACADAs, evidence-based prevention program contracts, GCADA, training and technical assistance (T/TA) and evaluation contracts, and New Jersey's Department of Education (DOE) participated in the onsite system review discussion to share their views of the substate system and how they all interact and coordinate.

It appears that in some counties, the regional coalitions, County AOD Coordinator, and municipal alliance programs are working in a well-coordinated fashion and in some cases are leveraging and expanding services. However prevention efforts are not as well coordinated in other counties. Some participants at the system review described their struggles to find common ground for integration and their challenges in partnering on multiple county efforts, and admitted they were still ironing out their different roles. New Jersey may need to expand coordination efforts carried out under Prevention Unification to include an analysis of existing and evolving infrastructure (e.g., county directors, LACADAs, municipal alliances, regional coalitions) in order to clarify roles and identify where efforts can be coordinated to minimize duplication and maximize resources.

Findings From Previous System Reviews

At the time of the August 2009, system review, New Jersey was facing a number of challenges, many of which have been addressed and are noted throughout this report. In particular, the former Division of Addiction Services (DAS)—now DMHAS—was encouraged to enhance its leadership by strengthening relationships with State agency partners and with those responsible for substance abuse prevention efforts outside of its direct purview. Multiple prevention planning efforts were being carried out at the State level that were not well coordinated.

The review team also recommended that DAS review and revise its vision statement to elevate the role of primary prevention and to review statewide substance abuse trend data to develop State-level prevention priorities that could have an impact on desired outcomes for population-level change. The high number of prevention strategies DAS used to target indicated populations and the lack of universal prevention strategies DAS employed were of concern. Strategies that have an impact on population-level changes, such as environmental strategies, only accounted for 5.6 percent of prevention strategies implemented. No compliance issues or associated required followup actions for prevention were identified during the 2009 system review.

Contextual Conditions

New Jersey lies between New York City and Philadelphia, in the heart of a highly urbanized area. With a land mass of 7,400 square miles, it is the fifth smallest State in the Nation; however, its 9 million residents give it a population density of 1,196 persons per square mile, the highest of any State. According to the 2010 U.S. Census (see table at the left), Whites make up 68.6 percent of the population, followed by Blacks (13.7 percent), Asians (8.3 percent), and those of mixed heritage or not reporting race (2.7 percent of the population). A growing number of Hispanics/Latinos now accounts for 17.7 percent of the population. While all 21 counties in New Jersey are officially classified as "metropolitan" by the U.S. Census Bureau,

2010 New Jersey Population	
White	68.6%
Black	13.7%
American Indian/Alaska Native	0.3%
Asian	8.3%
Native Hawaiian/Pacific Islander	0.0%
Two or more races	2.7%
Hispanic/Latino	17.7%
White, not Hispanic	59.3%

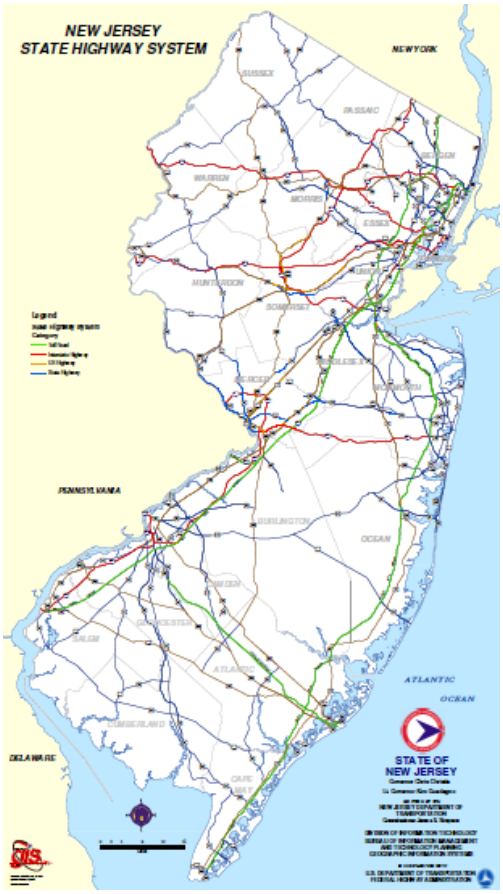
system review participants from the State described New Jersey as being urban, rural, and suburban.

New Jersey has a dense system of highways, railroads, tunnels, and bridges that connect it with New York City and Philadelphia. The map on page 12 illustrates the major arteries that crisscross the State. The New York–New Jersey region is the Northeast United States' center for narcotics trafficking, serving as both a gateway and a marketplace. The area is ideal for importation of drugs through two major international airports and several domestic airports; two major railroad complexes and hundreds of miles of subway tracks; an extensive waterfront with various points-of-entry, including the Port of New York (the third-largest port in the country); and a complex network of highways, bridges, and tunnels bringing more than a billion people into New York City each year. All of these factors influence substance abuse patterns and transportation.

The importance of casino-based tourism—epitomized by Atlantic City, which became the site of the country's first gambling casino outside of Nevada in 1978—is another potential factor for substance abuse and related consequences.

Although New Jersey's economy appears to be recovering, it also is lagging behind the national indicators. The State's March 2011 unemployment rate remained around 9.0 percent, whereas the national average was 8.2 percent.

New Jersey has five U.S. military bases that represent all branches of the armed services and house more



than 51,000 military personnel. Joint Base McGuire-Dix-Lakehurst is the largest and was created by the merger of Fort McGuire Air Force Base with Fort Dix (Army) and Naval Air Engineering Section Lakehurst in 2005. The base houses more than 44,000 people, including airmen, soldiers, sailors, and marines. The New Jersey National Guard consists of more than 9,000 guardsmen and guardswomen posted to 7 major commands located throughout the State.

The State has 31 public and 35 independent higher education institutions that serve more than 440,000 students.

State Substance Abuse Trends

Alcohol Trends

At the time of the 2009 system review, data from the 2006 National Survey on Drug Use and Health (NSDUH) indicated that New Jersey's reported rates of past-30-day alcohol use were higher than the national average across all age groups. Since that time, reported rates of substance abuse by New Jersey youth have been declining and are now lower than the national median across all substances. NSDUH data reflect that reported rates of past-30-day alcohol use for youth ages 12 to 20 declined from 30.7 percent in 2006 to 27.8 percent in 2009. Although similar comparisons using New Jersey's 2010 Middle School Survey report may be unreliable[2], the trend is consistent, showing a drop by 5 percentage points since 2007 in the number of middle school-aged youth who reported having used alcohol in the past 30 days.

According to New Jersey's Student Health Survey (NJSHS), reported rates of alcohol consumption have declined steadily since 2001 and were at their lowest in 2009. Although this is positive news, the survey also indicates that alcohol remains the drug of choice for New Jersey youth. NJSHS data for 2009 indicate that nearly three-fourths (74.6 percent) of New Jersey high school students reported drinking alcohol in their lifetime, with little variation in alcohol use by gender. Many more White students (79.7 percent) than Hispanic (74.6 percent) or Black students (63.2 percent) reported lifetime alcohol use in that year.

NJSHS data from 2009 also reflect that 45.2 percent of high school students reported having drunk alcohol on at least 1 day during the past month. Of this group, 4.6 percent reported having consumed alcohol on 10 or more of the last 30 days. In addition, more than one-quarter (26.7 percent) of New Jersey high school students reported having consumed five or more drinks on at least 1 day in the last 30 days. White students (33.1 percent) were more likely than Hispanic (23.1 percent) or Black (10.6 percent) students to have reported recent binge drinking.

Alcohol use by New Jersey adults is also declining. According to the NSDUH, the percentage of respondents over the age of 21 who reported having used alcohol in the past 30 days fell from 62.9 percent in 2003 to 57.6 percent in 2009. The proportion

[2] New Jersey's report notes that the wording of the question changed in the 2010 survey, which may account for the reported difference.

of heavy drinkers[3] among adults in New Jersey has varied from 4.0 percent to 5.2 percent in the past decade and remains at 4.3 percent according to the 2010 Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System (BRFSS). BRFSS data indicate that binge drinking among New Jersey adults has also varied from 14.3 percent to 13.6 percent since 2006, and stood at 13.8 percent in 2010. According to data from New Jersey's Treatment Episode data Set (TEDS), alcohol was cited as the primary substance of dependence for 19.5 percent of all admissions to the State's publicly funded treatment system in 2010. Alcohol in combination with another drug accounted for an additional 13.2 percent.

Tobacco Trends

NSDUH data reflect that New Jersey has some of the lowest reported rates of reported past-30 day tobacco and cigarette use for people over the age of 12 in the Nation. According to the NSDUH, the percentage of youth ages 12 to 17 who reported having used cigarettes in the past 30 days declined significantly from 12.2 percent in 2003 to 7 percent in 2009. This rate is 28 percent below the national median. During that same time period, the following three desirable trends were also noted: the average reported age at time of first use increased from 13.8 to 14.3 years, the percentage who reported disapproving of someone their age smoking a pack or more of cigarettes a day rose from 80 percent to 92.4 percent, and the percentage who thought their friends would disapprove if they smoked one or more packs of cigarettes a day also rose from 85 percent to 89.1 percent.

According to the BRFSS, New Jersey adults who smoke some days has declined steadily since 1995 to its lowest rate, 14.4 percent, reported in 2010. BRFSS data reflect that reported rates of daily smoking also declined during this period to 10.2 percent in 2010.

Illicit Drug Trends

The most commonly reported illicit drugs in New Jersey are marijuana by youth and heroin by adults; however, overall use rates of these substances are low when compared with other States. According to the 2010 NJSHS) report, more than one-third (35.3 percent) of high school students reported having tried marijuana in their lifetime. Further, 15.1 percent of students reported having done so on 20 or more occasions. According to New Jersey's 2010 Middle School Survey, past month marijuana use by middle school students increased from 2.1 percent in 2007 to 3.0 percent in 2010 and past year use increased from 3 percent to 5 percent during this period.

New Jersey's 2010 Middle School Survey found lifetime rates of use for each of cocaine, heroin, Oxycontin, sedatives/tranquilizers, amphetamines, steroids, methamphetamines, Ecstasy, and inhalants to be less than 0.5 percent in 2010. Total lifetime use for all these substances was 1.4 percent. The rate among "other" race/ethnic groups was 2.2 percent; among Hispanics it was 1.8 percent.

TEDS data reflect that persons under the age of 20 accounted for 12.5 percent of all admissions to the State's publicly funded treatment in 2010. Persons 12 to 17 years of age accounted for 25 percent of all admissions for marijuana; persons 18 to 20 years of age accounted for 16.1 percent of admissions for marijuana use.

NSDUH data also reflect that the percentage of New Jersey adults ages 18 and older who reported having used illicit drugs other than marijuana in the past 30 days fell from 3.0 percent in 2003 to 2.4 percent in 2009, which was 31 percent below the

STRENGTHS

- *Reported rates of substance abuse by New Jersey youth have been declining and are now lower than the national median across all substances.*

[3] The BRFSS defines heavy drinkers as adult men having more than two drinks per day and adult women having more than one drink per day.

national median. At the same time, heroin was the most commonly cited primary drug of dependence at time of admission into New Jersey's publicly funded treatment system, with 31.6 percent reporting use of this drug. An additional 10.3 percent of admissions were for other opiates. Nationally, only 21.4 percent of admissions were for use of heroin or other opiates combined.

Substance Abuse Needs Assessment

New Jersey uses an array of epidemiological, social indicator, and other data to inform State and local planning at the county and municipal levels. In particular, the State has collected information on ATOD consumption patterns and related risk and protective factors for New Jersey youth ages 10 to 18 since 1999 through four statewide student surveys that are conducted by different State agencies.

Student survey efforts consist of New Jersey's Youth Tobacco Survey (NJYTS), which is conducted by DHSS Office of Tobacco Control; the NJSHS, which is conducted by DOE; and the New Jersey Middle and High School Risk and Protective Factor Surveys conducted by DMHAS. Participation in the surveys is somewhat constrained by New Jersey State law requiring active parental permission for student participation. During the system review, however, SSA staff expressed hope that a recently proposed legislative bill to eliminate active consent would pass.

New Jersey began statewide youth tobacco surveillance using the NJYTS in 1999. The survey is an adaptation of the National Youth Tobacco Survey that includes State-added questions specific to programming and youth tobacco use trends in New Jersey. The first NJYTS was intended to provide a baseline for monitoring progress toward reducing tobacco use among youth. Since 2004, the survey has been administered every 2 years. Whereas previous administrations included both middle and high school students, recent budget cuts did not allow for the inclusion of middle school students in 2010. The 2010 survey was administered to 3,123 high school students in 38 schools during fall 2010, which resulted in 2,641 completed and usable questionnaires. During the system review, DHSS/Office of Tobacco Control staff indicated that funding cuts have significantly reduced services and they were uncertain of the future administration of the NJYTS.

DOE contracts with the Bloustein Center for Survey Research (BCSR) at Rutgers University to administer the NJSHS in odd-numbered years. This survey collects data on self-reported health behaviors from high school student using a core set of questions from the Youth Risk Behavior Survey (YRBS), supplemented by additional State-added questions.

In 2000, DOE began exploring means to expand the scope of the YRBS to address the needs of several State agencies and reduce duplication of effort in conducting student surveys in New Jersey schools. To keep up with changing trends in adolescent behavior, questions are added or rotated on a regular basis. For example, questions were added in the 2005 survey to measure student attitudes toward the use of tobacco, alcohol, and marijuana. Questions were also added in 2007 regarding online communication and self-mutilation. The 2009 questionnaire had new questions on bullying, participation in clubs and volunteer service, and school environment.

STRENGTHS

- *New Jersey uses an array of epidemiological, social indicator, and other data to inform State and local planning.*
- *The State has collected information on ATOD consumption patterns and related risk and protective factors for New Jersey youth ages 10 to 18 since 1999.*

CHALLENGES

- *Some local planning efforts are not utilizing State data reports.*
- *According to State staff, New Jersey's heroin and other opiate use death rate is high, but that the prevalence rate for these substances in New Jersey remains low.*

The survey reports are available online and can be downloaded and reproduced without restriction.

DMHAS contracts with BCSR to administer New Jersey's High School and Middle School Risk and Protective Factor Surveys biennially. The most recent high school survey, which was administered in 2007/2008, included a stratified random sample of 83 schools throughout the State (representing a 74-percent school participation rate). The middle school survey was last administered in 2009/2010 and contained data from 99 randomly selected schools throughout the State (representing a 70-percent school participation rate). Both questionnaires collect data on risk and protective factors that show the strongest correlations to drug use, including questions on students' feelings about school and their neighborhood; self-reported and peer use of ATODs; and the availability of ATODs. Notable differences by grade, gender, race/ethnicity, and county are highlighted throughout each report.

DMHAS also contracts with BCSR to conduct the New Jersey Household Survey on Drug Use and Health to collect adult substance abuse data. The survey uses a random sample to identify households. Interviews are conducted by telephone to assess the prevalence of legal and illegal substance use and identify the need and demand for substance abuse treatment. In addition to developing State- and county-level estimates of prevalence, need, and demand, the 2003 New Jersey household survey also sought to document the impact of the September 11, 2001, terrorist attacks on the use and abuse of drugs and alcohol in New Jersey. The 2009 Household Survey also assessed substance use and abuse characteristics of New Jersey veterans. DMHAS has since used this data to allocate a portion of its SABG funds to support evidence-based programming targeting Active Duty veterans and their families.

New Jersey's SEOW has been charged with collecting and analyzing epidemiological data to assess the magnitude of substance use-related consequences and related substance use patterns. In addition to the State survey data sources described above, combined with State archival and administrative data, the SEOW also accesses and analyzes data from national sources, such as the TEDS, NSDUH, YRBS, BRFSS, and Uniform Crime Reports.

The State's first Epidemiological Profile, which profiled population needs, resources, readiness to address ATOD problems, and gaps in service delivery, was published in 2006. An update that detailed consumption and consequence data at the State and county levels was published in 2008. The next update is expected in 2012. The SEOW has also produced County Chartbooks of Social and Health Indicators for New Jersey. In addition, the SEOW maintains and updates data reports and links to national sources that are housed on DHS/DMHAS Web site.

DMHAS and State partners have used the Epidemiological Profiles to identify the following five substance abuse priorities: underage drinking; binge drinking; use of illegal substances, with a focus on marijuana; medication misuse, with an emphasis on the use of prescription opioids among 18- to 25-year-olds; and use of new and emerging drugs of abuse.

Although regional and county coalitions are required to use needs assessment data to identify local priorities, it was unclear to the review team to what extent coalitions are using the data reports (e.g., county chart books) produced by the State. When providers that participated in the system review were asked how they used the data reports produced by the State in their planning efforts, several providers seemed unaware that these reports existed. In addition to expanding SEOW membership and the scope of data contained in the profile to include mental health indicators, DMHAS staff noted plans to use the SEOW to support local data utilization and analysis efforts, including providing data analysis and interpretation service to communities as necessary and appropriate. DMHAS might also want to examine its packaging and distribution of State-level data to ensure that the data are presented in a manner that can be easily understood by the entities carrying out local planning efforts.

Workforce Development and Capacity Building

Workforce Development

As documented throughout this report, New Jersey's substance abuse workforce consists of a vibrant, dynamic, and diverse array of paid staff, volunteers, coalitions, and organizations across a spectrum of disciplines and sectors at the municipal, county, regional, and State levels. The 2012 system review team noted, however, that for development purposes, DMHAS tends to define its prevention workforce rather narrowly as those agencies and individuals funded through the SABG. Accordingly, DMHAS T/TA system has been designed to meet the needs of paid prevention staff through a certification process and mandatory trainings supported by training through workshops and conferences and some TA.

The Addiction Professionals Certification Board of New Jersey, a not-for-profit organization, coordinates prevention specialist certification, which is based on the International Certification & Reciprocity Consortium's (IC&RC) minimum standards. The following are required to achieve the Certified Prevention Specialist (CPS) credential in New Jersey: completion of 120 hours of preapproved coursework; a minimum of a bachelor's degree in a human services-related field (e.g., social work, education, human services); documentation of 2 years' full-time experience (4,000 hours) in at least one of the five domains of prevention, including a 120-hour practicum; and successful completion of the IC&RC prevention written examination.

In addition, the following trainings are required to obtain the CPS credential:

- Assessment and Planning
  - Prevention Program Planning and Assessment
  - Community Assessment
  - Program Design
  - Evidence Based Prevention Models
- Environmental Prevention
  - Introduction to Methods and the Impact of Environmental Change
  - Assessment and Planning of Environmental Strategies
  - Implementation and Enforcement of Environmental Change
- Mobilization
  - Coalition Building and Maintenance
- Implementation
  - Coordinating Community Prevention Activities
  - Prevention Activities and Methods
- Evaluation
  - Prevention Program Evaluation
- Special Issues
  - Dynamics and Process of ATOD Dependency and Abuse
  - Impact of Substance Use Disorders on Families and Larger Systems
  - Prevention Issues with Special Populations
  - Prevention of Violent and Compulsive Behaviors
- Professional Development
  - Professional Growth

STRENGTHS

- *New Jersey's substance abuse workforce consists of a diverse array of paid staff, volunteers, coalitions, and organizations across a spectrum of disciplines and sectors at the municipal, county, regional, and State levels.*
- *DMHAS has established minimum workforce requirements for prevention organizations funded by the SABG.*
- *DMHAS and GCADA are working with CADCA to advance the SPF throughout New Jersey communities.*

- Ethics and Legal Issues for Prevention Specialist
- Cultural Competency
- Self Care for the Prevention Specialist
- Presentation Skills.

DMHAS has established minimum workforce requirements for prevention organizations funded by the SABG. DMHAS prevention contracts require that all provider organizations have on staff at least one CPS (or individual working toward CPS), Certified Health Education Specialist (CHES), or master/doctoral-level preventionist with a minimum of 3 years' verifiable experience on staff. Failure to have a CPS or an individual who has more than 50 hours of coursework for the CPS, a CHES, or a master's/doctoral-level preventionist on staff could result in contract noncompliance and a loss or suspension of funding. This requirement has changed slightly from previous years, having been revised to allow for a larger pool of applicants with the RFP for regional coalitions that was introduced in 2008.

In addition, funded agencies are also required to maintain a staff development plan with written policies for continuing education. Each professional full-time employee is required to participate in at least 28 hours of training each year.

DMHAS requires providers to complete T/TA in order to meet the following eight specified cultural and linguistic competence standards:

1. Promote and support the attitudes, behaviors, knowledge, and skills necessary for staff to work respectfully and effectively with clients and each other in a culturally competent work environment
2. Have a comprehensive management strategy to address culturally and linguistically appropriate prevention services, including strategic goals, plans, policies, procedures, and designated staff responsible for implementation
3. Develop and implement a strategy to recruit, retain, and promote qualified, diverse, and culturally competent prevention staff that are trained and qualified to address the needs of the racial, ethnic, and other minority communities being served
4. Require and arrange for ongoing education and training for prevention staff in culturally and linguistically competent service delivery
5. Provide all clients with limited English proficiency access to bilingual prevention staff or interpretation services
6. Provide oral and written notices, including translated signage at key points of contact, to clients in their primary language informing them of their right to receive no-cost interpreter services
7. Translate and make available signage and commonly used written client education materials and other materials for members of the predominant language groups in service areas
8. Use a variety of methods to collect and utilize accurate demographic, cultural, epidemiological, and clinical outcome data for racial and ethnic groups in the service area, and become informed about the ethnic/cultural needs, resources, and assets of the surrounding community.

CHALLENGES

- *The SSA does not have an assessment of prevention workforce needs or a workforce development plan.*
- *DMHAS has not identified the core prevention competencies beyond those required for certification.*
- *DMHAS tends to define its prevention workforce rather narrowly as those agencies and individuals funded through the SABG.*
- *DMHAS-funded regional and program staff seemed more familiar with qualitative data and its use for local prevention planning than the quantitative data that DMHAS collects and provides.*
- *Regional Coalitions assigned to a two-county planning area are challenged and may require tailored assistance.*

DMHAS contracts with PROCEED to provide T/TA on cultural competence and linguistically appropriate services to its funded prevention providers through Webinars, in-person trainings, and conference calls. According to DMHAS, the goal of the T/TA is to develop a cadre of substance abuse prevention providers capable of delivering culturally competent substance abuse prevention services that are responsive to the needs of the communities they serve.

DMHAS also contracts with the NJPN to develop and deliver training for the State's prevention and treatment workforce throughout the year at numerous sites statewide. The Addiction Training and Workforce Development Initiative provides scholarships to attend alcohol and drug counselor training to increase and enhance the addiction workforce in New Jersey. NJPN offers free Certified Alcohol and Drug Counselor and Licensed Clinical Alcohol and Drug Counselor (LCADC) training, as well as Certified Prevention Specialist training.

In addition, DMHAS has a memorandum of agreement with the Rutgers Institute of Alcohol Studies and the Rutgers School of Social Work to provide graduate-level addiction courses leading to dual licensure as both a Licensed Clinical Social Worker (or other New Jersey licensed behavioral health care professional) and an LCADC. The goal of the program is to increase the number of dually licensed credentialed staff working in licensed substance abuse agencies.

DMHAS issued new RFPs in 2011 for T/TA and evaluation support that were aligned with the scope of services outlined in the Funding for Regional Coalitions to Utilize Environmental Strategies to Achieve Population- Level Change RFP. The T/TA contract was awarded to NJPN and the evaluation support contract to Rutgers University in January 2012. During the system review, NJPN described its plan to offer in-person trainings, Webinars, site visits, and telephone consultation on capacity building, implementation of environmental programs and strategies, cultural competence, coalition development, and project sustainability to regional coalitions.

DMHAS and GCADA are working with CADCA to advance the use of the SPF throughout New Jersey communities. GCADA has contracted with CADCA to deliver a 3-week Coalition Academy to all Municipal Alliance members throughout New Jersey. In addition, DMHAS collaborated with CADCA to develop a train-the-trainer program in which current SPF-SIG funded communities will learn how to provide training on the SPF to prevention agencies, coalitions, municipal alliances, and county government planning staff in their counties or regions.

Other than the basic competencies required for certification, the system review team noted that DMHAS has not identified the core prevention competencies needed by different sectors of the prevention workforce to address unique prevention needs and conditions in the State, including those posed by the State's move to integrate mental health promotion and substance abuse prevention. In addition, DMHAS staff indicated during the system review that the Governor has expressed interest in analyzing the current behavioral health system to identify ways to improve services to address heroin and opiate use in New Jersey. During the system review, DMHAS requested CSAP assistance in identifying other States that have taken on similar efforts or produced a blueprint for State service improvements.

The system review team noted that the ability of DMHAS to build the capacity of its workforce to achieve desired prevention outcomes would be significantly enhanced by the identification of the core prevention competencies, beyond IC&RC, needed to address specific substance abuse trends and conditions in New Jersey. As part of this effort, DMHAS is encouraged to identify, analyze, and address specialized workforce competencies needed to effectively prevent the onset of heroin and other opiate use and abuse.

DMHAS might also consider the benefits of broadening its definition of the prevention workforce beyond just SABG subrecipients. Because comprehensive prevention requires coordinated efforts across sectors—particularly with regard to complex

emerging issues such as heroin and other opiate abuse—an expanded definition could help DMHAS, its contractors, and its partners identify where and how T/TA could be further leveraged to most effectively meet collective workforce needs.

Another particularly acute area of workforce development appears to involve building the capacity of substance abuse prevention coalitions and providers to use quantitative data for planning. The system review team noted that DMHAS subrecipients seem to be more familiar with qualitative data and their use for local prevention planning than with the quantitative data that DMHAS collects and provides.

In addition, some regional coalitions assigned to a two-county planning area are experiencing challenges with assessment and evaluation and may require tailored assistance. For example, one regional coordinator in attendance at the system review voiced challenges in knowing how to assess the needs of the different populations in her service area or how in depth the assessment activities should be. Despite a contract DMHAS has established with Rutgers University School of Social Work/Institute for Families to provide evaluation TA to subrecipients, some providers also seemed uncertain of the support available to them to address assessment and evaluation capacity issues.

It was unclear to the system review team whether DMHAS or Rutgers University has a plan for how to address these needs among providers. Because the T/TA and evaluation support contracts with Rutgers were awarded at the same time as the funding for the regional coalitions (January 2012), DMHAS, the coalitions, and Rutgers may still be learning how to best operationalize and support this new scope of services. DMHAS and Rutgers University might benefit from focusing on identifying and building the skills needed by SABG-funded prevention providers to use quantitative data for assessment, planning, and evaluation purposes.

Although DMHAS has established a committee to support workforce development, this effort is integrated into broader SSA planning efforts and is not guided by an overarching prevention-specific State substance abuse workforce assessment and development plan. As noted previously, DMHAS and its contractors use anecdotal information to identify T/TA needs. DMHAS does not have a formal workforce assessment that can measure the degree to which the different sectors of the workforce have the core competencies needed to effectively respond to emerging and priority issues and achieve desired population-level substance abuse outcomes.

DMHAS also does not have a prevention workforce development plan that can strategically inform and guide T/TA and other workforce development activities. The lack of a workforce assessment and plan were also noted in the 2009 CSAP system review, but they may become increasingly critical issues as the State continues with its integration of mental health, substance abuse, and primary care while also transitioning to broader, population-level public health approaches that can effectively address statewide and local priorities.

DMHAS efforts to build the capacity of the prevention workforce to succeed within an integrated behavioral health environment and use quantitative data and performance management processes to achieve targeted prevention outcomes would likely benefit from a formal assessment of prevention workforce needs. Assessment data could then be used to develop a workforce development plan with goals, objectives, and measurable outcomes for workforce recruitment, training, and retention. As a starting point, DMHAS might consider reviewing a range of workforce assessment tools and plans developed by other States to determine the most relevant components for New Jersey.

State Strategic Plan

In the past 2 years, DMHAS has joined State and community partners in the development of two plans that guide substance abuse prevention efforts in New Jersey: the "Governor's Council on Alcoholism and Drug Abuse 2010 Updated Statewide Master Plan

STRENGTHS

- *DMHAS and their partners have collaborated on the development of a statewide strategic plan.*

CHALLENGES

- *The statewide strategic plan has not been completed.*

for Alcoholism, Tobacco and Other Drug Abuse," and DMHAS's "2012 Substance Abuse Prevention Strategic Plan." The central focus of GCADA plan is infrastructure and the education of policymakers and community members, while the DMHAS plan focuses on reducing substance use.

GCADA is required by statute to develop a comprehensive, statewide alcoholism and drug abuse master plan. The current plan was updated in 2010, and DMHAS staff participated in its development as part of GCADA Interdepartmental Advisory Panel. The plan provides detailed information on the Municipal Alliance Network, and although it does not guide the allocation of SABG funds, it does guide the allocation of a substantial portion of dedicated State funds that finance the network.

The DMHAS Substance Abuse Prevention Strategic Plan is under development. DMHAS received TA from CSAP's Strategic Prevention Framework Advancement and Support Project to conduct a planning process with a 35-member planning committee comprising prevention providers, community representatives, and New Jersey State Government partners. This group has worked to integrate the efforts of multiple State and community stakeholders into a comprehensive, statewide strategic plan for prevention that would help the State achieve population-level outcomes.

The planning process has identified the following five overarching priorities: Reduce underage drinking; reduce binge drinking; reduce use of illegal substances, with a focus on marijuana; reduce medication misuse, with an emphasis on the use of prescription opioids among 18- to 25-year-olds; and reduce use of new and emerging drugs of abuse in New Jersey.

In addition, progress has been made to identify objectives, activities, and outcome measures. DMHAS has requested CSAP TA to finalize the strategic plan. The next step for completing the plan is to strengthen the logic models by aligning measurable outcomes with the behaviors and conditions needed to reduce or prevent the State's five substance abuse goals. These logic models could enhance the State's ability to strategically allocate resources to achieve outcomes by establishing:

- Clear goals related to priority substance abuse behaviors and related problems and consequences
- Specific objectives related to key intervening variables and causal conditions that are logically linked to priority substance abuse behaviors and related problems and consequences
- Targeted outcomes that represent quantifiable progress over time in achieving desired goals and objectives.
- An evaluation plan sufficient to monitor progress toward outcomes and provide information for midcourse adjustments as needed.

The final step in the strategic planning process will be to incorporate cultural competency and a sustainability plan.

Implementation—Compliance

Because New Jersey's FFY 2012 SABG application had not been approved by SAMHSA at the time of the 2012 system review, all compliance determinations were based on discussions with DMHAS staff during the system review and the State's FFY 2011 application.

Primary Prevention Set-Aside

New Jersey exceeds the 20-percent prevention set-aside requirement of the SABG. In FFY 2008, the SSA reported primary prevention expenditures of $12,603,566 out of a total SABG allocation of $46,779,531, or 26.7 percent. For FFY 2011, the SSA reported that intended allocations for primary prevention will decrease to $10,963,065

(23.5 percent) out of a total SABG allocation of $46,685,830.

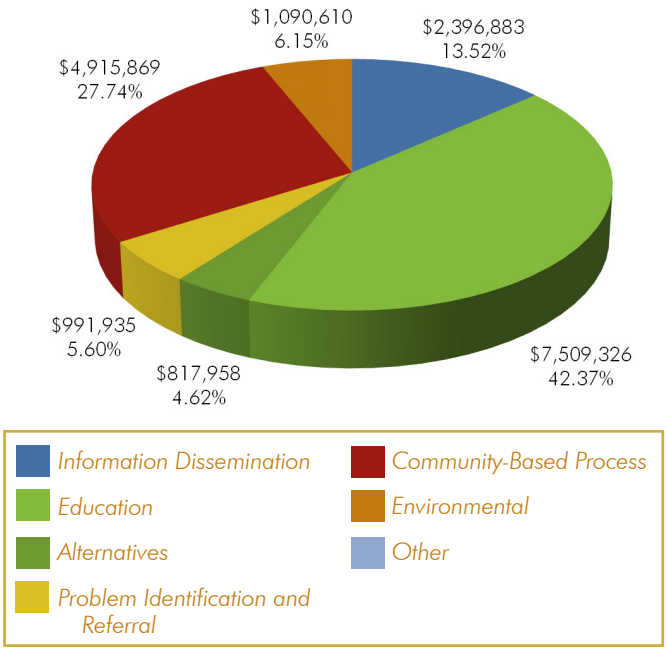
Six CSAP Prevention Strategies

Although the State elected not to report intended expenditures by the six CSAP prevention strategies in its FFY 2011 SABG application, figures representing New Jersey's SABG-funded actual expenditures for six strategies in FFY 2008 and planned allocations for FFY 2011 were provided onsite. The information is used in this section of the report.

New Jersey reported spending SABG funds on all six CSAP strategies during FFY 2008 (see figure below). The majority of funds was spent on Education (42.7 percent), followed by Community-Based Process (27.74 percent), and Information Dissemination (13.52 percent). Smaller percentages of SABG funds were spent to support Environmental strategies (6.15 percent), Alternative Activities (4.62 percent), and Problem Identification and Referral (5.6 percent).

For FFY 2011, New Jersey did not report by six strategies and DMHAS staff provided the following information during the system review. DMHAS intended to significantly increase the amount of funds for Environmental strategies (32 percent), while slightly reducing the amount of funds allocated for Education (40 percent), Community-Based Process (16 percent), and Information Dissemination, Alternative Activities, and Problem Identification and Referral (4 percent each). According to SSA staff, this shift was due in part to the 2009 CSAP system review recommendation to identify statewide prevention priorities that are based on data and will impact population-level change.

FFY 2008 New Jersey Total Funds Reported Expenditures by CSAP Strategies



SABG Compliance

- *DMHAS is in compliance with the SABG primary prevention 20-percent set-aside.*
- *DMHAS is in compliance with the SABG primary prevention expenditures reported by the six CSAP prevention strategies and Institute of Medicine classifications.*
- *DMHAS is in compliance with NOMs data reporting.*
- *DMHAS is in compliance with the requirement to providing public review and comment on the SABG application.*

Public Review and Comment on SABG Application

A notice regarding New Jersey's SABG application is posted on DMHAS Web site and disseminated through DMHAS providers' electronic mailing lists to facilitate public access and comment. Additional notices are posted in newspapers around the State.

National Outcome Measures

DMHAS maintains the Web-based Prevention Outcomes Management System (POMS). POMS was developed in-house in 2009 to collect basic process and demographic information, as well as program-level outcome data, about substance abuse prevention services. POMS data include the type of service; target audience; group and curriculum information; dates the service was performed; applicable CSAP strategy and domain; and outcome measures in the individual/peer, family, and school domains based on CSAP's core measures. DMHAS uses data

from POMS, combined with data from quarterly reports from providers that do not report in POMS, for Federal SABG NOMs reporting.

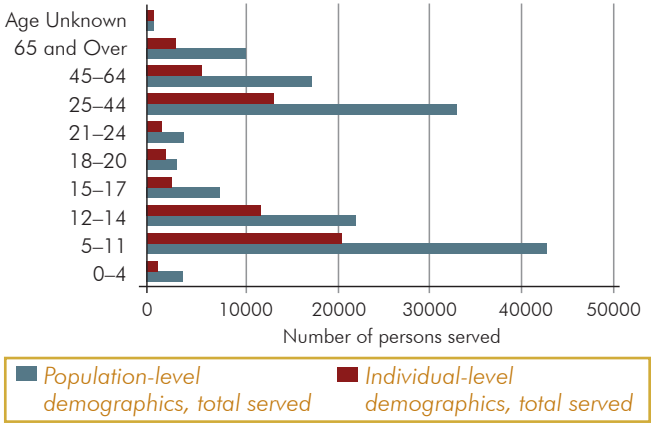
The State reported on each of the NOMs in the approved FFY 2011 SABG application. The SSA indicated it used the period July 1, 2009, through June 30, 2010, to report the NOMs and indicated the reported expenditure period as July 1, 2008, through June 30, 2009.

In FFY 2008, the State reported serving a total of 64,226 persons through individual-based strategies and a total of 148, 212 through population-based strategies (see figure below). Most people served through individual strategies were 5 to 11 years of age or younger (33 percent), followed by 25- to 44-year-olds (22 percent) and 12- to 14-year-olds (19 percent). Most people served through population-based strategies were also reported to be 5 to 11 years of age or younger (29 percent), followed by 25- to 44-year-olds (28 percent) and 12- to 14-year-olds (15 percent).

Although the FFY 2011 SABG application reported that 100 percent of DMHAS programs were evidence based in FFY 2008, it appears that some of the strategies used by contractors to address unique population needs (i.e., LGBTQ, military families, and older adults) are not evidence-based primary prevention programs.

DMHAS uses the criteria outlined in the SAMHSA guidance document "Identifying and Selecting Evidence-Based Interventions" in addition to Federal registries, such as the National Registry of Evidence-based Programs and Practices (NREPP) and those maintained by the U.S. Department of Education and OJJDP, to compile a list of approved programs, curriculums, and strategies. The NREPP Web site, however, cautions that NREPP rates only the quality of the research supporting intervention outcomes and the quality and availability of training and implementation materials. The Web site specifically advises that "NREPP ratings do not reflect an intervention's effectiveness." The Web site goes on to state that "NREPP does not provide an exhaustive list of interventions or endorsements of specific interventions. Use of NREPP as an exhaustive list of interventions is not appropriate, since NREPP has not reviewed all interventions. Policymakers and funders in particular are discouraged from limiting contracted providers and/or potential grantees to selecting only among NREPP interventions. Review of interventions and their posting on the NREPP Web site do not constitute an endorsement, promotion, or approval of these interventions by NREPP or SAMHSA" (http://nrepp.samhsa.gov/AboutNREPP.aspx).

FFY 2008 New Jersey Persons Served by Age Population-and Individual-Based Programs and Strategies



Implementation—Other

Prevention Budget and Funding

DMHAS reported that its FFY 2008 prevention budget represented SABG funds of $12,603,566, SPF-SIG funds of $2,053,017, and general revenue funds of $3,065,998 for a total prevention budget of $17,722.581.

Overall, 17.3 percent of the State's reported prevention expenditures came from State funds in FFY 2008. The State planned to increase that proportion to 28.3 percent in its FFY 2011 plan of expenditures. This increase is in part due to a projected decrease in SABG expenditures for prevention, as well as an increase in allocations of State general funds.

New Jersey has an Alcohol, Education, Rehabilitation and Enforcement Fund (AEREF) that is not administered by the SSA but provides support for the substate infrastructure through which many of the SSA's services are delivered. The AEREF is a nonlapsing,

revolving fund from which the 21 counties receive annual allocations equaling 10.75 percent of the annual revenues from a tax on the sale of alcoholic beverages. Under this program, counties must match 25 percent of their respective annual AEREF allocation with a contribution of county revenues. The funds are used to plan and deliver comprehensive addiction services across the full continuum of care. Among these services are prevention, early intervention, treatment, and recovery support, including a full range of addiction services for indigent adult and adolescent county residents. Counties are required to allocate 10 percent of AEREF to prevention information and education programs.

The AEREF is the primary source of revenue distributed annually to the State's 21 counties for alcohol and drug abuse services. A current annual cap of $11 million is deposited into the fund from the alcohol beverage tax to support community-based services. Approximately $9 million of the capped funds are disbursed annually to the counties through contracts with DHS.

The Family and Health Services program in the Department of Health coordinates programs on FASD and child abuse, and also receives approximately $35 million to provide services to women assessed for alcohol use/abuse during pregnancy. The State's fiscal year 2013 budget recommends appropriating $570,000 from the AEREF to fund the FASD program.

Funding Allocation Processes

DMHAS awards SABG prevention funds through two main types of competitive contracts: community-based services and special projects. This approach has resulted in four main categories of prevention expenditures that are funded by the SSA through the SABG and other funds:

- Seventeen community-based regional prevention coalitions for the provision of prevention programs with a focus on environmental strategies
- More than 60 community-based prevention providers that offer a variety of evidence-based curriculums

STRENGTHS

- *DMHAS requires the use of the SPF planning model and evidence-based strategies.*
- *DMHAS has minimum qualifications for prevention staff funded by the SABG.*

CHALLENGES

- *As of FFY 2008, DMHAS appeared to be reaching a very small percentage of the population through its funded prevention strategies, which, if not addressed, could compromise future efforts to achieve significant population-level outcomes.*
- *Regional coalitions and program contracts do not always complement each other in the communities where they both exist.*

- Two State institutions of higher education for early intervention services
- Twenty-one county governments for the provision of services in four domains of the continuum of care.

The 17 regional coalitions were selected based on 2008 needs assessment data that included archival and social indicators and composite incidents of risks to estimate the need for prevention services among New Jersey's 21 counties. Criteria considered the population, substance abuse treatment admissions and rates within the region, and prevalence of alcohol and prescription drug misuse among middle and high school students. Each region has a minimum of one county and according to the latest available data, must have reported a minimum of 2,000 treatment admissions.

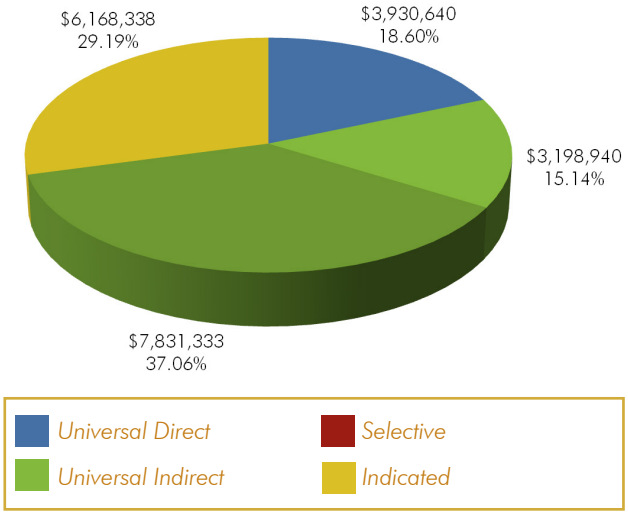
In addition to the categories listed above, DMHAS also noted the following major prevention initiatives in its FFY 2012 SABG report:

- Childhood Drinking Initiative, which funds the NJPN to coordinate the statewide Childhood Drinking Coalition
- SPF SIG, which funded 11 community programs

- Services to families of military veterans, which funds eight Family Assistance Centers at armories around the State
- Services to GLBTQ youth, which expanded existing programs for high-risk GLBTQ youth of color
- Culturally and linguistically competent prevention services, which funded development of new and enhancement of existing programs among DHS/DMHAS providers
- Stigma reduction, which funded education programs intended to reduce the stigma associated with substance abuse.

For FFY 2011, DMHAS reported that the primary population to be served by all prevention funds were selective populations (i.e., subsets of the total population that are considered to be at higher-than-average risk because of certain characteristics or inclusion in higher risk categories) at 37 percent (see chart below). This was followed closely by universal populations (i.e., populations selected without regard to individual risk, on the premise that all share the same general risk for being affected by or involved in the problems and consequences) at just under 34 percent. Twenty-nine percent of all allocations were targeted at indicated populations, or those that have been identified as exhibiting early warning signs of problems, such as experimentation with substance abuse or instances of intense use. DMHAS is encouraged to examine their allocation of SABG set-aside funds to ensure they support service delivery to populations in settings appropriate for primary prevention strategies.

FFY 2011 New Jersey Total Funds Intended Expenditures by IOM Strategies



As of FFY 2008, DMHAS appeared to be reaching a very small percentage of the population through its funded prevention strategies, which, if not addressed, could compromise future efforts to achieve significant population-level outcomes. As of 2010, the U.S. Census Bureau reported the State's population to be approximately 9 million residents. However, New Jersey reported serving just 64,226 persons through individual-based strategies and 148,212 through population-based strategies in FFY 2008 (forms P12a and P12b in the SABG application). This amounts to just 0.7 percent and 1.6 percent, respectively, of the State's entire population. As noted throughout this report, DMHAS has made significant shifts in allocation patterns since FFY 2008 to increase the reach and scope of prevention initiatives through community- and coalition-based approaches. As DMHAS continues with its strategic planning process, it might benefit from continuing to examine resource allocation processes across all funding streams to ensure that prevention funds are being equitably allocated to reduce health disparities and have adequate reach and scope to meet the prevention needs of all New Jersey residents.

Funding Requirements

DMHAS funds 17 regional coalitions and 56 evidence-based programs across all 21 counties.

Both types of competitive grants have requirements for a local needs assessment and the selection and implementation of evidence-based programs and strategies appropriate to address risk and protective factors to prevent or reduce alcohol and other substance abuse in individuals, families, and communities. However, during the system review, DMHAS staff noted that the regional coalitions and program contracts do not always complement each other in the communities where they both exist.

The RFP for Funding for Regional Coalitions to Utilize Environmental Strategies to Achieve Population-Level Change notes that all coalitions funded through the program are required to:

- Follow the five steps of the SPF in developing and implementing their project, including readiness, resource, and capacity/resource assessment
- Develop a strategic plan that articulates not only a vision for the prevention activities but also strategies for organizing and implementing [environmental] prevention efforts
- Establish strong collaborative relationships with any other prevention and/or public health-focused coalitions in the region
- Implement evidence-based environmental prevention programs, policies, and/or practices
- Include "logically connected and culturally competent" programs and strategies
- Implement environmental strategies
- Develop implementation plans to guide their work
- Develop an evaluation plan that has been developed in collaboration with the research and evaluation unit at DMHAS to assess community-level processes and outcomes
- Include cultural competency strategies
- Develop a plan for sustaining the strategies after DMHAS funds have been depleted
- Comply with DHS contracting rules and regulations.

DMHAS has requested TA from CSAP to assist in planning how to release funds in a way that will coordinate funded programs and environmental strategies in local areas.

Unique and Notable Accomplishment

- *DMHAS recently completed a new POMS module designed to collect implementation data on environmental prevention strategies.*

STRENGTHS

- *DMHAS has invested in prevention program evaluation to measure individual change through POMS.*

CHALLENGES

- *The current program evaluation instruments for measuring individual change do not fit well with the funded strategies.*

Evaluation

Subrecipient Evaluation

DMHAS conducts onsite visits to funded providers and uses a comprehensive monitoring tool to prepare site visit reports. The tool prompts reviewers to check on prevention specialist certification and other staff credentials, as well as the cultural diversity of the staff, and to review service targets, program manuals, plans, and reporting practices.

Each DMHAS program officer visits each contracted prevention provider for a minimum of one formal and one or two informal site visits per year. Additionally, each contracted provider submits a quarterly narrative program report that details program activity and progress made toward achieving the goals and deliverables outlined in its approved plan. This information is submitted in addition to the information submitted quarterly electronically through POMS.

DMHAS staff are aided in monitoring subrecipients by a Contract Reimbursement Manual and a Contract and Policy Information Manual. The manuals outline the terms that may be used to enforce all subrecipient or contractor funding awards, including requirements for interim cost reporting, audit, and internal controls.

In addition, most DMHAS-funded providers are required to use POMS to report information on services provided. DMHAS has invested in prevention program evaluation to measure individual change through POMS. However, during the system review, DMHAS staff indicated plans to modify this because the current program evaluation instruments for measuring individual change do not fit well with the funded strategies. POMS also collects data on

the number and demographics of people served by education and training activities for selective and indicated populations.

DMHAS recently completed a new POMS module designed to collect implementation data on environmental prevention strategies and plans to add modules designed to collect SPF implementation data and population outcome data using CSAP's SPF-SIG cross-site evaluation tool, Community-Level Instrument, in the coming months. The system review team considered this as a unique and notable practice. DMHAS has requested TA from CSAP to assist in identifying or developing evaluation instruments that are better aligned with funded programs.

Currently, DMHAS does not require a few funded providers who work with unique target populations (e.g., LGBTQ, military families, older adults) to use POMS. Instead, these contractors report and submit required data through quarterly reports. DMHAS then aggregates the data reported in POMS with the data reported in the quarterly reports in order to respond to CSAP NOMs requirements. During the system review, DMHAS indicated plans to enhance POMS so that all funded providers could report services directly into the database.

As noted previously, DMHAS initiated a contract with Rutgers University School of Social Work/Institute for Families in January 2012 to provide evaluation support to subrecipients. Types of support are the collection and analysis of epidemiological and social indicator data, the identification of baseline measures and intervening variables, GIS mapping, outcome evaluation, and other relevant areas of coalition and project evaluation.

State Evaluation

DMHAS does not currently have a State-level evaluation plan, but has requested CSAP TA to help it develop a statewide evaluation plan to monitor progress toward the outcomes identified in the DMHAS strategic plan once it is completed.

State Policies

Alcohol

DLPS's Division of Alcoholic Beverage Control (ABC) is responsible for enforcing State alcohol laws, investigating applications for State-issued alcoholic beverage licenses, and investigating all licensees for compliance with Alcoholic Beverage Control Laws and rules and regulations. There were 840 State-issued licenses and 60,500 permits for alcohol-related enterprises in SFY 2012. Appropriations for the regulation of alcoholic beverages will total approximately $7.4 million in 2013. Because of staffing reductions, DLPS now devotes investigative resources to addressing actual complaints instead of random inspection.

Both wholesale and retail alcohol sales are privatized in New Jersey, and alcohol sales laws are among the most complex in the country. On-premises licenses are allocated to towns based on population. The law allows for 1 license per 3,000 people. However, this allocation is dependent on whether the municipalities' existing licenses were grandfathered in or the town decides to allocate fewer licenses. The hours of sale for on-premises consumption are set not by the State but by local ordinance. New Jersey State law also provides that an on-premises establishment may, at the discretion of the owner, sell package goods of any type.

A municipal board or body administers issuance of certain licenses and may challenge the issuance of a State license. Municipalities may auction off licenses, and license fees go directly to the municipality.

At the State level, any person or corporation can hold only two licenses. Thus, with few exceptions, supermarkets, convenience stores, and gas stations rarely sell alcoholic beverages. Package sales are usually relegated to freestanding liquor stores, which often close at 10 p.m. even though they could remain open to sell beer and wine until all the bars in the same municipality close.

Municipalities may ban Sunday sales of all alcohol or may allow package sales of beer and wine. State law dictates that no hard liquor should be sold before 9 a.m. and after 10 p.m. any day of the week, and sales can be restricted further through local ordinance. However, retailers are specifically given the right to sell package beer and wine at any time on the premises; a municipality cannot set the hours for beer and wine package licenses differently than on-premises sales hours. Thus bars often sell packaged beer (and, more rarely, wine) until closing time. The only exceptions to this rule are Newark and Jersey City.

The minimum age for on- and off-premise sale of all alcoholic beverages is 18 years. New and renewing licensees and managers of establishments that sell alcohol for consumption off the premises are required to undergo server training. New Jersey also mandates beverage server training for persons serving alcohol on the premises. Rules for the server education course are established by the ABC Director.

Sales to persons under the age of 21 are prohibited. Clerks who sell to an underage person are subject to a disorderly persons charge, and the license is subject to administrative charges. Exceptions exist when the sale is made to an underage person who appeared to be of age and used a false identification.

Possession and consumption by a person under age 21 is banned, except in homes in the presence of a parent or for certain religious or medical purposes. Although parents may make alcohol available for their children to drink, making alcohol available for the purpose of minors' drinking is prohibited by anyone other than the parent of the specified minor. A social host is liable for damages caused by a person served only if the person was visibly intoxicated when served. The social host law does not include liability for damages to persons over the age of 21.

New Jersey has no keg registration laws. Possession of an unsealed container in a motor vehicle is presumption of consumption and is prohibited, with a $200 fine for violation. Minors who possess or consume alcohol in a motor vehicle may lose their driver's licenses for 6 months, or must wait an additional 6 months prior to obtaining a license.

For driving-under-the-influence first offenses, New Jersey law specifies slightly lower fines for an offender with a blood alcohol content between 0.08 and 0.10 than for one with a blood alcohol content greater than 0.10. For a driving-under-the-influence first offense in which the driver is under 21 and has a blood alcohol content between 0.01 and 0.08, the youth receives a 30- to 90-day license suspension, 30 to 60 days of community service, intoxicated driver education, and other penalties as determined by the court. Participation in the Intoxicated Driving Program is mandatory for license restoration. Intoxicated Driver Resource Centers develop treatment plans and report to the courts on client compliance. Violators may also be required to participate in a supervised visitation to a morgue, treatment facility, or trauma center to observe the consequences of alcoholism.

Alcohol vendors are required to post a notice approved by the ABC to warn patrons that alcohol consumption during pregnancy has been determined to be harmful to the fetus.

Other Drugs

In February 2009, the New Jersey Senate voted to legalize marijuana for medical use under the New Jersey Compassionate Use Medical Marijuana Act. Although the legislation was passed in 2010, the implementation process has been slow and dispensaries are not yet operational. More than 100 physicians have registered for participation in the program. Prior to this legislation, New Jersey had stringent laws on the manufacturing and possession of marijuana. There appears to be some interest in maintaining bans on synthetic marijuana products, however. On May 10, 2012, the New Jersey Division of Consumer Affairs in the Office of the Attorney General scheduled a hearing on regulation to make permanent New Jersey's comprehensive ban on synthetic marijuana.

It is a violation of New Jersey law if a person permits someone under the influence of a narcotic, hallucinogenic, or habit-producing drug to operate his or her vehicle, even if the vehicle owner is not under the influence.

New Jersey's Prescription Monitoring Program is run through DLP's Division of Consumer Affairs. The legislation was enacted in 2008, but the program was not operational until 2012. It is designed to monitor controlled substances in Schedules II, III, and IV, as well as human growth hormones. Data will be collected biweekly and made available to law enforcement.

ONDCP reports there were 19 drug courts in operation in New Jersey as of September 2011. Drug courts are the result of a cooperative initiative which began in 2002 between the Administrative Office of the Courts and the former DAS,. This agreement allowed the AOC to transfer treatment funding to DAS for offenders sentenced in superior court. Drug court participation is voluntary and clinically driven. GCADA reported that $24.5 million was expended on drug court treatment programs in SFY 2010.

Synar Program Development, Organization, Compliance, and Support

Synar Program Development and Organization

The New Jersey Department of Human Services, Division of Mental Health and Addiction Services (DMHAS) has primary oversight of the Synar program in New Jersey which includes pulling the Synar sample, analyzing data, and submitting the Annual Synar Report.

DMHAS has a memorandum of understanding (MOU) with the New Jersey Department of Health and Senior Services (DHSS), Public Health Service Branch Division of Family Health Services, Chronic Disease Prevention and Control Services, Office of Tobacco Control (OTC), TASE to conduct Synar inspections, enforcement, planning, and implementing support strategies such as merchant education. The MOU was written in 2004 when the New Jersey Division of Addiction Services (now DMHAS) was transferred from DHSS to the Department of Human Services. The MOU describes the organizational roles and responsibilities of both DMHAS and TASE; however it does not reflect the current reduction of services that has resulted from the drastic reduction in funding for OTC and TASE. The MOU has not been updated since 2004. It may benefit the State to revisit the MOU and update the document to reflect current agency names and programming expectations in light of the budget reductions.

OTC is responsible for general tobacco prevention program in the State. Along with housing the TASE program, OTC focuses on youth tobacco prevention, providing tobacco cessation support, decreasing exposure to environmental exposure to tobacco smoke, and reducing disparities related to tobacco use among different populations in New Jersey.

The New Jersey Chronic Disease Advisory Council is the State level advisory group for tobacco control programming and policy issues. In September 2011, the Advisory Council received a grant from the Centers for Disease Control and Prevention to integrate all chronic disease efforts including tobacco and nutrition. OTC is working with the council on transforming the definition of chronic disease in New Jersey by working to co-locate chronic disease services including nutrition and tobacco. They are also looking to include addiction as a chronic disease. Currently, New Jersey is looking to expand the steering committee to include representatives on substance abuse.

STRENGTHS

- *DMHAS and TASE have an MOU that outlines their roles and responsibilities for the Synar Program.*
- *The OTC mobilizes communities through partnerships, forming a statewide committee of tobacco advocates, including the ACS, NJ Breathes coalition, and other partners.*

CHALLENGES

- *DMHAS and TASE do not meet on a regular basis to share information and manage resources.*
- *The MOU between DMHAS and TASE has not been updated since 2004.*
- *Due to a reduction of State funds, TASE is operating with a minimum of services, so support strategies such as merchant education have been eliminated.*
- *DMHAS funds are limited to supporting the Synar coverage study.*

Description of Trends in the New Jersey Retailer Violation Rate and Other Tobacco Outcomes

With a retailer violation rate (RVR) of 10.2 percent (see table), New Jersey is in compliance with Synar regulatory requirements. New Jersey reported a baseline RVR of 44.4 percent in FFY 1997. In FFY 2003, the State achieved a rate below the

Retailer Violation Rates for Federal Fiscal Years 1997–2012 (in percent)																
	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Target	—	35	28	26	25	24	20	20	20	20	20	20	20	20	20	20
Reported	44.4	27	16.5	23.2	24.6	22.1	15.9	13	13.6	15.6	11.2	12.2	11.9	4.6	8.5	10.2

20 percent target (15.9 percent), and the rate has remained between 15 and 4.6 percent ever since. Since FFY 2010, it appears that the RVR is trending steadily upward. DMHAS and TASE would benefit from developing and implementing a plan that analyzes and addresses the factors contributing to this increase.

According to the National Survey on Drug Use and Health, the percentage of 12- to 17-year-olds in New Jersey that report using cigarettes in the last 30 days decreased between FFY 2002–2003 (12.2 percent) and FFY 2008–2009 (7.0 percent). The percentage of youth using tobacco products other than cigarettes has increased slightly between FFY 2002–2003 (3.7 percent) and FFY2008–09 (4.3 percent). The percent of youth who perceived moderate or great risk of harm from smoking one or more packs of cigarettes remained steady between FFY 2002–2003 (92.7 percent) and FFY 2008–2009 (93 percent).

CHALLENGES

- *New Jersey's RVR is on an upward trend. Neither TASE nor DMHAS have discussed a plan to address this trend.*

Summary of Synar Program

State Synar Program Compliance

Youth Access Law

TASE is responsible for enforcing the State's youth tobacco access law, which prohibits the sale or distribution of tobacco products to persons under the age of 19. New Jersey is one of four States that have increased the minimum age of sale of tobacco products from 18 to 19.

The youth tobacco access law provides graduated fines "for a person" who sells tobacco to minors; however, in practice, only store owners are cited. New Jersey has identified an interest in citing clerks as well and has requested information on how other States implement these citations.

Violations are assessed as civil penalties and begin at $250 for the first violation, $500 for a second violation and $1,000 for each subsequent violation. In addition, upon the recommendation of the municipality, following a hearing by the municipality, the Division of Taxation in the Department of the Treasury may suspend or, after a second or subsequent violation, revoke the license of a retail dealer. While several outlets have met the criteria for having a license suspended, it has been difficult to revoke licenses due to the layers of approval required to

Unique and Notable Accomplishment

In SFY 2005, New Jersey passed a law that changed the legal age to buy tobacco products from 18 to 19.

STRENGTHS

- *The State has a comprehensive youth tobacco access law that includes graduated penalties and warning sign requirements and allows for the revocation of tobacco licenses.*

CHALLENGES

- *Although New Jersey law allows for license revocation, this penalty is not enforced due to the layers of approval (including municipal level sign off) required.*
- *New Jersey law indicates that citations should be given to any person that sells tobacco to a minor. However, in practice only owners receive citations.*

implement this penalty. The State may benefit from collaborating with the Department of Taxation to address the implementation of tobacco retailer license suspension and revocation.

Licensing Law

A license and fee are required for each retail location. The Department of Treasury manages the licensing process, maintains the list of licensed outlets, and collects license fees. The license fee is $50 for each location and the license is required to be renewed annually. A significant strength of New Jersey's system is that $40 from each tobacco license is directed to the DHSS for youth tobacco access efforts.

Enforcement

Enforcement is always combined with the Synar survey. Due to funding cuts which began in FFY 2004, the number of inspections had been reduced from 8,500 Synar and non-Synar inspections to 491Synar inspections and re-inspections in FFY 2011. If an inspection results in a sale, the tobacco inspectors will file a complaint in the municipality in which the violation occurred and re-inspect the outlet within 90 days. The retailer then receives a summons from the municipal court, and a fine is ordered by the municipal judge. The summons may result in multiple fines, including the youth tobacco access fine as well as a fine for failure to display or re-new a license.

As reported in the FFY 2012 Annual Synar Report, New Jersey issued a total of 42 citations for violations of youth tobacco access laws in FFY 2011; 42 to store owners and 0 to salesclerks. Twenty-four fines were assessed; 24 to store owners and 0 to sales clerks. No licenses were suspended or revoked. Currently the revenue from fines is directed to the municipality in which the violation occurred and is not directed to youth tobacco access prevention activities.

TASE is dedicated to tobacco enforcement and despite funding cuts, the agency is actively looking for ways to sustain the State's enforcement program. The State may benefit from exploring opportunities to leverage fines from youth access violations to be used for youth tobacco access enforcement and education.

STRENGTHS

- *There is no warning process in New Jersey, which means that store owners are fined on the first offense.*
- *TASE re-inspects any outlet from the Synar survey that violates the youth tobacco access law within 90 days of the first violation.*
- *TASE continues to actively seek funds to sustain and expand tobacco inspections.*

CHALLENGES

- *Due to major reductions in funding, New Jersey has reduced the total number of inspections from 8,500 Synar and non-Synar inspections in FFY 2004 to 491Synar inspections and re-inspections in FFY2011.*
- *The revenues from fines are directed to the municipality in which the violation occurred and are not directed to youth tobacco access enforcement.*
- *Although New Jersey allows for license revocations, this penalty is not enforced due to layers of approval, including the required municipal level signatures.*

OTC is also the agency that holds the Food and Drug Administration (FDA) contract for retail tobacco inspections. The Synar and FDA programs are run separately to ensure there is no duplication of retail inspections or confusion due to inspection protocol differences.

Random, Unannounced Inspections and Valid Probability Sample

New Jersey uses a list frame as the basis of the Synar survey. The list frame is based on the Licensed Tobacco Retailer list maintained by the Treasury Department, and included 11,842 outlets in FFY 2012. The list is updated annually based on license renewal forms. Each year, DMHAS provides TASE with corrections to the list to provide to Treasury, but the list that TASE receives the following year may not reflect the most current information. Comparing the license list to corrections made the previous year is difficult and time consuming for DMHAS staff.

CHALLENGES

- *The license list provided by the Department of Treasury contains inaccurate information that is not regularly corrected based on information TASE finds in the field, which allows the inaccurate information to perpetuate from year to year.*

DMHAS draws the Synar sample from the Licensed Tobacco Retailer list. New Jersey uses a stratified simple random sample design. New Jersey has three defined strata based on the distribution of outlets throughout the State. The 21 New Jersey counties are stratified into three groups based on the proportion of outlets in that county divided by the total number of outlets in the State. Stratum 1 is defined as counties with 6 percent of the outlets in the State or less; Stratum 2 is defined as counties with 6 to 10 percent of the outlets in the State; and Stratum 3 is defined as counties that have more than 10 percent of the State's outlets. The sampling design described onsite matches Appendix B of the Annual Synar Report.

Because New Jersey uses a list frame, they are required to conduct a coverage study. The last coverage study was conducted in calendar year 2010 using a simple random sample design. Areas were defined as all of the census tracts in the State, based on the 2000 census. Nineteen areas were randomly sampled and canvassed, and 132 outlets were located. Of those outlets, 116 were matched to the Synar list frame, resulting in a coverage rate of 87.9 percent. The State is planning to conduct their next coverage study in calendar year 2013.

Synar inspections are conducted July 1–September 30. DMHAS provides the Synar sample to OTC, and then OTC distributes the sample list proportionally to the four adult inspectors who arrange Synar inspections with youth inspectors.

The TASE adult inspectors are trained by the OTC Program Coordinator and staff and follow the guidelines of the New Jersey Guidelines for Prohibiting the Sale of Tobacco Products to Minors training manual developed by TASE. This training manual provides specific training information on how to conduct proper inspections. Adult TASE inspectors train the youth inspectors, utilizing the training manuals noted above.

The inspection team consists of one adult inspector and one youth inspector. Youth are recruited from schools, community centers and faith-based organizations, and must be between 16 and 18 years of age.

New Jersey requires that a current dated photograph of each youth inspector be kept on file with a copy of his or her birth certificate and signed parental consent. The safety of the youth inspector is important at all times. In the event that either the youth inspector or adult supervisor perceive or suspect a possible threat, danger or harm, the adult supervisor is authorized to postpone or cancel the inspection.

The adult inspector provides transportation for the youth inspector to and from the selected sites. While in the vehicle, the adult and youth inspector discuss the strategy for the site they are about to enter. The adult inspector enters the site first, posing as a normal shopper in view of where the tobacco products are sold. The youth inspector enters later. After the attempt to buy a tobacco product, the youth leaves the premises and the adult inspector follows after him or her. The adult inspector writes up a notice of inspection and returns to the site to introduce himself as a TASE employee and asks to speak to the manager. The inspector provides the manager the notice of inspection and provides merchant education material.

The inspection protocol as described onsite is consistent with the description provided in Appendix C of the Annual Synar Report.

TASE uses scannable forms to collect their Synar inspection data. Once scanned, the data and inspection forms are provided to DMHAS for data analysis and importing into the Synar Survey Estimation System (SSES) Data Entry Template. DMHAS runs SSES software to develop the tables for the Annual Synar Report.

Members of the system review team pulled a random sample (10 percent) of the completed inspection sheets and reviewed them for completeness and then compared them with the SSES raw data submitted in the FFY 2012 Annual Synar Report to verify data accuracy. The review yielded no errors.

Members of the system review team observed five Synar inspections. No sales were made during these inspections. All five observed inspections followed the approved protocol.

Retailer Violation Rate

In FFY2012, New Jersey reported a retailer violation rate of 10.2 percent with a standard error of 1.5 percent which is below the SAMHSA target rate. As noted above, the RVR is steadily increasing and the State may benefit from developing a plan to address the increase.

CHALLENGES

- *The RVR has been increasing over the last 3 years.*

Reporting

The Annual Synar Report was completed and submitted on time on December 1, 2012 and was made available for public comment before submission to SAMHSA, as required, through the State of New Jersey's Web site: http://www.state.nj.us/humanservices/providers/grants/public.

State Synar Program Support

Synar Budget and Funding

New Jersey plans to spend $486,070 on the Synar program and support strategies in FFY 2012. Of those funds, only $11,070 are SABG funds, which are spent on data analysis and sampling. The remaining funds are State funds generated from license fees. Of that amount, $274,083 was spent on staffing and management; $50,000 on inspections; $90,000 on community education and support; and $60,917 in other expenditures. Currently, the State uses $40 of every $50 license fee for youth tobacco access activities. TASE is currently exploring ways to increase the license fee, which would provide additional revenue for the program.

As a result of the elimination of the $7.1 million State excise tax appropriation for OTC from the New Jersey SFY 2011 budget, all State-funded tobacco control programs were terminated as of July 1, 2010. The elimination of the excise tax appropriation is still in effect for SFY 2012. Enforcement efforts are not funded using SABG funds, but are funded through revenue produced through license fees.

Strategic Planning

New Jersey has developed a DHSS agency-wide strategic plan for tobacco prevention and control called the "Strategic Plan 2008–2013." This plan was developed by OTC. The plan does not include a discussion of youth tobacco access goals or strategies. It was noted during the review that the State may benefit from bringing together its Synar partners and developing a strategic plan that includes Synar, and that the Chronic Disease State Plan, a plan currently in development and lead by the Department of Family Services, may provide an opportunity for coordinated planning and information sharing.

Unique and Notable Accomplishment

- *New Jersey uses $40 of every $50 license fee for youth tobacco access efforts.*

STRENGTHS

- *State statute requires that TASE receives part of the tobacco license fee from each outlet.*
- *In order to expand the available funds for youth tobacco access activities, TASE is exploring ways to increase licensing fees or use tobacco-related fines as additional revenue streams.*

CHALLENGES

- *Due to budget cuts that began in FFY 2004 and have continued into FFY 2011, all State-funded tobacco control program were terminated as of July 1, 2010.*

STRENGTHS

- *The State is planning to incorporate youth tobacco access goals and outcomes from the current tobacco plan into the chronic disease 5-year plan, which would link the two plans together.*

CHALLENGES

- *The State Tobacco Strategic Plan is not yet completed.*
- *Although a significant amount of data on compliance check inspections is collected, it is not used to improve or inform program direction.*

TASE collects a great deal of information during the inspection process including the type of outlet that was inspected (e.g., grocery store, gas station) and clerk characteristics. Currently, TASE does not have the staff time or funding to use this information for planning, identifying areas where RVRs are high, and evaluating current efforts. It would benefit the State to utilize this data in a strategic way to best target the TASE's efforts.

Policy Development and Education

The State has a relationship with the New Jersey Global Advisors on Smoke-free Policy (GASP), which is a non-profit organization devoted to smoke-free air policies in New Jersey. GASP is spearheading efforts to expand smoke-free policies and to advocate for policies that would support OTC and TASE including increasing license fees, and directing revenue from youth tobacco access and licensing violations to OTC and TASE. GASP also tracks tobacco policies that are passed at the municipal level. During the review it was noted that currently there is little political support for these expanded smoke-free air policy proposals or increases to the licensing fee.

TASE and DMHAS are working toward the adoption of smoke-free policies that extend beyond the clean indoor air policies to include smoke-free hospital campuses and smoke-free residential treatment facilities.

STRENGTHS

- *Both TASE and DMHAS are working toward the adoption of smoke-free policies that extend beyond the clean indoor air policies to include smoke-free hospital campuses and smoke-free residential treatment facilities.*
- *GASP identifies the number of local municipalities that have passed ordinances related to tobacco use and youth tobacco access that are stricter than State law.*

CHALLENGES

- *Although both TASE and DMHAS are working toward the same goal of smoke-free hospital campuses and smoke-free residential treatment facilities, there has been no coordination, sharing of information or data to coordinate these efforts.*

State Youth Tobacco Access Support Strategies

Because of the budget cuts to the OTC that houses TASE, starting in New Jersey SFY 2011, the TASE program only conducted the mandated Synar inspections and re-inspections of outlets that violated during the Synar inspection. As a consequence of the budget cut, all of the TASE-funded support strategies including merchant education, training, and media, were eliminated. For this FFY reporting year, merchant education was only provided by adult and youth inspectors and student associations while conducting inspections. TASE still has a few copies of materials from previous years in English and Spanish, but will not be printing additional copies.

OTC is still working on community mobilization strategies around general tobacco prevention through partnerships, forming a statewide committee of tobacco advocates, including the American Cancer Society (ACS), New Jersey Breathes coalition, and other partners. The OTC works closely with the New Jersey Tobacco Advisory Council and has a grant with Princeton Leadership to continue to involve more schools in the Comprehensive Tobacco-Free School Policy program. The identified schools involved in the program receive training and technical assistance regarding the rationale for

preventing the initiation of first use through social norming and adopting a comprehensive policy.

A media campaign that addresses youth access to tobacco products was not conducted due to budget constraints. There has also been limited efforts to develop new media addressing general tobacco prevention because the New York and Pennsylvania media markets overlap with most of the New Jersey market, so most of the residents are already impacted by media campaigns sourced in those States. OTC is able to supplement those media spots with a limited radio presence. DHSS is able to maintain the TASE Web site and capitalize on earned media opportunities.

STRENGTHS

- *Current merchant education materials are available in Spanish and English, although quantities are limited.*

CHALLENGES

- *TASE does not have any funds to conduct merchant education training or to purchase or reprint merchant education materials.*
- *The State no longer has any media communication strategies in place and relies on some earned media and advertising out of New York and Philadelphia that targets parts of the State.*

Appendix A

System Review Analysis

New Jersey Substance Abuse Prevention and Synar System Review Recommendations

May 1–3, 2012

Prevention Recomendations

Prevention System Organization and Implementation

	Potential Enhancements	SSA Resources To Be Used	Will Request TA From CSAP	State Information Request
1	**Establish a conceptual framework for primary prevention services in New Jersey.** DMHAS might develop a conceptual framework for prevention that can consistently guide SABG funded primary prevention services within an integrated behavioral health system. The framework should include a written definition for primary prevention that can clearly distinguish activities intended to prevent or delay onset of substance abuse from those that are intended for early intervention, treatment, or relapse prevention purposes.			
2	**Analyze substate infrastructure to clarify roles, improve coordination, and maximize efforts.** New Jersey may need to expand coordination efforts carried out under Prevention Unification to include an analysis of existing and evolving infrastructure (e.g., county directors, LACADAs, municipal alliances, regional coalitions) and to clarify roles and identify where efforts can be coordinated to minimize duplication and maximize resources.			
3	**Review State blueprints for healthcare reform.** During the system review, DMHAS expressed interest in developing a blueprint for healthcare reform and requested CSAP's assistance in identifying how other States have positioned prevention within the healthcare reform model.			

Needs Assessment

Potential Enhancements		SSA Resources To Be Used	Will Request TA From CSAP	State Information Request
4	**Ensure that State data are readily available and easily understood.** DMHAS might want to examine its packaging and distribution of State-level data to ensure that the data are presented in a manner that is easily understood and readily available by the entities carrying out local planning efforts.			
5	**Identify data collection strategies for heroin and other opiate use and those factors contributing to use rates within New Jersey.** DMHAS staff indicated during the system review that the Governor has expressed interest in analyzing the current behavioral health system to identify ways to improve services to address heroin and opiate use. The SSA also identified the challenge in understanding the magnitude of heroin and other opiate use within the State and requested TA from CSAP in identifying data collection strategies specific to these substances.			

Workforce Development and Capacity Building

Potential Enhancements		SSA Resources To Be Used	Will Request TA From CSAP	State Information Request
6	**Define the core competencies needed to address substance abuse trends and conditions in New Jersey.** DMHAS ability to build the capacity of its workforce to achieve prevention outcomes would be significantly enhanced by the identification of the core prevention competencies, beyond IC&RC, needed to address specific substance abuse trends and conditions in New Jersey.			
7	**Assess and address the needs of the substance abuse prevention workforce.** DMHAS efforts to build the capacity of the prevention workforce to succeed within an integrated behavioral health environment and use quantitative data and performance management processes to achieve targeted prevention outcomes would likely benefit from a formal assessment of prevention workforce needs. Assessment data could then be used to develop a workforce development plan with goals, objectives, and measurable outcomes for workforce recruitment, training, and retention. As a starting point, DMHAS might consider reviewing a range of workforce assessment tools and plans developed by other States to determine the most relevant components for New Jersey.			
8	**Enhance prevention providers' understanding of why and how to use quantitative data.** DMHAS and partners may need to focus on building the skills of the SABG-funded prevention providers in using data for planning so that providers understand why and how to use quantitative data.			
9	**Expand the definition of workforce to include members who contribute to the achievement of substance abuse outcomes.** DMHAS might consider the benefits of broadening its definition of the prevention workforce beyond just SABG subrecipients. Because comprehensive prevention requires coordinated efforts across sectors—particularly with regard to complex emerging issues such as heroin and other opiate abuse—an expanded definition could help DMHAS, its contractors, and its partners to identify where and how T/TA could be further leveraged to most effectively meet collective workforce needs.			

Strategic Plan

	Potential Enhancements	SSA Resources To Be Used	Will Request TA From CSAP	State Information Request
10	**Finalize logic models to enhance State's ability to achieve documentable outcomes.** New Jersey's ability to achieve documentable outcomes in reduced substance abuse problems and consequences would be enhanced by finalizing New Jersey's logic models. These logic models could enhance the State's ability to strategically allocate resources to achieve outcomes by establishing: ■ Clear goals related to priority substance abuse behaviors and related problems and consequences ■ Specific objectives related to key intervening variables and causal conditions that are logically linked to priority substance abuse behaviors and related problems and consequences ■ Targeted outcomes that represent quantifiable progress over time in achieving desired goals and objectives. ■ An evaluation plan sufficient to monitor progress toward outcomes and provide information for midcourse adjustments as needed.			

Implementation

SABG Compliance

DMHAS is in compliance with the SABG primary prevention 20-percent set-aside.

DMHAS is in compliance with the SABG primary prevention expenditures reported by the six CSAP prevention strategies and Institute of Medicine classifications.

DMHAS is in compliance with NOMs data reporting.

DMHAS is in compliance with the requirement to providing public review and comment on the SABG application.

Potential Enhancements	SSA Resources To Be Used	Will Request TA From CSAP	State Information Request
None noted.			

Other Implementation

	Potential Enhancements	SSA Resources To Be Used	Will Request TA From CSAP	State Information Request
11	**Analyze funding allocation processes across all prevention funding streams.** As DMHAS continues with its strategic planning process, it might benefit from continuing to examine resource allocation processes across all funding streams to ensure that prevention funds are being equitably allocated to reduce health disparities and have adequate reach and scope to meet the prevention needs of all New Jersey residents.			
12	**Coordinate program and coalition resources.** DMHAS has requested TA to assist in planning how to release funds in a way that will coordinate funded programs and environmental strategies in local areas.			
13	**Ensure SABG set-aside funds are devoted to primary prevention.** DMHAS is encouraged to examine their allocation of SABG set-aside funds to ensure they support service delivery to populations in settings appropriate for primary prevention strategies.			

Evaluation

	Potential Enhancements	SSA Resources To Be Used	Will Request TA From CSAP	State Information Request
14	**Develop evaluation tools better aligned with funded strategies.** DMHAS has requested TA to assist in identifying or developing evaluation instruments that are better aligned with funded programs.			
15	**Develop an evaluation plan.** DMHAS does not currently have a State-level evaluation plan but has requested CSAP TA to help it develop a statewide evaluation plan to monitor progress toward the outcomes identified in the DMHAS strategic plan once it is completed (see Potential Enhancement 9).			

Synar Analysis

Synar Program Development and Organization

State Synar Program Organization

	Potential Enhancements	SSA Resources To Be Used	Will Request TA From CSAP	State Information Request
1	The State may benefit from regular communication and meeting time between the SSA and TASE to coordinate tobacco efforts, resources, and information.			
2	DMHAS and TASE may benefit from revisiting their MOU agreement and updating it to reflect current roles and responsibilities that may have changed due to the reduction in funding.			

NOMs and RVR Trends

	Potential Enhancements	SSA Resources To Be Used	Will Request TA From CSAP	State Information Request
3	DMHAS and TASE would benefit from developing and implementing a plan that analyzes and addresses the factors contributing to the increase in the RVR.			

State Synar Program Compliance

State Law

Required Followup Action

None noted.

	Potential Enhancements	SSA Resources To Be Used	Will Request TA From CSAP	State Information Request
4	The State may benefit from collaborating with the Department of Treasury to address the implementation of tobacco license suspension and revocation protocols.			
5	The State identified that it is interested in examples of other States that issue citations to clerks.			

Enforcement

Required Followup Action

None noted.

	Potential Enhancements	SSA Resources To Be Used	Will Request TA From CSAP	State Information Request
6	The State may benefit from exploring opportunities to leverage the fines for youth tobacco access violations to be used for youth tobacco access enforcement and merchant education.			

Random, Unannounced Inspections and Valid Probability Sample

Required Followup Action

None noted.

	Potential Enhancements	SSA Resources To Be Used	Will Request TA From CSAP	State Information Request
6	The State may benefit from exploring ways to strengthen the partnership between the Department of Treasury and TASE to improve the quality of the license list.			

Retailer Violation Rate

Required Followup Action

None noted.

Potential Enhancements	SSA Resources To Be Used	Will Request TA From CSAP	State Information Request
None noted.			

Annual Synar Report

Required Followup Action

None noted.

Potential Enhancements	SSA Resources To Be Used	Will Request TA From CSAP	State Information Request
None noted.			

Synar Program Support

State Synar Budget and Funding

	Potential Enhancements	SSA Resources To Be Used	Will Request TA From CSAP	State Information Request
8	The State may benefit from developing a sustainability plan for youth tobacco access programming. This plan should extend beyond TASE to include DMHAS and other stakeholder agencies that TASE supports.			

State/SSA Strategic Plan for Youth Tobacco Access Prevention

	Potential Enhancements	SSA Resources To Be Used	Will Request TA From CSAP	State Information Request
9	The State may benefit from developing a statewide multiagency plan on tobacco issues that includes youth access implementation that could connect DMHAS and TASE.			
10	The State may benefit from utilizing analyzed data collected on compliance check inspections to inform merchant education and to sustain program efforts.			

State Synar Program Policy Development and Education

	Potential Enhancements	SSA Resources To Be Used	Will Request TA From CSAP	State Information Request
11	The State may benefit from improving communication and coordination between DMHAS and DHSS regarding tobacco policy, enforcement, and Synar efforts.			

State Youth Tobacco Access Support Strategies

	Potential Enhancements	SSA Resources To Be Used	Will Request TA From CSAP	State Information Request
12	TASE could establish strategic partnerships to offset the minimal costs associated with the production of merchant education materials.			
13	TASE may benefit from expanding its merchant education materials to include other languages.			
14	TASE may benefit from adapting merchant education material from other States as a way to expand their merchant education materials.			
15	TASE could explore ways to re-involve State and local partners in merchant education and other support strategies that have had their roles reduced due to budget cuts.			

Appendix B

Participant List From the System Review

Name	Title	Organization
State Participants		
Barbara Adolphe	Executive Director	Center for Prevention and Counseling
Rebecca Alfaro	Executive Director	Governor's Council on Alcoholism and Drug Abuse
Roger Borichewski	Assistant Director	Division of Mental Health and Addiction Services, New Jersey Department of Human Services
Suzanne Borys	Assistant Director Planning, Research and Evaluation	Division of Mental Health and Addiction Services, New Jersey Department of Human Services
Doug Bratton	Executive Director	Partners In Prevention (NCADD Hudson)
Pamela Capaci	Executive Director	Prevention Links
Darren Clark	TASE Program Officer, Office of Tobacco Control	Chronic Disease Prevention and Control Services, Division of Family Health Services, New Jersey Department of Health and Senior Services
Angelo Conover	Media Director	Partnership for a Drug-Free New Jersey
Kimberly Cremer	Program Management Officer	Division of Mental Health and Addiction Services, New Jersey Department of Human Services
Robert Culleton	Research Scientist	Division of Mental Health and Addiction Services, New Jersey Department of Human Services
Russel Dunnings	NJ Statewide FDA Project Coordinator	Princeton Center for Leadership Training
Kate Faldetta	Associate Director	Cape Assist
Lesley Gabel	Safe Communities Coalition Project Director	Hunterdon Prevention Resources
Christopher Goeke	Executive Director	Morris County Prevention is Key
Bob Goldschlag	Director, DART Coalition	Barnabas Health Institute For Prevention
Aunsha Hall		The North Jersey Community Research Initiative
Donald Hallcom	Director, Prevention and Early Intervention Services	Division of Mental Health and Addiction Services, New Jersey Department of Human Services
Barry Hantman	Program Management Officer	Division of Mental Health and Addiction Services, New Jersey Department of Human Services
Laura Hernandez-Paine	Acting Service Director/Program Manager	Chronic Disease Prevention and Control Services, Division of Family Health Services, New Jersey Department of Health and Senior Services

Name	Title	Organization
State Participants		
Nashon Hornsby, Esq.	Administrative Director	Division of Family Health Services, New Jersey Department of Health Services
Naomi Hubbard		Camden County Council on Alcoholism & Drug Abuse, Inc.
Lynn Kovich	Assistant Commissioner	Division of Mental Health and Addiction Services, New Jersey Department of Human Services
Diane Litterer	Executive Director	New Jersey Prevention Network
Janis Mayer	Program Coordinator, Office of Tobacco Control	Chronic Disease Prevention and Control Services, Division of Family Health Services, New Jersey Department of Health and Senior Services
Raquel Mazon-Jeffers	Deputy Director	Division of Mental Health and Addiction Services, New Jersey Department of Human Services
Brian Moss	Deputy CFO/Fiscal Administrator	Division of Mental Health and Addiction Services, New Jersey Department of Human Services
Patrick Mulvenna	TASE Tobacco Inspector, Office of Tobacco Control	Division of Family Health Services, New Jersey Department of Health and Senior Services
N. Andrew Peterson, Ph.D.	Associate Professor	Rutgers University, School of Social Work
Gloria M. Rodriguez	Assistant Commisioner	Division of Family Health Services, New Jersey Department of Health and Senior Services
John Rountree	Section Supervisor, Fiscal Services Unit	Division of Mental Health and Addiction Services, New Jersey Department of Human Services
Carson Sand	Student Associate (Synar), Office of Tobacco Control	Division of Family Health Services, New Jersey Department of Health and Senior Services
Glen Sherman		Office of the Vice President for Student Affairs, William Patterson University
Dona Sinton	Block Grant/Synar Coordinator	Division of Mental Health and Addiction Services, New Jersey Department of Human Services
Donald Starn		Prevention Plus of Burlington County
Joel Torres	Essex Prevention Coalition Coordinator	Family Connections, Inc.
Gary L. Vermeire	Coordinator, Safe and Drug-Free Schools Unit	Office of Student Support Services, Division of Programs and Operations, New Jersey Department of Education
Limei Zhu	Research Scientist	Division of Mental Health and Addiction Services, New Jersey Department of Human Services

Name	Title	Organization
CSAP Team		
Andrea M. Harris, M.S., LCADC, CPP	Public Health Advisor	Division of State Programs, Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration
Michael Weaver	Public Health Advisor	Division of State Programs, Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration
Mary Ellen Shannon	Regional Services Manager	Strategic Prevention Framework Advancement and Support Project
Patty Martin	Prevention Specialist	Strategic Prevention Framework Advancement and Support Project

Appendix C

Sources of Information Reviewed

The following tables list the sources of information consulted during the system review process for the New Jersey prevention system and Synar program (e.g., reports, Web sites, State documents).

Sources of Prevention Information	
New Jersey FFY 2011 SABG Application	New Jersey FFY 2012 Substance Abuse Prevention and Treatment Block Grant, pending CSAP approval
New Jersey 2012 Combined Behavioral Health Assessment and Plan, pending approval	New Jersey Substance Abuse Prevention and Synar System Review Report, August 4–6, 2009
Substance Abuse Prevention and Synar System Review Report, FFY 2006	State Contacts Directory Page in *e-Prevention*
New Jersey State and County *QuickFacts*	New Jersey State of Profile of Drug Indicators
New Jersey State Profile of Underage Drinking	New Jersey States In Brief Substance Abuse and Mental Health Issues At-A-Glance
New Jersey Adolescent Behavioral Health In Brief	Grant Awards by State Summaries FY 2011
Governor Christopher Christie, National Governors Association, Governor's Information	The Geography of New Jersey
New Jersey FDIC State Profile	New Jersey Permanent Statutes
Organizational Charts (5)	Standards for Agencies Providing Substance Abuse Prevention Services for the DMHAS
New Jersey DHS–DMHAS Substance Abuse Prevention Strategic Plan	Charter
State Epidemiological Outcomes Workgroup Membership List and Minutes of Meetings	DRAFT Healthy New Jersey 2020 Objectives
New Jersey 2010 Updated Statewide Master Plan	Active Contract Ceiling Prevention Contracts Report
Measurement Items for Domain-Based Outcomes	NJ DHS-DAS/OPEI Formal Site Visit Report
Contract between the State of New Jersey DHS and _____ Contract Number #11-xxx-ADA-0	NJ-SAMS Pre-Admission Module (PAMS)
NJ-SAMS DAS Income and Initiative Eligibility Module	2010 Estimates of Met and Unmet Demand for Adult Population in New Jersey
The NJSAMS Report Heroin Admissions to Substance Abuse Treatment in New Jersey	Prevention Outcome Management System New Jersey POMs-NJ and Environmental Add-on Module
New Jersey Substance Abuse Monitoring System Description	NJ Detailed County Report # Served by Age and # Served by Race/Ethnicity
NJ DHS DAS Office of Prevention Services Quarterly Contract Progress Report	New Jersey DHS DMHAS Substance Abuse Treatment Provider Performance Report
New Jersey Service by Domain, Strategy & Curriculum	Evidence-based Prevention Curricula
DMHAS Stakeholder Meeting September 22, 2011	Formal Site Visit Report
Standards for Agencies Providing Substance Abuse Prevention Service for the DMHAS	2010 New Jersey Middle School Risk and Protective Factor Survey
Title 26 26:2BB-4 Governor's Council	RFP: Funding for Regional Coalitions to Utilize Environmental Strategies to Achieve Population-Level Change
RFP Funding for Training, Technical Assistance, and Evaluation Support for Regional Prevention Coalitions	New Jersey State Epidemiological Profile for Substance Abuse 2008

Sources of Prevention Information	
Resource Guide for Military, Veterans & Families	Web page for Statistical Reports 2010 Substance Abuse Overview http://www.nj.gov/humanservices/das/news/reports/statistical
Epidemiological Reports–County Chartbook of Social Indicators Web page http://www.state.nj.us/humanservices/das/news/ reports/epidemiological/	DMHAS Prevention Unit Staffing Profile
Contract Requirements Cultural Competence DMHAS-Funded Prevention Contractees	Workforce Development Activities
New Jersey Prevention Unification Process	Funding Priorities–Identification of regions for regional coalitions
Navigating the Process of Becoming a Certified Prevention Specialist	Prevention Presentation to CSAP at the New Jersey System Review, May 1–3, 2012
Prevention Outcomes Management System New Jersey System, May 1–3, 2012	

Sources of Synar Information	
New Jersey Annual Synar Report FFY 2012	Synar Survey Sampling Plan and Inspection Protocol Review Form, Final and Initial Versions
SSES Tables 1–4	New Jersey Substance Abuse and Synar System Review Report, August 4–6, 2009
New Jersey Substance Abuse and Synar System Review Report, FFY 2006	New Jersey Synar System Assessment Report, February 25–27, 2003
Technical Assistance Reports (1)	Sections from the 2011 SABG and Tables 6,7, and 8 from the 2012 Behavioral Health Plan and Assessment (pending approval as of 4/12/2012)
NJ-S-10-30-03	New Jersey SSA Directory State Contacts
New Jersey SLATI State Information	Consent for Youth Inspectors
Compliance Check Inspection Report	Dear Parent or Guardian letter recruiting youth inspectors
2.9 Synar Program/Partnerships NJTAC Committee Contact Information, Shaping NJ Statewide Partners, New Jersey Chronic Disease Advisory Council	Directory of Local Health Departments in New Jersey (2.9 Synar Program and Partnerships)
Division of Family Health Services, Chronic Disease Prevention & Control Services, Organizational Chart	Tobacco Age of Sale Enforcement (TASE): A Joint Program Between State and Local Health Officials and the Merchant Community Training and Protocol Manual
TASE Year 2011–2012	Office of Tobacco Control Grantee Contact Information
FDA Contract with State of New Jersey	Strategic Plan 2008–2013
Appendix D: List Sampling Frame Coverage Study (2011)	Law Enforcement Training Materials (TASE Manual)
TASE Notice of Inspection Results Form	Memorandum of Understanding Between DHS and DHSS
DHSS/TASE Merchant Education Materials (Employee Agreement and Checklist and other material)	New Jersey Department of Health and Senior Services, Office of Tobacco Control, Synar Presentation to CSAP at the New Jersey System Review, May 1–3, 2012

Appendix D

Summary of New Jersey's Estimated FFY 2011 and Planned FFY 2012 Prevention and Synar Budgets

Estimated FFY 2011 and Planned FFY 2012 Prevention Budgets by Program Area and Revenue Source and Amount

Estimated FFY 2011 Prevention Budget

New Jersey Department of Human Services, Division of Mental Health and Addiction Services, Prevention Budget					
	Revenue Source and Amount				
Program Area	SABG	Percentage of SABG	Federal (Other)	State	Total
College Students	$548,067	1.17%	0	0	$548,067
Environmental	1,908,576	4.09%	0	$1,030,000	2,938,576
Older Adults	405,641	0.87%	0	0	405,641
Public Information	2,194,055	4.70%	0	2,016,938	4,210,993
Service for GLBTQ Youth	225,000	0.48%	0	0	225,000
Services for Children & Adolescents	2,417,599	5.18%	0	0	2,417,599
Services for Disabled	162,105	0.35%	0	0	162,105
Services for Families & Children	2,577,022	5.52%	0	0	2,577,022
Services for Veterans	325,000	0.70%	0	0	325,000
Training – Technical Assistance	200,000	0.43%	0	0	200,000
Total	$10,963,065	23.48%	0	$3,046,938	$14,010,003

Planned FFY 2012 Prevention Budget

Program Area	Revenue Source and Amount				
	SABG	Percentage of SABG	Federal (Other)	State	Total
College Students	$548,067	1.17%	0	0	$548,067
Environmental	2,841,441	6.09%	0	$515,000	3,356,441
Environmental SPF	0	0	$1,684,381	0	1,684,381
Older Adults	365,476	0.78%	0	0	365,476
Public Information	536,121	1.15%	0	2,136,238	2,672,359
Service for GLBTQ Youth	225,000	0.48%	0	0	225,000
Services for Children & Adolescents	2,755,599	5.90%	0	0	2,755,599
Services for Disabled	162,105	0.35%	0	0	162,105
Services for Families & Children	2,532,588	5.42%	0	0	2,532,588
Services for Veterans	325,000	0.70%	0	0	325,000
Training – Technical Assistance	450,000	0.96%	0	0	450,000
Total	$10,741,397	23.01%	$1,684,381	$2,651,238	$15,077,016

Estimated FFY 2011 and Planned FFY 2012 Synar Budgets by Synar Category, Responsible Agency, and Revenue Source and Amount

Estimated FFY 2011 Synar Budget

Synar Category	Respon-sible Agency	Revenue Source and Amount								Total
		State Funds	Licensing Fees	Fines	SABG	Founda-tions	Retailer Associa-tions	Tobacco Industry or Settlement	Other	
Management/ Staffing	TASE	$274,083								$274,083
Sample Design	DMHAS				$7,548					7,548
Coverage Study	DMHAS				5,032					5,032
Inspections	TASE	44,287								44,287
Merchant Education	TASE									
Training	TASE									
Community Education & Support	TASE	94,000								94,000
Data Analysis To Determine RVR	DMHAS				3,522					3,522
Enforcement	TASE									
Other (please describe)	TASE	57,630								57,630
	Total	$470,000			$16,102					$486,102

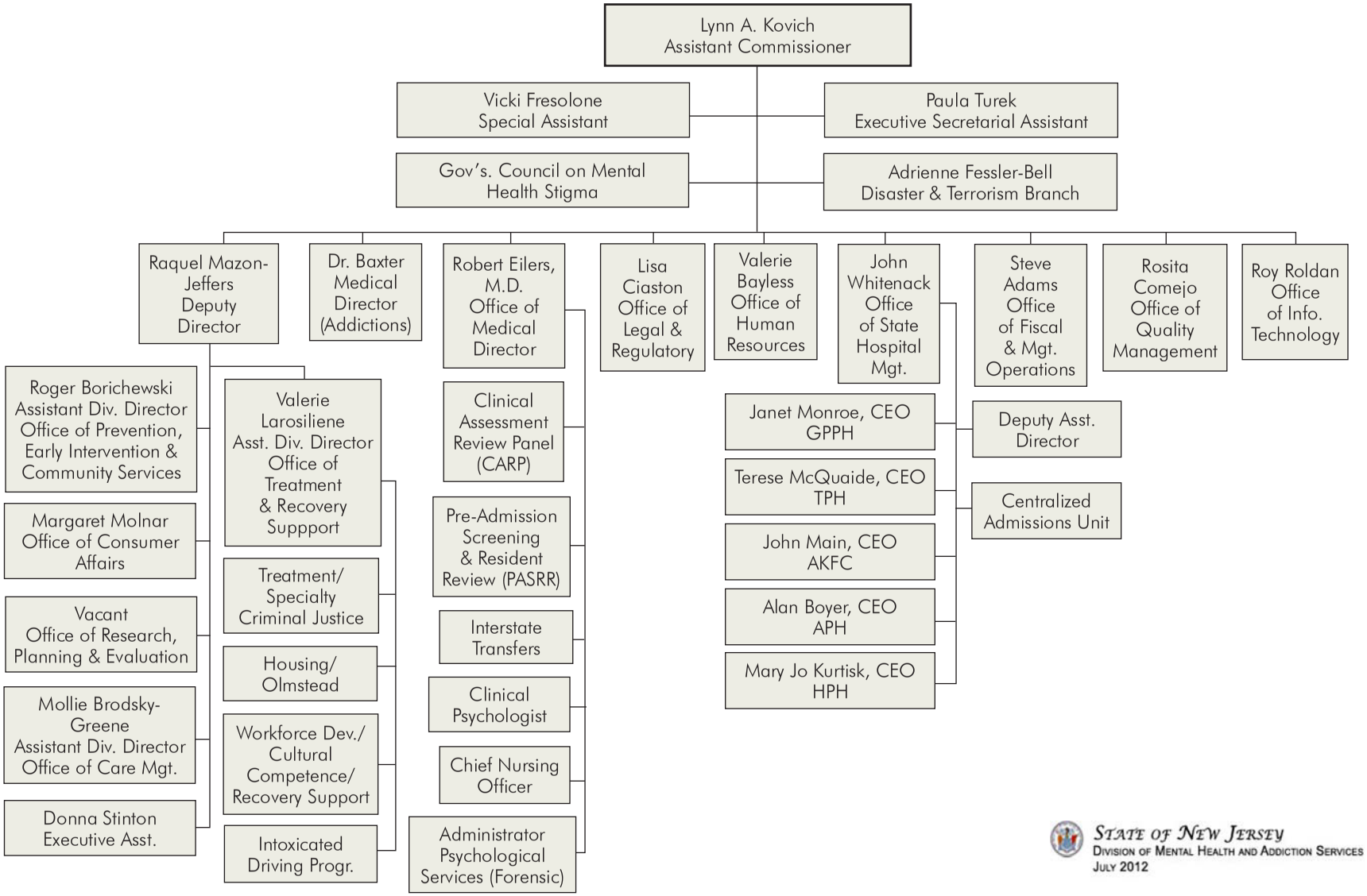
Planned FFY 2012 Synar Budget

Synar Category	Responsible Agency	Revenue Source and Amount								Total
		State Funds	Licensing Fees	Fines	SABG	Founda-tions	Retailer Associations	Tobacco Industry or Settlement	Other	
Manage-ment/ Staffing	TASE	$274,083								$274,083
Sample Design	DMHAS				$7,548					7,548
Coverage Study	DMHAS									
Inspections	TASE	50,000								50,000
Merchant Education	TASE									
Training	TASE									
Community Education & Support	TASE	90,000								90,000
Data Analysis To Determine RVR	DMHAS				3,522					3,522
Enforcement	TASE									
Other (please describe)	TASE	60,917								60,917
	Total	$475,000			$11,070					$486,070

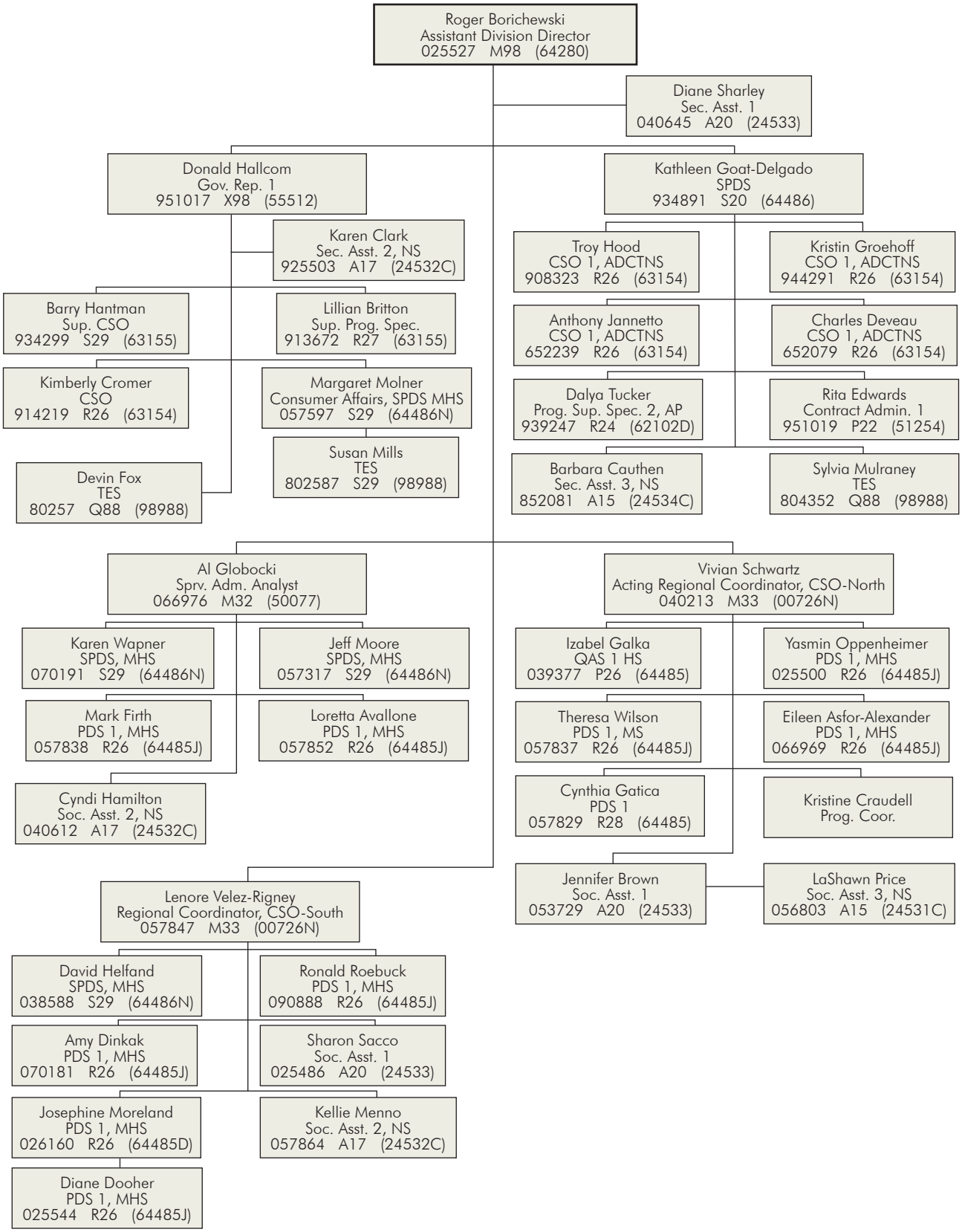
Appendix E

SSA Organizational Charts

Division of Mental Health and Addiction Services



Office of Prevention, Early Intervention and Community Services



Appendix F

Abbreviations

ACS	American Cancer Society
AEREF	Alcohol, Education, Rehabilitation and Enforcement Fund
AOD	alcohol and other drugs
ATOD	alcohol, tobacco, and other drugs
BCSR	Bloustein Center for Survey Research–Rutgers University
BRFSS	Behavioral Risk Factor Surveillance System
CADAA	County Alcoholism and Drug Abuse Authority
CADCA	Community Anti-Drug Coalitions of America
CHES	Certified Health Education Specialist
CPS	Certified Prevention Specialist
CSAP	Center for Substance Abuse Prevention
DAS	Division of Addiction Services
DCF	Department of Children and Families
DHS	Department of Human Services
DHSS	Department of Health and Senior Services
DLPS	Department of Law and Public Safety
DMHAS	Division of Mental Health and Addiction Services
EUDL	Enforcing Underage Drinking Laws
FDA	Food and Drug Administration
FFY	Federal fiscal year
GASP	Global Advisors on Smoke-free Policy
GCADA	Governor's Council on Alcoholism and Drug Abuse
GLBTQ	gay/lesbian/bisexual/transgender/questioning
IC&RC	International Certification & Reciprocity Consortium
LACADA	Local Advisory Committee on Alcohol and Drug Abuse
LCADC	Licensed Clinical Alcohol and Drug Counselor
MOU	memorandum of understanding
NJPN	New Jersey Prevention Network
NJSHS	New Jersey's Student Health Survey
NJYTS	New Jersey's Youth Tobacco Survey
NOMs	National Outcome Measures
NREPP	National Registry of Evidence-based Programs and Practice

NSDUH	National Survey on Drug Use and Health
OJJDP	Office of Juvenile Justice and Delinquency Prevention
OPEICS	Offices of Prevention, Early Intervention and Community Services
ORPE	Office of Research, Planning, and Evaluation
OTC	Office of Tobacco Control
PDFNJ	Partnership for a Drug-Free New Jersey
POMS	Prevention Outcomes Management System
RFP	request for proposals
RVR	retailer violation rate
SABG	Substance Abuse Prevention and Treatment Block Grant
SAMHSA	Substance Abuse and Mental Health Services Administration
SEOW	State Epidemiological Outcomes Workgroup
SFY	State fiscal year
SIG	State Incentive Grant
SPF	Strategic Prevention Framework
SSA	Single State Authority
SSES	Synar Survey Estimation System
TA	technical assistance
TASE	Tobacco Age-of-Sale Enforcement
TEDS	Treatment Episode Data Set
T/TA	training and technical assistance
YRBS	Youth Risk Behavior Survey

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