New Jersey

UNIFORM APPLICATION
FY 2026 Mental Health Block Grant Report

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

OMB - Approved 05/28/2025 - Expires 01/31/2028
(generated on 08/10/2026 2.52.56 PM)

Center for Mental Health Services
Division of State and Community Systems Development

A. State Information

State Information

State Unique Entity Identification

Unique Entity ID	MLGMLZ76EMC3

I. State Agency to be the Grantee for the Block Grant

Agency Name	New Jersey Division of Mental Health and Addiction Services
Organizational Unit	Office of Planning, Research, Evaluation, Prevention and Olmstead
Mailing Address	5 Commerce Way PO Box 362
City	Hamilton Township
Zip Code	08691-0362

II. Contact Person for the Grantee of the Block Grant

First Name	Renee
Last Name	Burawski
Agency Name	New Jersey Department of Human Services, Division of Mental Health and Addiction Services
Mailing Address	PO Box 362
City	Trenton
Zip Code	08625-0362
Telephone	(609) 438-4298
Fax	609-341-2302
Email Address	Renee.Burawski@dhs.nj.gov

III. State Expenditure Period (Most recent State exependiture period that is closed out)

From	7/1/2024
To	6/30/2025

IV. Date Submitted

NOTE: This field will be automatically populated when the application is submitted.

Submission Date	12/1/2025 3:25:55 PM
Revision Date	1/5/2026 2:02:32 PM

V. Contact Person Responsible for Report Submission

First Name	YUNQING
Last Name	LI
Telephone	(609)359-4737
Fax	
Email Address	yunqingli@gmail.com

0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

B. Implementation Report

MHBG Table 1 Priority Area and Annual Performance Indicators - Progress Report

Priority #: 1

Priority Area: Pregnant Women/ Women with Dependent Children

Priority Type:

Population(s): PWWDC

Goal of the priority area:

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

Objective:

Increase number of pregnant women or women with dependent children receiving recovery support services.

Strategies to attain the goal:

• Provider Meetings. Biannual meetings are held with the Maternal Wrap Around (MWRAP) providers, Integrated Opioid Treatment and Substance Exposed Infants (IOT-SEI) providers, and the Department of Children and Families (DCF). A variety of topics such as information sharing, data collection, best practices, continuum of care, medication assisted treatment, referrals and access to services, recovery supports, Plans of Safe Care, systems collaboration, program accomplishments, challenges, and training needs are addressed. • Professional Development. All contracted licensed women's treatment providers receiving funding through the women's set aside block grant are required to address the full continuum of treatment services. Services include family-centered treatment, evidence-based parenting programs, trauma-informed and trauma-responsive treatment using Seeking Safety, Strengthening Families, evidence-based parenting classes, recovery supports, etc. and to provide assistance with housing supports by linking women to transitional, permanent and/or supportive or sober living homes such as an Oxford House. Providers with DMHAS contracts that provide maternal child health services for pregnant and parenting persons as per contract requirements are required to have new staff successfully complete the National Center on Substance Abuse and Child Welfare (NCSACW) online tutorials "Understanding Child Welfare and the Dependency Court: A Guide for Substance Abuse Treatment Professionals" and document completion of tutorials in their employee personnel files. • All women's services contracts address the continuum of care ranging from prevention, treatment and recovery supports. • In March 2024, the NJ DMHAS Office of Treatment and Recovery Supports contracted providers (women's treatment and maternal child health special initiatives) received training on Improving Clinical Recovery Services for Pregnant and Parenting People. The training was provided by SAMHSA's State TA provider, JBS International. The two-part virtual sessions included Family Centered Treatment and Trauma Informed Care including Stigma Education. • Plans of Safe Care. All women's treatment and pregnant and parenting maternal child health specialty services including the MWRAP and IOT-SEI Initiatives) provider contract language requires Plans of Safe Care for pregnant and postpartum persons (PPP). Plans of Safe Care will address the needs of the mother, infant and family to ensure coordination of, access to, and engagement in services. For a pregnant woman, the Plan shall be developed prior to the birth event whenever possible and in collaboration with treatment providers, health care providers, early childhood service providers, and other members of the multidisciplinary team as appropriate. Documentation of the Plan must be included in the woman's file. The DMHAS Monitoring Unit has updated their monitoring site review tool to include Plans of Safe Care under the women's set aside section for block grant funded providers. • Interim Services. In 2019 NJ DMHAS added language to Fee for Service (FFS) Network Annex A's to ensure all FFS funded treatment agencies provide Interim Services as an engagement service at all levels of care to ensure priority PPP consumers awaiting admission to their assessed level of care anywhere in the state could receive interim services within 48 hours at facilities closer to home. Interim services for PPP consumers is designed to reduce the adverse health effects of substance use, promote individual health, and reduce the risk of transmitting disease to sexual partners and their infants by providing individualized education, case management, referrals and MAT if needed, while awaiting admission. Statewide technical assistance on interim services was provided to all provider contractees. Interim services continues to be in the DMHAS FFS network. • In Depth Technical Assistance (IDTA) Neonatal Abstinence Syndrome and Substance Exposed Infants (NAS SEI). As a SAMHSA Prescription Drug Abuse Policy Academy State, in 2014, NJ applied for a unique technical assistance opportunity through the SAMHSA supported NCSACW to address the multi-faceted problems of NAS and SEI. NJ DHS/DMHAS as the lead State agency, partnered with DCF and DOH, and submitted a successful application (no funding attached). The IDTA goal was to develop uniform policies/guidelines that address the entire spectrum of NAS and SEI from pre-pregnancy, prevention, early intervention, assessment and treatment, postpartum and early childhood. The IDTA provided technical assistance to NJ to strengthen collaboration and linkages across multiple systems such as addictions treatment, child welfare, and medical communities to improve services for pregnant women with opioid and other substance use disorders and outcomes for their babies. The Core Team included over 60 individuals representing multiple State Departments and Divisions, community stakeholders, treatment providers, and the medical community. Three goals were established: (1) Increase perinatal SEI screening at multiple intervention points; (2) Leverage existing programs and policy mechanisms to collaboratively increase the rate at which women screening positive on the 4P's Plus get connected for a comprehensive assessment by establishing formal warm-handoffs and other safety net measures; and (3) Leverage existing programs and policy mechanisms to collaboratively increase the rate at which women delivering SEIs and their babies and any other eligible children, receive early support services for which they are eligible. Three workgroups were formed. The Labor, Delivery and Engagement (Infants) Workgroup developed a comprehensive survey (Birthing Hospital Survey) with input from the medical community and perinatal cooperative. • IDTA Birthing Hospital Survey. The Labor, Delivery and Engagement (Infants) Workgroup developed a comprehensive survey with input from the medical community and perinatal cooperatives. The Birthing Hospital Survey was disseminated statewide March 2017 to the labor and delivery hospitals. The survey sought to understand how pregnant women with SUD and SEI are identified, treated, and triaged with partners at discharge, and if treatment for NAS was explored. The results were intended to guide Departments in establishing statewide guidelines

for best practice; aid in the development of cross system models to ensure families get access to services; establish education needs on issues of SEI/NAS and identify high risk areas. In an effort to increase access to SUD treatment and reduce unmet treatment needs of pregnant or parenting women with an Opioid Use Disorder (OUD), based from the Birthing Hospital Survey findings, the DMHAS engaged Rutgers/Robert Wood Johnson Medical School (Rutgers/RWJ) to provide technical assistance and training through the Extension for Community Healthcare Outcomes (ECHO) Program. The DMHAS Office of Treatment and Recovery Supports has supported ECHO Programs for Pregnant and Parenting Persons with Opioid Use Disorder. • New Jersey was awarded another round of IDTA through the NCSACW 2023 Policy Academy: Advancing Collaborative Practice and Policy: Promoting Healthy Development and Family Recovery for Infants, Children, Parents, and Caregivers Affected by Prenatal Substance Exposure. NJ State Policy Academy representatives includes the Departments of Health, Children and Families and Human Services. and the Governor's Office. The DMHAS Women's Treatment Coordinator represents DHS. Representatives from the medical, addictions and perinatal community also participate on this IDTA. The overall goal was increasing awareness of pregnant persons and SUD, through increased education and maximizing messaging through the perinatal work force, increase awareness and access to treatment, Plans of Safe Care, and improving screenings in hospitals and healthcare providers. Four goals have been established: Goal 1: Conduct a statewide landscape analysis of resources targeted at individuals with a Substance Use Disorder (SUD) and understand how referrals are made to appropriate resources and levels of care. Goal 2: Address gaps in the SUD system of care to establish a comprehensive and fluid collaborative approach among state agencies, healthcare providers, and community-level and non-profit organizations to address substance use during and after pregnancy. Goal 3: By 2025, create and execute a state-wide prenatal Plans of Safe Care process that enables Community and Clinical Partners to formally support a birthing person. Goal 4: Support birthing hospitals in updating their protocol related to screening and referring birthing people with SUD; and subsequently engaging in a comprehensive approach to implementing Plans of Safe Care in New Jersey. • Project ECHO Maternal Child Health. The Pregnant and Parenting Persons with Opioid Use Disorder (MCH PPP OUD) ECHO provides education and training to primary care practitioners, SUD treatment providers, behavioral health practitioners, and other stakeholders in clinic settings and at home, utilizing a web-based video collaboration between a multi-disciplinary team of specialists and primary care practitioners on best practices for the assessment, case management, intervention, treatment and recovery support services for PPP with an OUD. The goal is to increase the capacity and competency of providers, community support organizations and clinical teams to support prevention, treatment and recovery of PPP with OUD. ECHO positions communities to reduce the NAS birth rates, improve use of medication assisted treatment, family formation and early infant development; improve access to physical and mental health care by educating more providers, midwives, doulas, and other health care professionals on best practices during prenatal and perinatal periods. The anticipated start date for the Program was set for March 2020. However, with the advent of the global COVID-19 pandemic, and the national and state orders to shelter in place effective late March 2020, limitations on who could go to the hospital added a level of complexity to care for those mothers expecting to give birth during this time or in recovery at home. These events required an immediate response to address the public health emergency. In late March 2020, DMHAS agreed to postpone the traditional MCH PPP-OUD ECHO Series until such time that the providers could return to a focus on pregnant and parenting women with an OUD. The ECHO team (DMHAS, Rutgers/RWJ and Hub members) refocused resources to provide COVID-19 MCH and OUD ECHO sessions. This temporary change in scope enabled the MCH PPP-OUD ECHO team to address treatment issues, access to healthcare services and how to meet the needs of specific populations of women during this crisis. The MCH PPP-OUD Hub team completed seven (7) COVID-19 maternal child health and OUD sessions between April and the first week of June 2020, and MCH PPP-OUD ECHO with COVID-19 (included as a discussion topic) reconvened June 15, 2020 through December 2020. MCH PPP-OUD ECHO series is scheduled after July of 2021. Each series was designed as 12 bi-weekly sessions. Project ECHO series with the new curriculums took place early Spring 2022 and concluded late summer. DMHAS renewed the MCH PPP-OUD ECHO series with 18 sessions scheduled through 2023. The curriculum covers the following areas: screening for SUD; new guidelines for prescribing buprenorphine; starting treatment: the patient contract, pharmacy partner and social services; managing buprenorphine treatment and follow-up; opioid dependency reporting guidelines; and hot topics. In an effort to reach out to practitioners and prescribers, the first ECHO 8 sessions were scheduled for a special evening time with a focus on the latest FDA approved techniques for MAT, integrated care, and wraparound services. DMHAS extended the MCH PPP-OUD ECHO through September 30, 2025. This ECHO's curriculum focuses on maternal opioid intervention and care coordination. Each of the series includes 18 sessions with five Community Workshops through August 2024 and another 18 sessions with five community workshops through August 2025. Didactic topics within the 18 sessions range from integrative approach to care for pregnant persons; bridging the gap from patient to plan: implementation that is meaningful and impactful; prenatal care with an opioid/substance use disorder; and navigating the system to maximize successful family formation. • Maternal Wrap Around Program (MWRAP). MWRAP is a statewide program located in seven regions. MWRAP was awarded through an RFP in 2018 and services included intensive case management and recovery support services for opioid dependent pregnant and postpartum persons. Opioid dependent women were eligible for services during pregnancy and up to one year after the birth event. MWRAP served thirty (30) unduplicated women in each region. The MWRAP goal was to alleviate barriers to services for pregnant opioid dependent persons through comprehensive care coordination implemented within the five major timeframes when intervention in the life of the SEI can reduce potential harm of prenatal substance exposure: pre-pregnancy, prenatal, birth, neonatal and early childhood. MWRAP is intended to promote maternal health, improve birth outcomes, and reduce the risks and adverse consequences of prenatal substance exposure. The onset of the COVID-19 pandemic resulted in many significant safety precautions at the national and state level. The stay-at-home orders, such as closures of businesses, schools, restrictions in gatherings has had an impact on the social determinants of health (food, security, employment, income, access to medical care, etc.). Pregnant and parenting persons with a history of substance use disorder could be at risk for increase in substance use or experience relapse due to feelings of isolation, lack of family supports, or social support systems. Their mental health could be adversely affected exhibiting depression during pregnancy and postpartum. In State fiscal year 2022 the MWRAP statewide initiative eligibility criteria was expanded to include pregnant persons with substance use disorder, not exclusive to opioid dependency. The number of unduplicated women per MWRAP region was expanded to 50. Improving maternal child health outcomes is a major agenda for NJ through the adoption of Nurture NJ, led by First Lady Tammy Murphy. Nurture NJ is a statewide, multi-agency campaign dedicated to this issue. Reach NJ, the central call-in line for NJ residents who are looking for help with a SUD dedicated their public service announcement campaign to pregnant persons during late Fall 2022. MWRAP provided training to ReachNJ who will now offer MWRAP as a resource and provide warm hand-offs. MWRAP services provides the support needed to help pregnant and parenting women with SUD maintain a healthy recovery, resulting in less overdoses, and improved birth outcomes and maternal child health. In SFY 2024, MWRAPs received another expansion, with each MWRAP region required to provide services to sixty (60) unduplicated women. A total of 420 unduplicated pregnant persons will be eligible for services. • Nurture NJ focuses on improving collaboration and programming between Departments, agencies and stakeholders to achieve its goal to make NJ the safest place in the country to give birth and raise a baby. Nurture NJ wants to ensure that all women are healthy and have access to care before pregnancy and is a high quality equitable system of care with services from prenatal to postpartum provided in a supportive community environment. NJ's Maternal Mortality Report (2016-2018) identified a total of 125 pregnancy associated deaths that had a temporal relationship to pregnancy within 365 days. 74 pregnancy-associated (not

related deaths) were attributed to SUD occurring from day 43 postpartum to day 100. These deaths could have been prevented. Lack of continuity of care and/or proper care coordination was identified as the top contributing factor. Postpartum women with a history of SUD and co-occurring disorder are most vulnerable for relapse and should have access to resources that can help support her infant and families. Supporting maternal mental well-being strengthens not only mothers, parents and women but also their families and their communities. SAMHSA has prioritized addressing maternal mental health conditions and co-occurring SUD. The DMHAS Women's Services Coordinator submitted a successful application to the Center for Mental Health Services, Learning Collaborative: Maternal Mental Health and will be participating on this Learning Collaborative through August 2024. The goal is to build on existing policies including the MWRAP and IOT-SEI maternal child health pregnant and parenting persons initiatives to improve access to services and reduce barriers to care. • The DMHAS Women's Services Coordinator represents DMHAS on the Maternal and Child Health Policy Innovation Program (MCH PIP) Alumni Policy Academy from August 2023 through April 2024 convened by National Academy for State Health Policy (NASHP) with support from the Health Resources and Services Administration, Maternal and Child Health Bureau (HRSA-MCH). NJ Medicaid, DOH, DHS and DCF are state partners on the MCH PIP with NJ Medicaid as the lead state agency. The overall goal is to improve maternal health outcomes by addressing SDOH-related barriers (e.g., transportation, child care, language/low literacy, discrimination) to accessing maternity care; effective referral processes for health-related social needs of pregnant and parenting persons. DMHAS maternal child health initiatives (IOT-SEI and MWRAP) provide intensive case management, recovery supports, and specialty services to assist pregnant and parenting persons with SUD and co-occurring to access care, address barriers and SDOH to help improve maternal health outcomes. • Integrated Opioid Treatment and Substance Exposed Infants (IOT-SEI) Initiative. Five awards across the State, funded with the Governor's State Opioid funds. This Initiative provides an array of integrated services for opioid dependent pregnant women, their infants and family. Providers are required to ensure a full continuum of services and to establish mechanisms to develop a coordinated and cohesive approach for working together across systems that include, SUD treatment, medical community, maternal child health, and child welfare. Initiative focuses on alleviating barriers to services. Services range from: mother's medical/prenatal and obstetrical care, SUD treatment for OUD including MAT, new born/infant medical care, child welfare services as identified, intensive case management, recovery supports, assistance with housing, case management and other wraparound services. Providers must ensure that there is comprehensive care coordination from prenatal through the birth event, postpartum, and early childhood. • Data Collection (MWRAP and IOT-SEI). DMHAS Researcher is collecting and analyzing data to understand the impact of each program on outcomes for the mother and her child, to evaluate program effectiveness, make recommendations for program improvement and sustainability. COVID-19 specific data was collected starting July 2020. The purpose of the data was to understand how individual participants were affected and what specific steps were taken to address COVID-19 related challenges. Data collected included the impact of social determinants of health on health outcomes in the time of COVID-19 such as housing, transportation and healthcare. • Supportive Housing. DMHAS developed a Women's Intensive Supportive Housing (WISH) Program. WISH provides permanent supportive housing for pregnant and/or parenting women with a co-existing substance abuse disorder and mental illness who are homeless or at risk of homelessness and being discharged from a licensed long-term residential substance abuse treatment and/or halfway house facility. An RFP was developed and released in January 2015 for the development of a WISH team to provide case management and supportive housing services for 10 women and their children. The RFP was awarded in 2015 to a licensed treatment provider who specializes in women's gender specific treatment, offers a continuum of care, and has a longstanding history of providing supportive housing and has demonstrated success in managing permanent supportive housing programs. Since 2014, DMHAS has a Memorandum of Understanding (MOU) with NJ DCF, DCP&P to fund ten (10) supportive housing subsidies annually for the "Keeping Families Together" (KFT) program for parents involved with the child welfare system who are homeless or at imminent risk and in which one or more adults in the family is diagnosed with a co-occurring mental health illness and substance use disorder. DCP&P contracts with a provider for the KFT program in Essex County. • Sober Living. New Jersey contracts with Oxford House Inc. which has dedicated women's homes and women with children homes. The contract has been expanded to develop additional homes for special populations including women with children. Women and Children Oxford Houses are required to provide lockboxes to each for medication storage. Residents in Oxford Houses is responsible for their individual medication lock boxes. Outreach staff conduct annual training (Overdose Specific) at each Chapter meeting at the annual state workshop. Currently, there are 14 Oxford House Chapters throughout the state. This is in response to the heroin overdose epidemic in the state of New Jersey and its effects related to Oxford House. Each home is required to maintain Naloxone kits on site. In 2022 Oxford House continued to see an increase in members applying for membership with OUD. This increase created a more significant need for naloxone training and information on access to Medical Assisted Recovery (MAR) options. The New Jersey Oxford House outreach team continues to educate members on MAR and the importance of being an active member of their recovery community. • Systems Collaboration PPW. Twelve (12) of New Jersey's 21 counties continue to have monthly DCP&P Child Welfare Substance Use Disorder Consortia meetings which have moved to virtual meetings. Child welfare staff, DMHAS, Division of Family Development, Substance Use Disorder Provider Agencies, Work First New Jersey, Substance Abuse Initiative (WFNJ SAI) providers, and Boards of Social Services meet each month and plan on how to better serve families, leading to more effective policies and practices to meet the needs of infants, children and families. The Consortia also addresses ASFA timelines, Plans of Safe Care, and reunification for children in out of home placement. Through collaboration, multiple agencies working with the same family can improve communication to reduce the gaps in service delivery and improve coordination of services. The Consortia allow for cross systems collaboration with local treatment programs and other community partners who can provide the expertise needed to better serve families in the child welfare system. • Advertising Campaign. New Jersey continues its statewide advertising campaign centered around opioid use and bringing public awareness to call ReachNJ, the 24/7 Addiction Hotline, for treatment. New messaging, beginning in August 2022, has added pregnant women, along with student athletes and older adults, as target groups. This is a statewide campaign that utilizes television and radio advertisements, bus wraps, billboards and social media to encourage New Jerseyans to access treatment. Recently the TV ad aired on NBC during the Macy's Thanksgiving Day Parade and later that evening during an NFL football game.

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

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Increase the number of individuals receiving recovery support services in the Maternal Wraparound Program (MWRAP).

Baseline measurement (Initial data collected prior to the first-year target/outcome):	SFY 2023: 381 individuals received recovery support services in the Maternal Wraparound Program consisting of 111 mothers, 45 babies/birth, 40 children under 1 year old and 185 children 1-17 years old.
"First-year target/outcome measurement (Progress – end of SFY 2024):	Increase the number of individuals receiving MWRAP recovery support services in SFY 2024 by 1%.
Second-year target/outcome measurement (Final end of SFY 2025):	Increase the number of individuals receiving MWRAP recovery support services by another 1% by the end of SFY 2025. The change in SFY 2025 will be measured by calculating the percentage difference from SFY 2023 to SFY 2025.

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

Data Source:

The number of individuals receiving MWRAP recovery services from SFY 2023 – 2025 will be tracked by five providers using the MWRAP intake survey, birth survey, discharged survey, and reported through the MWRAP reporting roster.

New Data Source*(if needed)*:

Description of Data:

Data tract by the MWRAP reporting roster captures bio data, enrollment and admission data, follow-up contact data, maternal health related data, SUD and OUD related data, other care and support data, legal data, exit data, and summary of care.

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

Providers interactive program discussion and a structured online staff retention survey showed that some data issues/caveats that affect outcome measures, which are being effectively addressed, include the following: • Differences in electronic health record (EHR) systems across providers • Harmonizing plan of safe care (PSC) across providers • Strengthening referrals across services providers at all levels of care • Stigmatization • Difficulty recruiting qualified staff • Staff turnover/Attrition

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

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

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

Priority #: 2

Priority Area: Persons Who Inject Drugs (PWID)

Priority Type:

Population(s): PWID

Goal of the priority area:

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

Objective:

Increase the percentage of PWID entering treatment for whom MAT is planned.

Strategies to attain the goal:

• Low Threshold Buprenorphine Program at Harm Reduction Centers. Continue to implement low threshold buprenorphine induction programming at all statewide Harm Reduction Centers (HRCs) while also continuing to encourage collaboration and affiliation agreements between the HRCs and substance use disorder agencies to ensure referral to comprehensive treatment programs, when clinically indicated. • Mobile Medication Units. Providing services in convenient locations, specifically through existing and new mobile medication programming, in order to reduce barriers and engage individuals in care as easily as possible. • Expanded Hour OTPs. Continuance of an expanded hour Opioid Treatment Program (OTP) initiative in efforts to provide increased (i.e. evening) hours that are not typically provided in efforts to assist individuals with easier access to services. • Public Awareness Campaign. Educating providers and reducing stigma and discrimination for individuals with an OUD, family members and the public about the benefits of medications for Opioid Use Disorder (MOUD) through its public awareness campaign that was initially launched in 2020. • Opioid Overdose Prevention Trainings. Contracts with three regional Opioid Overdose Prevention Program (OOPP) providers and an Opioid Overdose Prevention Network (OOPN) provider to

continue to offer community education and trainings for individuals at-risk for an opioid use disorder, their families, friends and loved ones to recognize an opioid overdose and to subsequently provide naloxone kits to individuals in attendance. A component of these trainings have been and will continue to be to discuss treatment, including MOUD. In addition to populations listed above, training will continue to be inclusive of, but not limited to other populations such as schools, jails, licensed Substance Use Disorder (SUD) agencies, Office of Emergency Management, Emergency Medical Services (EMS), teams, fire departments, homeless shelters and community health clinics. • Opioid Overdose Recovery Programs. Linking individuals reversed from an opioid overdose, who are seen bedside by recovery specialists and patient navigators at emergency departments, via the 21 county Opioid Overdose Recovery Programs (OORPs) to treatment and/or recovery support services in their communities. • Support Teams for Addiction Recovery. Statewide contracts awarded to providers in all 21 counties for a Support Team for Addiction Recovery (STAR) program to provide case management and wraparound services for individuals with an OUD. Goals include linking clients to needed services, housing, primary care and treatment to include MOUD. • Telephone Recovery Supports. Telephone Recovery Support (TRS) is a statewide program to assist individuals to reduce relapse and to enhance the recovery experience. The service calls high risk participants with an OUD, for up to four months, longer if needed, to provide encouragement, support and information. • Maternal Wrap Around Program. Maternal Wrap Around Program (MWRAP), is a statewide program that was awarded through an RFP in 2018. MWRAP has had several expansions and is located in seven regions throughout the state, all counties provide MWRAP, with each region serving approximately 60 unduplicated pregnant women with substance use disorder, their infants and families. MWRAP provides intensive case management and recovery support services. Services are available to pregnant women and up to one year after the birth event. The MWRAP goal is to alleviate barriers to services for pregnant opioid dependent women through comprehensive care coordination that is implemented within the five major timeframes when intervention in the life of the SEI can reduce potential harm of prenatal substance exposure: pre-pregnancy, prenatal, birth, neonatal and early childhood. MWRAP is intended to promote maternal health, improve birth outcomes, and reduce the risks and adverse consequences of prenatal substance exposure. Improving maternal child health outcomes is a major agenda for NJ through the adoption of Nurture NJ, led by First Lady Tammy Murphy. Nurture NJ is a statewide, multi-agency campaign dedicated to this issue. Reach NJ, the central call-in line for NJ residents who are looking for help with a SUD dedicated their public service announcement campaign to pregnant women during late Fall 2022. MWRAP provided training to ReachNJ who will now offer MWRAP as a resource and provide warm hand-offs. MWRAP services provides the support needed to help pregnant and parenting women with SUD maintain a healthy recovery, resulting in less overdoses, and improved birth outcomes and maternal child health. • Integrated Opioid Treatment and Substance Exposed Infants (IOT-SEI) Initiative: Five awards across the State, funded with the Governor's State Opioid funds. This Initiative provides an array of integrated services for opioid dependent pregnant women, their infants and family. Providers are required to ensure a full continuum of services and to establish mechanisms to develop a coordinated and cohesive approach for working together across systems that include, SUD treatment, medical community, maternal child health, and child welfare. Initiative focuses on alleviating barriers to services. Services range from: mother's medical/prenatal and obstetrical care, SUD treatment for OUD including MAT, new born/infant medical care, child welfare services as identified, intensive case management, recovery supports, assistance with housing, case management and other wraparound services. Providers must ensure that there is comprehensive care coordination from prenatal through the birth event, postpartum, and early childhood. • Strategic Prevention Framework for Prescription Drugs: In September 2021, DMHAS was awarded its second "Strategic Prevention Framework for Prescription Drugs (SPF Rx)" five-year grant from SAMHSA to implement the NJAssessRx initiative. NJAssessRx expands interagency sharing of the state's Prescription Drug Monitoring Program data and gives DMHAS the capability to use data analytics to identify prescribers, prescriber groups and patients at high risk for inappropriate prescribing and nonmedical use of opioid drugs. Informed by the data, DMHAS and its prevention partners will strategically target communities and populations needing services, education or other interventions. The target population is youth (ages 12-17) and adults (18 years of age and older) who are being prescribed opioid pain medications, controlled drugs, or human growth hormone (HGH), and are at risk for their nonmedical use. • State Opioid Response (SOR) Grant. In FY 2023, New Jersey received just over $133 million through SOR for a two-year period. The goal of the SOR is to address the State's opioid crisis as well as a rising issue of stimulant use disorder by providing treatment, family and peer recovery support, community prevention and education programs and training. The key objectives of funding are to increase access to medication-assisted treatment (MAT), reduce unmet treatment need, reduce opioid-related deaths, and provide services to address individuals who have a stimulant use disorder. • Jail MAT and Technical Assistance. As part of SOR and state funding, DMHAS collaborates with all 21 counties in NJ who have established Medication Assisted Treatment (MAT) programs or enhanced existing MAT services for inmates with OUD at county correctional facilities. DMHAS utilizes funds to have its two Centers of Excellence (COEs) provide technical assistance to correctional facilities to assist them in the provision of these services. In addition, DMHAS has worked with county correctional facilities to establish justice involved re-entry services for detainees where case managers at county jails conduct intake assessments and establish pre-release plans for needed services in the community. • Interim Services. Interim Services is a requirement of DMHAS provider contracts. An initiative developed in October 2019 has allowed DMHAS to pay for these services through a fee-for-service (FFS) mechanism. The Interim Services initiative provides funding to all contracted FFS agencies to support individuals awaiting admission to treatment following a substance use disorder (SUD) assessment. Interim Services are an engagement level of service intended to link individuals to services they may not be able to access due to lack of provider capacity. This service has been designed to be provided by agencies contracted for any licensed ASAM level of care. Interim services have been made available to any individual eligible for treatment within the public system who cannot be admitted for the assessed level of care within 72 hours. Prior to this initiative, agencies enrolled in the Block Grant initiatives were required to provide this service. • Homeless Shelter Initiative. DMHAS continues to increase access to buprenorphine and other ancillary services for individuals with a substance use disorder through current programming available at homeless shelters. Contracted providers will continue to develop the capacity to provide low threshold medication as well as other support services for individuals who reside or drop in at the shelters, linking them to treatment and recovery services, when appropriate. • Community Training. DMHAS will continue a train-the-trainer program through Rutgers University to educate the community on medications that can be utilized to support recovery and provide NJ-specific treatment and recovery resources. The goal of this project is to educate, support, and mentor graduate students to provide these free educational talks to community groups throughout the State. • Cultural Competency Training and Practice for Opioid Treatment Providers. DMHAS contracts with a provider whose goal is to help narrow the treatment gap experienced by Black/African Americans (AA) who are diagnosed with opioid and stimulant use disorders and who are statistically less likely to receive or access services. Another significant goal of this initiative is to increase the prescribing of Medication for Opioid Use Disorders (MOUD) among the Black/AA community. • Paramedicine Initiative. DMHAS continues to develop a pilot program to fund one of its university partners to develop pilot paramedicine programs in the State to administer buprenorphine for opioid withdrawal symptoms and provide next day linkage to care to community providers. • Office Based Addiction Treatment. The Division of Medical Assistance and Health Services (DMAHS), in collaboration with DMHAS, continues a program to cover and support medications for opioid use disorder at Office Based Addiction Treatment (OBAT) providers. This program coordinates the delivery of multiple reimbursable services provided by primary care providers and community behavioral health specialists to NJ FamilyCare members with an addiction diagnosis. OBAT providers link patients to OTPs or

other treatment services, when appropriate. • Long-Term Residential Incentive Payment. A new innovation is paying Long Term Residential agencies for providing Medication Assisted Treatment (MAT) to clients. Effective June 1, 2020, the Long-term Residential (LTR) reimbursement rate was increased, as well as the ability to pay for MAT and MAT-related services. On August 20, 2021, the Department of Health (DOH) issued Guidance 7-2021 that reported Long Term Residential (LTR) facilities do not need to seek approval from DOH to prescribe medication, other than Methadone, for the treatment of substance use disorders. As a result, effective October 15, 2021, the base rate for Long Term Residential [H0019HF] includes the MAT add-on of $5.00 per unit and increased to $152.60 per day inclusive of Room and Board. Beginning July 1, 2020, additional incentive payments became available for the utilization of MAT and MAT capacity in LTR. The incentive rate creates the capacity to prescribe and administer MAT, which minimally includes Buprenorphine, but also may include Naltrexone and other FDA-approved products for Opioid Use Disorder (OUD) and for Alcohol Use Disorder (AUD). The rates and incentives are structured as follows: 1) The increased base LTR treatment rate with the MAT add-on plus Room and Board per diem. 2) When an LTR provider site has least 40% of eligible clients receiving an approved medication for treatment of an OUD or an AUD, the provider's rate will increase by $10.00 per unit of service. This incentive threshold applies to medications arranged for using an external provider (e.g., Methadone from an OTP; Buprenorphine from OBAT) and provided by the LTR Provider. 3) The LTR provider can bill for medications inclusive of administration costs in addition to the new rates. To qualify for the incentive rate, Medicaid and DMHAS will determine a 40% MAT utilization rate through NJSAMS reporting at client discharge. This benchmark is measured as those individuals who are medication-eligible who receive qualifying medications as reported in the NJSAMS Discharge data. The measurement will include all discharges, including duplicated and unduplicated individuals. The medications that qualify are FDA-approved for the treatment for OUD and AUD and are inclusive of Buprenorphine, Sublocade, Methadone, Naltrexone (for OUD), and Naltrexone for Disulfiram, Acamprosate (for AUD); note that, at a minimum, Buprenorphine must be provided to receive the incentive. The benchmark will be measured by site based on the overall data, initially every three months starting July 1, 2020 for fiscal year 2021 and then every six months thereafter, which continues today. The applicable incentive rate applies to all billed LTR units for the prospective period when the provider site meets the 40% benchmark incentive criteria. • DMHAS, through a RFP process, initiated a Building Capacity in Mental Health and Substance Use Disorder initiative focusing on medications for SUD, i.e., buprenorphine, naloxone, naltrexone and methadone. The initiative enables agencies to offset the cost to create capacity to prescribe medications in licensed mental health programs as well as in licensed SUD treatment programs who provide treatment to individuals with co-occurring disorders (COD). • Expanded Outpatient Hours. An RFP was issued in August 2022 to expand outpatient treatment services and enhance access to treatment by removing barriers such as traditional service hours. Ten SUD outpatient treatment providers were awarded a contract to provide these services in October 2022. These expanded hours will provide increased access to outpatient treatment for individuals with an SUD. The purpose of this expansion for outpatient services is to support, enhance and encourage the emotional development and the development of consumer's life skills in order to maximize their individual functioning during alternate times from standard business hours (after hours and weekends). Providers are required to expand their hours at a minimum of six (6) days per week with the goal of extending hours into the evening and admitting new consumers for these services during these times. This program is funded with ARPA SUBG funds.

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

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Increase the percentage of PWID admissions for whom MAT is planned.
Baseline measurement (Initial data collected prior to the first-year target/outcome):	SFY 2023: MAT planned for 60% of PWID admissions.
"First-year target/outcome measurement (Progress – end of SFY 2024):	Maintain a minimum of 60% of PWID treatment admissions for whom MAT is planned .
Second-year target/outcome measurement (Final – end of SFY 2025):	Increase the percentage of PWID treatment admissions for whom MAT is planned by 2% from SFY 2024 by the end of SFY 2025. The change in SFY 2025 will be measured by calculating the percentage difference from SFY 2023 to SFY 2025.

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

Data Source:

The percentage of PWID for whom MAT is planned in SFY 2023 through SFY 2025 will be tracked by the SSA's New Jersey Substance Abuse Monitoring System (NJSAMS).

New Data Source*(if needed)*:

Description of Data:

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

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

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

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

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

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

Priority #: 3

Priority Area: Heroin/Opioid Users

Priority Type:

Population(s): Other

Goal of the priority area:

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

Objective:

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

Strategies to attain the goal:

• Public Awareness Campaign. Continue to utilize a public awareness campaign focusing on reducing stigma/discrimination for individuals with an OUD, family members and the public about the benefits of utilizing medications to support recovery for an Opioid Use Disorder (MOUD). • Building Capacity Initiative. Initiative focuses on addressing challenges faced by both licensed mental health and substance use disorder programs that require start-up funds to increase their capacity to offer MAT, specifically buprenorphine to their clients. Contracted MH and SUD programs are expected to build capacity to offer MAT in compliance with all federal and New Jersey state regulations. • Vivitrol Enhancement. DMHAS will continue the Vivitrol Enhancement through its Fee-for-Service (FFS) Network. This enhancement allows providers to be reimbursed for the provision of Vivitrol as well as other ancillary services in FFS initiatives. Licensed SUD agencies can be enrolled in the enhancement if have proper approval of policies and procedures from the Department of Health, Certificate of Need & Licensing (CN&L). • Buprenorphine Enhancement. DMHAS will continue the Buprenorphine Enhancement, similar to the one created for Vivitrol, that reimburses FFS Network providers for the provision of buprenorphine at their agencies. Licensed SUD agencies are able to participate in the enhancement with proper approval (MAT Waiver) issued by CN&L. • Jail MAT and Case Management Initiative. DMHAS collaborates with the State's 21 county jails that established MAT programs or enhanced existing MAT services for inmates. In addition, DMHAS works with county correctional facilities and have established justice involved re-entry services for detainees where case managers at county jails conduct intake assessments and establish pre-release plans for needed services in the community, which include linking individuals to community MAT services. • American Society of Addiction Medicine Booklets. DMHAS will continue to provide a statewide distribution of American Society of Addiction Medicine (ASAM) booklets entitled "Opioid Addiction Treatment: A Guide for Patients, Families and Friends" which provide facts about treatment, including MAT as a best practice, and provides NJ-specific resources to accessing treatment and recovery services. These guides are provided in English, Spanish and Braille and goal is to provide in additional languages that are prevalent in New Jersey. In addition, DMHAS worked with the NJ Division of Deaf and Hard of Hearing (DDHH) to create a video link in American Sign Language (ASL). • Community Training. DMHAS will continue its Memorandum of Agreement (MOA) with Rutgers University, Robert Wood Johnson Medical School for a train-the-trainer program on Medications for Opioid Use Disorder (MOUD), the opioid epidemic (specific to New Jersey) and concepts of SUD (specific to OUD) for a minimum of 40 graduate students at Rutgers University. This project will continue to educate, support, and mentor graduate students to give free educational talks, through use of PowerPoint presentations, to community businesses and organizations in efforts to reduce stigma/discrimination around medication to support an individual's recovery. • Low Threshold Buprenorphine Induction at Harm Reduction Centers. Continue low threshold buprenorphine induction programming at all statewide Harm Reduction Centers (HRCs) while also continuing to encourage collaboration and affiliation agreements between the HRCs and substance use disorder agencies to ensure referral to comprehensive treatment programs, when clinically indicated. • Expanded Hour Opioid Treatment Program. Continuance of an expanded hour Opioid Treatment Program (OTP) initiative which provides increased (i.e. evening) hours that are not typically provided in efforts to assist individuals with easier access to services/care. • Cultural Competency Training and Practice for Opioid Treatment Providers. DMHAS contracts with a provider whose goal is to help narrow the treatment gap experienced by Black/African Americans (AA) who are diagnosed with opioid and stimulant use disorders and who are statistically less likely to receive or access services. Another significant goal of this initiative is to increase the prescribing of Medication for Opioid Use Disorders (MOUD) among the Black/AA community. • Long-Term Residential Incentive Payment. A new innovation is paying long term residential providers for providing MAT to clients. Effective June 1, 2020, the Long-term Residential (LTR) reimbursement rate was increased, as well as the ability to pay for Medication Assisted Treatment (MAT) and MAT related services. On August 20, 2021, the Department of Health (DOH) issued Guidance 7-2021 that reported Long Term Residential (LTR) facilities do not need to seek approval from DOH to prescribe medication, other than Methadone, for the treatment of substance use disorders. As a result, effective October 15, 2021, the base rate for Long Term Residential [H0019HF] includes the MAT add-on of $5.00 per unit and increased to $152.60 per day inclusive of Room and Board. Beginning July 1, 2020, additional incentive payments became available for the utilization of MAT and MAT capacity in LTR. The incentive rate creates the capacity to prescribe and administer MAT, which minimally includes Buprenorphine, but also may include Naltrexone and other FDA-approved products for Opioid Use Disorder (OUD) and for Alcohol Use Disorder (AUD). The rates and incentives are structured as follows: 1. The increased base LTR per diem rate for treatment plus Room and

Board. 2. When an LTR provider site has least 40% of eligible clients receiving an approved medication for treatment of an OUD or an AUD, the provider's rate will increase by $10.00 per unit of service. This incentive threshold applies to medications arranged for using an external provider (e.g., Methadone from an OTP; Buprenorphine from OBAT) and provided by the LTR Provider. 3. The LTR provider can bill for medications inclusive of administration costs in addition to the new rates. To qualify for the incentive rate, Medicaid and DMHAS will determine a 40% MAT utilization rate through NJSAMS reporting at client discharge. This benchmark is measured as those individuals who are medication-eligible who receive qualifying medications as reported in the NJSAMS Discharge data. The measurement will include all discharges, including duplicated and unduplicated individuals. The medications that qualify are FDA-approved for the treatment for OUD and AUD and are inclusive of Buprenorphine, Sublocade, Methadone, Naltrexone (for OUD), and Naltrexone for Disulfiram, Acamprosate (for AUD); note that, at a minimum, Buprenorphine must be provided to receive the incentive. The benchmark will be measured by site based on the overall data, initially every three months starting July 1, 2020 for fiscal year 2021 and then every six months thereafter, which continues today. The applicable incentive rate applies to all billed LTR units for the prospective period when the provider site meets the 40% benchmark incentive criteria. • MOUD Survey. Vital Strategies is working with the DMHAS and has developed a survey on the use of MOUD to be sent to all licensed SUD providers. The goal is to better understand the utilization of MOUD by providers, if there is reluctance to use MOUD and identify what barriers exist. This information can inform DMHAS as to actions needed to promote the use of MOUD by providers. • DMHAS finalized a Memorandum of Agreement (MOA) with the Rutgers Northern and Rowan Southern Centers of Excellence (COE) to provide technical assistance and training to the statewide county jails that participate in the County Correctional Facilities MAT and Case Management program. • Homeless Shelter Initiative. DMHAS continues to increase access to buprenorphine and other ancillary services for individuals with a substance use disorder through current programming available at homeless shelters. Contracted providers will continue to develop the capacity to provide low threshold medication as well as other support services for individuals who reside or drop in at the shelters, linking them to treatment and recovery services, when appropriate. • Mobile Medication Units. Providing services in convenient locations, specifically through existing and new mobile medication programming, in order to reduce barriers and engage individuals in care as easily as possible. • DMHAS worked with the Department of Health, Certificate of Need & Licensing (CN&L) to eliminate the need for a MAT Waiver that was previously required at residential SUD treatment agencies.

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

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Increase the percentage of heroin/other opiate admissions for whom MAT was planned.
Baseline measurement (Initial data collected prior to the first-year target/outcome):	SFY 2023: MAT planned for 57% of heroin/other opiate admissions.
"First-year target/outcome measurement (Progress – end of SFY 2024):	Increase the percentage of heroin/other opiate admissions for whom MAT is planned by 1%.
Second-year target/outcome measurement (Final – end of SFY 2025):	Increase the percentage of heroin/other opiate admissions for whom MAT is planned by another 1%. The change in SFY 2025 will be measured by calculating the percentage difference from SFY 2023 to SFY 2025.

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

Data Source:

The number of heroin/other opiate admissions for whom MAT was planned from SFY 2023 - 2025 will be tracked by the SSA's New Jersey Substance Abuse Monitoring System (NJSAMS).

New Data Source*(if needed)*:

Description of Data:

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

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

None

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

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

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

Priority #: 4

Priority Area: TB

Priority Type:

Population(s): TB

Goal of the priority area:

TB (Persons with or at risk of tuberculosis who are receiving SUD treatment services)

Objective:

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

Strategies to attain the goal:

Ongoing monitoring. Monitors will review compliance during the annual site visit, and require an acceptable plan of correction for non-compliance. If repeat deficiencies are found, an alternate plan of correction and proof of implementation will be required.

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

Annual Performance Indicators to measure goal success

Indicator #: 1

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

Baseline measurement (Initial data collected prior to the first-year target/outcome): According to SFY 2023 Annual Site Monitoring Reports of DMHAS' SUPTRS Block Grant contracted agencies, 94% of the agencies that were monitored (34 of 36 agencies) were in compliance with offering every client a tuberculosis evaluation.

"First-year target/outcome measurement (Progress – end of SFY 2024): An increase of 3% above the baseline measure.

Second-year target/outcome measurement (Final – end of SFY 2025): An additional increase of 2% above the first-year target measure.

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

Data Source:

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

New Data Source*(if needed)*:

Description of Data:

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

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

None

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

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

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

Priority #: 5

Priority Area: Tobacco

Priority Type:

Population(s): PP

Goal of the priority area:

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

Objective:

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

Strategies to attain the goal:

Beginning in January 2012, DMHAS funded 19 Regional Prevention Coalitions covering NJ's 21 counties, all of whom utilize the SPF model to guide their work. These coalitions are all required to address tobacco use among youth. The coalitions use, primarily, environmental strategies along with occasional individual approaches as appropriate. Below is a listing of approaches used by the coalitions to address tobacco use among adolescents in their regions. Environmental Strategies • Enhance Access/Reduce Barriers – Enhance access to effective prevention strategies and information through the use of a social media campaign and the development of human capital and networks of support. • Enhance Barriers/Reduce Access - Increase education among merchants who sell tobacco products. • Enhance Barriers/Reduce Access – Work with municipal and county government to ban smoking from restaurants and other public places, including schools, workplaces, and hospitals. • Change Consequences/Enhance Access/Reduce Barriers – Work with municipal and county government to assure that tobacco laws are enforced at the local level. • Change Physical Design – Through the compliance check report and GIS mapping, provide municipalities and state tobacco control with details regarding how outlet density and location impact tobacco availability to youth. • Modify/Change Policies – Enhance or create policies related to smoking among 12-17 years olds on a countywide level. Individual Strategies • Provide information – Educate parents and youth on the dangers of tobacco use by youth through awareness efforts, workshops, and countywide events. These programs will be provided through county alcohol and drug funding, municipal alliances, and other community organizations. • Provide Information – Educate youth on the dangers of tobacco use through by means of evidence-based middle and elementary school prevention programs and other community-based initiatives. Legislation • The State of New Jersey enacted a statute to raise the age to sell tobacco products from persons 19 years of age to 21 years of age effective November 1, 2017 (P.L.2017, Chapter 118). Other • DMHAS funds community-based services targeting high-risk individuals or groups in each of New Jersey's 21 counties. Many of these providers are also focused on the prevention of tobacco use among youth. • DMHAS, the Department of Health, and the Department of Treasury collaborated in 2023 to develop strategies to reduce underage tobacco sales in New Jersey. One strategy that has been implemented in February 2023 is the addition of information on Treasury's online cigarette licensing application regarding the consequences of underage sales (fines, and/or suspension or revocation of tobacco license) and ways tobacco retailers can avoid underage sales at. Links to merchant education materials were also added to the licensing application's front page.

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

Annual Performance Indicators to measure goal success

Indicator #: 1

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

Baseline measurement (Initial data collected prior to the first-year target/outcome): According to 2021 NSDUH data, 1.97 percent of the target population reported tobacco product use (any) during the month prior to participating in the survey.

"First-year target/outcome measurement (Progress – end of SFY 2024): A reduction of .10% below the baseline measure.

Second-year target/outcome measurement (Final – end of SFY 2025): An additional reduction of .05% below the first year measure.

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

Data Source:

2021 National Survey on Drug Use and Health: Model-Based Prevalence Estimates (50 States and the District of Columbia), Tobacco Product Use in the Past Month, by Age Group and State: Percentages, Annual Averages Based on 2021 NSDUH data for New Jersey.

New Data Source*(if needed)*:

Description of Data:

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

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

None

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

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

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

Priority #: 6

Priority Area: Alcohol

Priority Type:

Population(s): PP

Goal of the priority area:

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

Objective:

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

Strategies to attain the goal:

Beginning in January 2012, DMHAS funded 19 Regional Prevention Coalitions covering NJ's 21 counties, all of whom utilize the SPF model to guide their work. These coalitions are all required to address underage drinking among youth. The coalitions use, primarily, environmental strategies along with occasional individual approaches as appropriate. Below is a listing of approaches used by the coalitions to address underage drinking among adolescents in their regions. Environmental Strategies • Enhance Access/Reduce Barriers – Enhance access to effective prevention strategies and information through the use of a social media campaign and the development of human capital and networks of support. • Enhance Barriers/Reduce Access - Increase education among merchants, bars, and restaurants who sell alcoholic beverages. Also, provide education to parents and guardians. • Change Consequences/Enhance Access/Reduce Barriers – Work with municipal and county government to assure that underage drinking laws are enforced at the local level. • Change Physical Design – Through the compliance check report and GIS mapping, provide municipalities and state Alcoholic Beverage Commission with details regarding how outlet density and location impact tobacco availability to youth. • Modify/Change Policies – Enhance or create policies related to underage drinking among 12-20 years olds on a countywide level. Individual Strategies • Provide information – Educate parents and youth on the dangers of underage drinking by youth through awareness efforts, workshops, and countywide events. These programs will be provided through county alcohol and drug funding, municipal alliances, and other community organizations. • Provide Information – Educate youth on the dangers of underage drinking by means of evidence-based middle and elementary school prevention programs and other community-based initiatives.

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

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Binge Alcohol Use in the Past Month by persons aged 12-20.

Baseline measurement (Initial data collected prior to the first-year target/outcome): According to 2021 NSDUH data, 17.98 percent of the target population reported binge drinking during the month prior to participating in the survey.

"First-year target/outcome measurement (Progress – end of SFY 2024): A reduction of .50% below the baseline measure.

Second-year target/outcome measurement (Final – end of SFY 2025): An additional reduction of .05% below the baseline measure.

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

Data Source:

Alcohol Use and Binge Alcohol Use in the Past Month among Individuals Aged 12 to 20, by Age Group and State: Percentages, Annual Averages Based on 2021 NSDUH data for New Jersey

New Data Source*(if needed)*:

Description of Data:

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

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

None

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

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

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

Priority #: 7

Priority Area: Marijuana

Priority Type:

Population(s): PP

Goal of the priority area:

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

Objective:

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

Strategies to attain the goal:

Beginning in January 2012, DMHAS funded 19 Regional Prevention Coalitions covering NJ's 21 counties, all of whom utilize the SPF model to guide their work. These coalitions are all required to address marijuana use among youth. The coalitions use, primarily, environmental strategies along with occasional individual approaches as appropriate. Below is a listing of approaches used by the coalitions to address marijuana use among adolescents in their regions. Environmental Strategies • Enhance Access/Reduce Barriers – Enhance access to effective prevention strategies and information through the use of a social media campaign and the development of human capital and networks of support. • Change Consequences/Enhance Access/Reduce Barriers – Work with municipal and county government to assure that marijuana use and possession laws are enforced at the local level. • Modify/Change Policies – Enhance or create policies, laws, and ordinances related to marijuana use among 12-17 years olds on a countywide level. Individual Strategies • Provide information – Educate parents and youth on the dangers of marijuana use by youth through awareness efforts, workshops, and countywide events. These programs will be provided through county alcohol and drug funding, municipal alliances, and other community organizations. • Provide Information – Educate youth on the dangers of marijuana use by means of evidence-based middle and elementary school prevention programs and other community-based initiatives.

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

Annual Performance Indicators to measure goal success

Indicator #: 1

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

Baseline measurement (Initial data collected prior to the first-year target/outcome): According to 2021 NSDUH data, 8.13 percent of the target population reported marijuana use during the year prior to participating in the survey.

"First-year target/outcome measurement (Progress – end of SFY 2024): A reduction of .05% below the baseline measure.

Second-year target/outcome measurement (Final – end of SFY 2025): An additional reduction of .05% below the baseline measure.

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

Data Source:

Marijuana Use in the Past Year, by Age Group and State: Percentages, Annual Averages Based on 2021 NSDUH data for New Jersey

New Data Source*(if needed)*:

Description of Data:

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

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

None.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

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

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

Priority #: 8

Priority Area: Prescription Drugs

Priority Type:

Population(s): PP

Goal of the priority area:

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

Objective:

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

Strategies to attain the goal:

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

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

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Opioid Prescriptions in New Jersey.

Baseline measurement (Initial data collected prior to the first-year target/outcome): According to data from NJ CARES – A Realtime Dashboard of Opioid-Related Data and Information (maintained by the Office of the New Jersey Attorney General), in 2021, 3,537,890 prescriptions for opioids were provided in New Jersey.

"First-year target/outcome measurement (Progress – end of SFY 2024): A reduction of .75% below the baseline measure.

Second-year target/outcome measurement (Final – end of SFY 2025): An additional reduction of .25% below the baseline measure.

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

Data Source:

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

New Data Source*(if needed)*:

Description of Data:

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

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

None

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

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

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

Priority #: 9

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

Priority Type: MHS

Population(s): SED

Goal of the priority area:

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

Objective:

To build capacity among clinicians to be able to utilize the Attachment, Regulation and Competency (ARC) Model with the youth and families they serve. The ARC Model is an evidence-based, flexible, components-based intervention developed for children and adolescents who have experienced complex trauma, along with their caregiving systems.

Strategies to attain the goal:

In order to increase their capacity to provide this intervention to New Jersey youth and families, a cohort of IIC Clinicians will be trained in year one, with a subset of these trainees receiving "train-the-trainer" training in year two.

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

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	A cohort of clinicians will be trained in the Attachment, Regulation, and Competency (ARC) Model, a subset of whom will also be trained to provide ARC Model training to other clinicians.
Baseline measurement (Initial data collected prior to the first-year target/outcome):	0
"First-year target/outcome measurement (Progress – end of SFY 2024):	40 clinicians will be trained in the ARC Model.
Second-year target/outcome measurement (Final – end of SFY 2025):	Of the 40 clinicians trained in year 1, 10 will be provided "train-the-trainer" training to ensure sustainable capacity building.

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

Data Source:

Internal Data

New Data Source*(if needed)*:

Description of Data:

The number of clinicians who successfully completed the ARC Model training.

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

None.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

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

How first year target was achieved *(optional)*:
A cohort of 46 clinicians, members of our Intensive In-Community (IIC) network, were successfully recruited for and completed the ARC model training.

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

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

How second year target was achieved:

Of the 40+ clinicians trained in year 1, 14 were identified to complete the "train-the-trainer" training. The 14 participants are scheduled to graduate from the program in January 2026, at which time they will be qualified to train upcoming cohorts in the ARC model. This new group of trainers will train staff from their agencies as well as statewide cohorts in partnership with Rutgers University.

Priority #: 10

Priority Area: Heroin

Priority Type:

Population(s): PP

Goal of the priority area:

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

Objective:

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

Strategies to attain the goal:

Beginning in January 2012, DMHAS funded 19 Regional Prevention Coalitions covering NJ's 21 counties, all of whom utilize the SPF model to guide their work. These coalitions are all required to address the use of illegal substances (including heroin) among youth. The coalitions use, primarily, environmental strategies along with occasional individual approaches as appropriate. Below is a listing of approaches used by the coalitions to address perceptions of risk regarding heroin use among adolescents in their regions. Environmental Strategies • Enhance Access/Reduce Barriers – Enhance access to effective prevention strategies and information through the use of a social media campaign and the development of human capital and networks of support. • Change Consequences/Enhance Access/Reduce Barriers – Work with municipal and county government to assure that laws regarding the use of illegal substance (including heroin) are enforced at the local level. • Modify/Change Policies – Enhance or create policies designed to increase perceptions of risk and harm related to the use of heroin among 12-17 years olds on a countywide level. Individual Strategies • Provide information – Educate parents and youth on the dangers of illegal substances (including heroin) by youth through awareness efforts, workshops, and countywide events. These programs will be provided through county alcohol and drug funding, municipal alliances, and other community organizations. • Provide Information – Educate youth on the dangers of illegal substance and heroin use by means of evidence-based middle and elementary school prevention programs and other community-based initiatives.

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

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Perceptions of Great Risk from Trying Heroin Once or Twice among persons aged 12-17.
Baseline measurement (Initial data collected prior to the first-year target/outcome):	According to 2021 NSDUH data, 60.96 percent of the target population reported Perceptions of Great Risk from Trying Heroin Once or Twice.
"First-year target/outcome measurement (Progress – end of SFY 2024):	An increase of .50% above the baseline measure.
Second-year target/outcome measurement (Final –	An additional increase of .05% above the first year measure

end of SFY 2025):

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

Data Source:

Perceptions of Great Risk from Trying Heroin Once or Twice, by Age Group and State: Percentages, Annual Averages Based on 2021 NSDUH data for New Jersey

New Data Source*(if needed)*:

Description of Data:

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

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

None

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

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

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

Priority #: 11

Priority Area: Support the integration of physical health and mental health/wellness for all New Jersey youth.

Priority Type: MHS

Population(s): SED

Goal of the priority area:

To provide New Jersey pediatricians with the tools they need to support youth with mental health needs. The Pediatric Psychiatry Collaborative (PPC) provides quick access to psychiatric consultation and facilitates referrals for accessing ongoing behavioral health care. Pediatricians are encouraged to integrate behavioral health resources into their practices and work with child and adolescent psychiatrists as well as other behavioral health providers.

Objective:

To increase utilization of the PPC services and supports, we will increase the percentage of PPC-enrolled pediatricians who refer at least one youth to the PPC for services or supports.

Strategies to attain the goal:

There are currently 665 pediatricians who have partnered with the PPC; in FY22 45% of these physicians referred a youth to the PPC at least once. To improve upon this rate, additional training / reminders / opportunities for connection will be provided to member pediatricians.

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

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	The percentage of PPC-enrolled pediatricians who have made at least one referral for a youth to receive PPC services and/or supports will increase.
Baseline measurement (Initial data collected prior to the first-year target/outcome):	For FY22, 45% of pediatricians enrolled in the PPC made at least one referral for a youth to receive services or supports from the PPC.
"First-year target/outcome measurement (Progress – end of SFY 2024):	For FY24, the rate of pediatricians enrolled in the PPC who made at least one referral for a youth to receive services or supports from the PPC will increase to 48%.
Second-year target/outcome measurement (Final –	FY25, the rate of pediatricians enrolled in the PPC who made at least one referral for a

end of SFY 2025): youth to receive services or supports from the PPC will increase to 50%.

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

Data Source:

The New Jersey Pediatric Psychiatry Collaborative

New Data Source*(if needed)*:

Description of Data:

The provider will provide the percentage of pediatricians enrolled in the PPC who referred at least one youth to the PPC for services or supports.

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

None.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

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

How first year target was achieved *(optional)*:
In addition to increased recruitment efforts, additional training / reminders / opportunities for connection were provided to all member pediatricians. Of the 892 total pediatricians enrolled in the PPC during FY24, 437 made at least one referral, increasing the referral rate to 49%.

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

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

How second year target was achieved:

The PPC has been prioritizing reengaging currently enrolled providers that may not have referred in a while or are having issues with the referral process and need assistance; continued outreach efforts and educational/training opportunities. Of the 951 pediatricians enrolled in the PPC, 495 of them submitted at least one referral in the reporting year, increasing the referral rate to52%.

Priority #: 12

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

Priority Type: MHS

Population(s): SED

Goal of the priority area:

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

Objective:

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

Strategies to attain the goal:

A cohort of clinicians and supervisors will be trained in the Clinical Practice Series in Infant / Early Childhood Mental Health, which includes professional formation and reflective supervision methods, providing capacity to support very young children and their caregiving system with urgent, and/or complex needs.

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

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: A cohort of clinicians and supervisors will be trained in the Clinical Practice Series in Infant / Early Childhood Mental Health.

Baseline measurement (Initial data collected prior to the first-year target/outcome): 0

"First-year target/outcome measurement (Progress – end of SFY 2024): 40 clinicians and supervisors will be engaged in the Clinical Practice Series in Infant / Early Childhood Mental Health training.

Second-year target/outcome measurement (Final – end of SFY 2025): 40 clinicians and supervisors will complete the Clinical Practice Series in Infant / Early Childhood Mental Health training.

New Second-year target/outcome measurement *(if needed)*: 35 clinicians and supervisors will complete the Clinical Practice Series in Infant / Early Childhood Mental Health training.

Data Source:

Internal Data

New Data Source *(if needed)*:

Not needed.

Description of Data:

the number of clinicians who successfully completed the training.

New Description of Data: *(if needed)*

Not needed.

Data issues/caveats that affect outcome measures:

None.

New Data issues/caveats that affect outcome measures:

None.

Report of Progress Toward Goal Attainment

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

Reason why target was not achieved, and changes proposed to meet target:
The time commitment required, coupled with the ongoing workforce challenges being experienced by all industries and jurisdictions, made this an opportunity that was not feasible for a significant portion of the Intensive In-Community (IIC) network of clinicians. Ultimately, 37 clinicians engaged in the Clinical Practice Series in Infant / Early Childhood Mental Health training. As a result, we will adjust our year two target to read: 35 clinicians and supervisors will complete the Clinical Practice Series in Infant / Early Childhood Mental Health training.

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

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

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

How second year target was achieved:

40 clinicians and supervisors completed the Clinical Practice Series in Infant/Early Childhood Mental Health training. 44 additional clinicians and supervisors began the Clinical Practice Series and are expected to complete it in 2026.

Priority #: 13

Priority Area: Housing Services in Community Support Services

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

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

Objective:

SMHA continues to increase opportunities for community living among mental health consumers by developing additional housing units and

maintaining levels of occupancy to satisfy the needs of consumers served in Community Support Services.

Strategies to attain the goal:

Community Support Services (CSS) is a mental health rehabilitation service that assists the consumer in achieving mental health rehabilitative and recovery goals as identified in an individualized rehabilitation plan (IRP). CSS promotes community inclusion, housing stability, wellness, recovery, and resiliency. Consumers are expected to be full partners in identifying and directing the types of support activities that would be most helpful to maximize successful community living. This includes use of community mental health treatment, medical care, self-help, employment and rehabilitation services, and other community resources, as needed and appropriate. The adoption of CSS supports an individual's ability to successfully live in independent, lease-based housing (e.g. supportive housing). The SMHA will utilize a number of strategies to help attain the objective. 1. The Office of Planning, Research, Evaluation, Prevention and Olmstead works collaboratively with provider agencies, state hospital key personnel, DMHAS staff and other Divisions across the state to implement an overall paradigm of community integration. 2. Continued use of the Individual Needs for Discharge Assessment (INDA) facilitates the treatment and discharge planning processes. The INDA serves as both an assessment tool geared toward evaluating needs or barriers that the consumer may face upon discharge and a mechanism by which to assign state hospital consumers to prospective community service providers. The INDA will be continually used by the SMHA to facilitate transition into the community and anticipate and address any barriers that may hinder or preclude placement within the community. 3. Separation of Housing and Services in service delivery has enabled consumers to choose a housing provider and a different service provider. Consumers are not required to use a particular provider, and their refusal to receive services will not impact their housing. This separation enables the SMHA to track expenditures, utilization, outcomes, and demands for services. 4. The Bed Enrollment Data System (BEDS)/Vacancy Tracking System was developed to help DMHAS manage and track vacancies. The system has replaced the process of cold calls to agencies and the utilization of quickly outdated paper tracking sheets. Utilization of a web-based system provides real-time access to vacancy information and helps facilitate assignments and avoid outdated spreadsheets. Analysis of the utilization of Supportive Housing vs. supervised settings (e.g. group homes and supervised apartments) allows for assessment of the Division's progress toward community integration. The system will also enable planning at both the individual consumer level for placement purposes and system-wide for purposes of enhancements in community resources. 5. Assignment Process - In May 2015, New Jersey DMHAS revised its Administrative Bulletin 5:11 directing engagements of consumers by community providers. Under this revision, assignments of consumers replaced the concept of referrals to community providers by hospital treatment teams, requiring providers to either accept the assigned consumer or communicate their needs to DMHAS for additional supports necessary to serving the assigned consumer. The goal of this new policy was the early familiarity of consumers and providers through mandatory provider participation in the discharge planning process and engagements such as recreational day trips; visits to prospective apartments for rent; discharge preparations; and overnight visits (upon request of the consumer and/or hospital treatment team). SMHA staff will monitor the continued development of new Supportive Housing opportunities. The BEDS data system will foster more timely and accurate tracking of residential resources, as well as facilitate their more efficient utilization (e.g., to reduce vacancy rates and increase community placements), and enable monitoring of compliance with Administrative Bulletin 5:11 (Residential Placement from Psychiatric Hospital).

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

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Consumers who remain in Community Support Services (CSS) during the fiscal year as a proportion of total consumers served in Community Support Services.
Baseline measurement (Initial data collected prior to the first-year target/outcome):	The total number of clients served in CSS in SFY 2022 was 5575. The total number of individuals terminated (including individuals who left voluntarily, agency-initiated terminations and individuals who transitioned to a different level of care or service) in SFY 2022 was 808. Therefore, the percentage of consumers who remain in Community Support Services is 85.5%
"First-year target/outcome measurement (Progress – end of SFY 2024):	The percentage of consumers who remain in Community Support Services during SFY 2024 will be no less than 88% of total consumers served in Community Support Services.
Second-year target/outcome measurement (Final – end of SFY 2025):	The percentage of consumers who remain in Community Support Services during SFY 2025 will be no less than 88% of total consumers served in Community Support Services.

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

Data Source:

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

New Data Source*(if needed)*:

Description of Data:

The QCMR Database collects quarterly, cumulative, program-specific data from each of the service providers contracted by DMHAS. The current QCMR for Community Support Services contains 50 data elements. The key data fields relevant for this performance indicator are "Ending Active Caseload (Last Day of Quarter)" and Number of terminations in the Quarter. In SFY 2022, 39 agencies contracted by the SMHA to provide QCMR data for Community Support Services.

New Description of Data:*(if needed)*

Based on SFY 2024 QCMR data on the Community Support Services (CSS) Program, of the 5,777 consumers served by CSS, 405 preventable terminations occurred. “Preventable terminations” include: consumers terminated from CSS due to: “lost to contact”, “admitted to supervised housing”, “hospitalized for >6 months”, “jailed/incarcerated for >3 months” , “client refusals”, and “other”. Terminations that are not preventable (and therefore are not calculated in this indicator) include: “no longer requires CSS”, “moved out of catchment area”, and “deceased”.

Data issues/caveats that affect outcome measures:

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

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

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

How first year target was achieved *(optional)*:
This target was achieved in SFY 2024 (93%). Numerator (preventable terminations from CSS): 405, denominator (clients served by CSS n SFY2024): 5,777. This target was achieved by various means including quality of housing resources, staff-to-consumer engagement, and the need for housing in the state of New Jersey.

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

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

How second year target was achieved:

Based on SFY 2025 QCMR data on the Community Support Services (CSS) Program, of the 5,894 consumers served by CSS, 383 preventable terminations occurred. This target was achieved in SFY 2025 (93.5%).

Priority #: 14

Priority Area: Early Serious Mental Illness (ESMI)

Priority Type: MHS

Population(s): ESMI

Goal of the priority area:

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

Objective:

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

Strategies to attain the goal:

Objectives will be addressed through the implementation of a Coordinated Specialty Care (CSC) model. CSC is an evidence-based recovery-oriented approach involving clients and family members as active participants. All services are highly coordinated with primary medical care. New Jersey’s CSC services are provided for youth and adults between the ages of 15 to 35 years who have experienced psychotic symptoms for less than 2 years with or without treatment. Since November 2016, three teams in New Jersey have been funded to provide CSC services. They cover all 21 counties using extensive outreach efforts. The three provider agencies are Oaks Integrated Care for Southern region, Rutgers University Behavioral Health Center for Central region, and CarePlus NJ for Northern region. Each CSC team is comprised of six members, mostly masters level clinicians, who contribute to high levels of care. They take on the roles of Team Leader, Recovery Coach, Supported Employment and Education Specialist, Pharmacotherapist, Outreach and Referral Specialist, and Peer Support Specialist. The New Jersey CSC model emphasizes treatment through the following components: outreach, low-dosage medications, cognitive and behavioral skills training, Individualized Placement and Support (IPS), supported employment and supported education, peer support, case management, and family psychoeducation. New Jersey plans to continue utilizing the 10% set-aside funding in the FY 2024-25 to support the CSC teams in providing evidence-based services for individual with ESMI. The CSC programs serve up to 70 individuals per agency with clinical staff at 6.6 FTE levels in FY 2023.

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

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Medication adherence among individuals who need psychotropic medication prescribed for ESMI treatment.

Baseline measurement (Initial data collected prior to the first-year target/outcome): In SFY 2022, 359 individuals were in the CSC programs. 317 of the 359 individuals were taking or in need of antipsychotic medication for the treatment of their psychosis at intake. 91% (289) of the 317 individuals were adherent to their medication regimen.

"First-year target/outcome measurement (Progress – end of SFY 2024): In SFY 2024, it is anticipated that at least 88% of the individuals who are taking or in need of antipsychotic medication adhere to the medication regimen.

Second-year target/outcome measurement (Final – end of SFY 2025): In SFY 2025, it is anticipated that at least 88% of the individuals who are taking or in need of antipsychotic medication adhere to the medication regimen.

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

Data Source:

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

New Data Source*(if needed)*:

Description of Data:

The three CSC service providers submit the client level clinical diagnostic data quarterly to DMHAS. The CSC clinical diagnostic database tracks client referral and intake; functional status; program involvement; education and employment; medication and substance use; suicide ideation; hospitalization; and client discharge information. The DMHAS is in the process of creating a comprehensive client level data system that includes data elements from all DMHAS contracted community programs. The client level data system will include all CSC program elements currently collected through the CSC clinical diagnostic database and additional measures required by federal and state data reporting and evaluation. The client level data will provide a detailed description of the ESMI population receiving CSC services in New Jersey and will help capture the treatment and recovery progress of CSC clients so that DMHAS can improve services for early serious mental illness population in New Jersey.

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

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

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

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

How first year target was achieved *(optional)*:
Yes; 917 clients were prescribed psychotropic medication regimen with 803 adhering to the regimen as prescribed. 88%

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

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

The target is at least 88% of the individuals who are taking or in need of antipsychotic medication adhere to the medication regimen. The actual is 83%. The target goals were not met largely due to the expansion of the Coordinated Specialty Care (CSC) program. Newly established programs require time to fully staff, build client capacity and successfully implement service models. During this reporting period, DMHAS expanded its CSC program to include individuals with Affective Psychosis and also implemented a new step-down program, Community Integration (CSC CI). In Spring 2024, three newly awarded CSC CI programs began providing services, increasing the total to five programs/locations serving 18 New Jersey counties. Each provider agency is responsible for operating both a CSC program and a CI program, and the development and growth process for these programs contributed to delays in meeting the adherence target.

How second year target was achieved:

Priority #: 15

Priority Area: Behavioral Health Crisis Services through the 988 Suicide and Crisis Lifeline

Priority Type:

Population(s): BHCS

Goal of the priority area:

Access to behavioral health crisis services through the 988 Suicide and Crisis Lifeline will help to de-escalate individuals in suicidal, mental health, or substance-use related crisis and connect them to appropriate mental and/or behavioral health services throughout New Jersey.

Objective:

Among individuals calling the 988 Suicide and Crisis Lifeline from within NJ, at least 90% will have their calls answered by a New Jersey 988 Lifeline center by September 30, 2025.

Strategies to attain the goal:

The objective of this project will be achieved through increasing capacity and expanding operations in current 988 Lifeline centers as well as establishing additional 988 Lifeline centers in the state. NJ currently has five (5) 988 Lifeline centers certified by Vibrant Emotional Health (Vibrant) for meeting the minimum clinical, operational and performance standards. Those centers are: Contact of Burlington County, CONTACT of Mercer County (COMC), Caring Contact, Mental Health Association in New Jersey (MHANJ), and Rutgers University Behavioral Health Care (R-UBHC). Collectively, these centers offer statewide coverage for incoming calls to NJ's 21 counties. R-UBHC is the only center in NJ that currently offers 24/7 call services. Carelon Behavioral Health (Carelon) was recently awarded the NJ 988 Managing Entity contract. Carelon's responsibilities will include collecting, recording, and analyzing all 988 data from the NJ Lifeline centers. In 2021, the National Suicide Prevention Lifeline in NJ received 45,819 calls. In the first eleven months of 988, NJ has received approximately 53,000 calls. By the end of year one, NJ is projected to surpass the number of calls received in 2021 by over 10,000. So far, these increases in volume have occurred without statewide messaging. Since the transition to 988, NJ's monthly in-state call answer rate has fluctuated between 70% and 85%, reaching a recent high of 85%. As a statewide Public Awareness Campaign is scheduled for the coming months, it is anticipated that the statewide answer rate will drop in response to higher call volumes. To reach the goal of at least 90% annually, additional capacity is needed (staffing, technology, IT, space, overhead, etc.) and gaps in coverage hours (evenings, nights and weekends) must be filled. The State Fiscal Year (SFY) 2024 budget includes $10 million for 988 Lifeline operations. NJ DMHAS plans to expand 988 Lifeline center operations (for current and/or future centers) through a competitive procurement process to allocate these funds. This expansion will add capacity to the NJ 988 system and allow a higher rate of response to calls 24 hours a day, every day of the year. This funding opportunity is anticipated to be published and awarded in the Fall of 2023. NJ DMHAS also recently applied for the SAMHSA 988 State and Territory Improvement Grant. If awarded, it would provide the state with approximately $12 million over the next three (3) years to improve the response to 988 contacts originating in NJ. Funding from this grant would be used to build/expand the NJ 988 workforce to answer at least 90% of total calls routed to NJ Lifeline centers. Award notification is expected from SAMHSA in August 2023. If awarded, a funding opportunity for current and incoming 988 Lifeline centers is expected to be published and awarded in the Spring of 2024.

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

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: 988 Suicide and Crisis Lifeline statewide answer rate percentage

Baseline measurement (Initial data collected prior to the first-year target/outcome): In SFY 2022, before the transition to the 988 Suicide and Crisis Lifeline, NJ's five National Suicide Prevention Lifeline centers answered approximately 77% of calls statewide. Post-transition, in the first eleven months of SFY 2023, the annual average in-state answer rate is approximately 79%. Since the transition to 988, NJ's monthly in-state call answer rate has steadily improved from 70%, reaching a recent high of 85%.

"First-year target/outcome measurement (Progress – end of SFY 2024): In SFY 2024, it is anticipated that at least 85% of calls coming into the 988 Suicide and Crisis Lifeline from NJ will be answered by a center in-state.

Second-year target/outcome measurement (Final – end of SFY 2025): In SFY 2025, it is anticipated that at least 90% of calls coming into the 988 Suicide and Crisis Lifeline from NJ will be answered by a center in-state.

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

Data Source:

Vibrant, the contract administrator for the 988 Suicide and Crisis Lifeline, collects and distributes monthly answer rate data to the Division of Mental Health and Addiction Services (DMHAS). Carelon Behavioral Health (Carelon), the NJ 988 Managing Entity, will also be collecting and reporting individual center data and statewide center data, including call answer rate, to NJ DMHAS on a monthly basis.

New Data Source*(if needed)*:

Description of Data:

Individual center and statewide data on Key Performance Indicators, including calls routed and those answered, are collected and reported monthly to NJ DMHAS by Vibrant. Vibrant collects this data utilizing its own internal data processes. Individual centers will collect data utilizing their own data management systems and report that data to Carelon monthly. Once compiled and analyzed, data

reports will be shared with DMHAS staff.

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

Discrepancies currently exist between Vibrant data and data collected in-house by the individual centers. Vibrant is working with the centers to minimize these discrepancies.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

Reason why target was not achieved, and changes proposed to meet target:
In SFY24, NJ 988 Lifeline centers answered 77% of calls received (60,582/77,265); below the first-year target of 85%.

In August of 2023, NJ DMHAS, in partnership with the NJ Department of Human Services (DHS)- contracted marketing vendor, MarketSmith, launched a statewide public awareness campaign. As a result of this campaign, NJ Lifeline centers saw an increase in contacts.

The State Fiscal Year (SFY) 2024 budget included $10 million for 988 Lifeline operations. NJ DMHAS had planned to award state funding by Fall 2023. However, due to the time-consuming nature of established state procurement rules, funding has been delayed.

In pursuit of a 90% in-state answer rate, NJ DMHAS utilized $10 million in State Fiscal Year 2024 (SFY24) appropriations to enhance NJ 988 call, chat and text services. A Request for Proposals (RFP) to award these funds was posted in March of 2024. In September 2024, approximately $7 million from this State-funding opportunity was awarded to two (2) of the preexisting 988 Lifeline centers in NJ: MHANJ and R –UBHC. Utilizing these funds, both centers will be increasing their capacity to provide greater call response and will begin providing chat and text services for NJ 988.

In SFY24, NJ DMHAS was awarded the SAMHSA 988 State and Territory Improvement Grant, providing the state with approximately $12 million over the next three (3) years to improve the response to 988 contacts originating in NJ. Using a portion of these grant funds, NJ DMHAS extended contracts with the two (2) Lifeline centers that did not receive awards from the original procurement (Caring Contact and CONTACT of Mercer County) so that they can continue their work with the Lifeline system These contracts have been extended through March 2025. Unfortunately, as of 07/31/2024, Contact of Burlington County (CBC) is no longer providing services for the 988 Suicide and Crisis Lifeline in NJ. To provide ongoing funding past this date, NJ DMHAS is drafting a Request for Letters of Interest (RLI), using a portion of these grant funds to current NJ 988 Lifeline network-approved centers to answer at least 90% of total calls and/or chats and texts that are routed to their center. NJ DMHAS plans to have this RLI posted by late Fall 2024.

NJ DMHAS is also currently drafting an RFP to further expand the 988 Lifeline workforce. The goal of this procurement is to establish an additional 24/7/365 call, chat and text center to respond to at least 90% of total contacts that are routed to the center. This procurement will include unallocated funds from the initial State funding opportunity and funds from the SAMHSA Improvement Grant. Funding awards are anticipated to be made in SFY25.

The NJ 988 system has seen a steady increase in call volume since transition, increasing approximately 16% annually. While volume has increased, the 988 Lifeline centers have also continued to increase the number of answered calls. In Calendar Year (CY) 2021, the NSPL centers in NJ received 45,820 calls of which they answered 35,756 (78%). In CY2022, the NSPL transitioned to 988 mid-year and the centers in NJ received 53,651 calls of which 41,215 (77%) were answered. In CY2023, the first full year of 988, those same centers received 62,219 calls of which 49,462 (79.5%) were answered.

NJ 988 Lifeline centers continue to recruit and onboard staff to expand the capacity for responding to calls, chats and texts. In addition, DMHAS has met with Vibrant representatives to reconfigure the routing of calls to NJ to improve the statewide answer rate. Future funding opportunities and ongoing funding streams are vital to reaching and maintaining this goal. As volume increases, the demand for staffing and other infrastructure to support 988 operations (e.g. technology, space, overhead, etc.) has increased. Therefore, in addition to current federal and state funding, NJ DMHAS is working with other State agencies and departments to identify sufficient, ongoing funding to support these expanding needs. Various options are being explored, including Medicaid Federal Financial Participation and funding from private insurance.

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

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

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

In SFY25, NJ 988 Lifeline centers answered 81% (69,454/85,380) of calls originating in New Jersey; below the second-year target of 90%. Throughout SFY25, NJ DMHAS worked with its 988 Lifeline centers to enhance their operations and established additional funding to further support the centers into the future. However, due to increased demand and the time-consuming state solicitation process, New

Jersey has not fully realized the goal as outlined. Below summarizes actions taken towards this goal and the continued efforts being made to meet this national 988 performance standard.

By October 2024, NJ DMHAS finalized awards totaling approximately $7 million in ongoing SFY funding to two of the four current NJ 988 Lifeline centers (Rutgers University Behavioral Health Care (R-UBHC) and the Mental Health Association in New Jersey (MHANJ)) to further expand their staffing capacity to respond to 988 contacts. In addition, utilizing SAMHSA 988 State and Territory Improvement Grant funds, NJ DMHAS issued one-year extensions to the contracts of the two 988 centers that were not awarded SFY funding (Caring Contact and CONTACT of Mercer County (COMC)). These funds allowed the two centers to maintain their 988 center operations while NJ DMHAS drafted a sustainable funding opportunity specific to these two centers.

In March 2025, NJ DMHAS published a Request for Letters of Interest (RLI) directed toward Caring Contact and COMC for the purposes of establishing increased and sustained funding for their 988 center operations. At the end of SFY25, approximately $3 million in total was awarded to the two centers for the purposes of expanding their 988 center capacity to support the state in achieving and maintaining a 90% in-state answer rate.

At the close of SFY25, NJ DMHAS was also able to utilize SAMHSA 988 grant funding to award 20% contract extensions to both MHANJ and R-UBHC for the purposes of further expanding their center operations.

From SFY24 to SFY25, NJ 988 experienced a 10% increase in call volume. While volume has increased, the 988 Lifeline centers have been able to continue to increase the number of calls answered. In SFY25, NJ 988 centers responded to 14% more calls than in SFY24. However, due to the increase in demand, the 90% answer rate has not been achieved.

Increases in demand can be attributed to the high-profile public messaging campaign that began in March 2025. Comparing data from February 2025 (prior to the media campaign launch) to June 2025, NJ saw a 43.7% increase in call demand.

Data thus far for SFY26 shows a more significant increase in demand with 62.5% more calls being routed than in SFY24 and 47% more calls being routed than in SFY25. Thus far for SFY26, New Jersey is averaging 10,480 calls per month compared to 6,448 in SFY24 and 7,115 in SFY25.

Utilizing these funding opportunities, NJ 988 Lifeline centers continue to recruit and onboard staff to expand the capacity for responding to contacts. NJ DMHAS is also working with centers to establish improved routing based on center staffing and has worked with Vibrant to discuss workforce management strategies to support the centers.

As previously mentioned, as volume increases, the demand for staffing and other infrastructure to support 988 operations (e.g. technology, space, overhead, etc.) has increased. Therefore, in addition to current federal and state funding, NJ DMHAS is working with other State agencies and departments to identify sufficient, ongoing funding to support these expanding needs. Various options are being explored, including Medicaid Federal Financial Participation and funding from private insurance.

How second year target was achieved:

0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

COVID Testing and Mitigation Program Report
for the Community Services Mental Health Block Grant (MHBG)
for Federal Fiscal Year Ending September 30, 2025
Due Date: December 31st, 2025

For the Federal Fiscal Year ending September 30, 2025, please upload a Word or PDF document in Table 1 of the FY26 MHBG Report on the COVID Testing and Mitigation activities and expenditures by answering the following question, due by December 31, 2025.

List the items and activities of expenditures completed from October 1, 2024, through September 30, 2025 (if no activities were completed, please add 'Not Applicable' on the table)

COVID Testing and Mitigation Program Report for STATE	
Item/Activity	Amount of Expenditure
Personal Protective Equipment (PPE)	$240.25

C. State Agency Expenditure Report

MHBG Table 2A (URS Table 7A) - State Agency Expenditure Report

This table collects information on mental health expenditures by sources of funding. This includes funding from the MHBG, Medicaid, other federal funding sources, state, local, other funds, and MHBG supplemental funds including COVID-19, ARP, and BSCA.

Reporting Period Start Date: 7/1/2024 Reporting Period End Date: 6/30/2025

Activity)	Source of Funds										
	A. Substance Abuse Block Grant	B. Mental Health Block Grant	C. Medicaid (Federal State & Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare), etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. COVID -19 Relief Funds (MHBG)[1]	I. ARP Funds (MHBG)[2]	J. Bipartisan Safer Communities Funds[3]	K. Total
1. Substance Abuse Prevention and Treatment											$0
a. Pregnant Women and Women with Dependent Children											$0
b. All Other[3]											$0
2. Evidence-Based Practices for Early Serious Mental Illness including Psychotic Disorders (10 percent of total award MHBG)[4]		$2,629,153	$0	$0	$0	$0	$0	$0	$0	$0	$0
3. Tuberculosis Services											$0
4. Early Intervention Services for HIV											$0
5. State Hospital			$52,927,916	$0	$406,657,926	$0	$0	$0	$0	$0	$0
6. Other Psychiatric Inpatient Care			$0	$0	$0	$0	$0	$0	$0	$0	$0
7. Other 24-Hour Care (Residential Care)		$5,049,058	$404,865,233	$0	$197,255,135	$0	$0	$0	$0	$0	$0
8. Ambulatory/Community Non-24 Hour Care		$16,001,710	$869,693,286	$7,365,331	$374,575,601	$0	$400,000	$21,772,336	$15,719,487	$612,997	$0
9. Crisis Services (5 percent set-aside)[5]		$1,411,800	$0	$1,236,014	$18,139,235	$0	$0	$0	$0	$0	$0
10. Administration (Excluding Program and Provider Level)[6]		$2,828,565	$1,730,787	$6,467,257	$16,386,279	$0	$0	$5,196,569	$3,273,620	$57,497	$0
11. Total	**$0**	**$27,920,286**	**$1,329,217,222**	**$15,068,602**	**$1,013,014,176**	**$0**	**$400,000**	**$26,968,904**	**$18,993,107**	**$670,495**	**$2,432,252,791**
Comments on Data:											

[1]The 24-month expenditure period for the COVID-19 Relief supplemental funding is March 15, 2021 – March 14, 2023. Column G should reflect the COVID-19 Relief supplemental funding allotment portion used during the state reporting period. ***Note: If your state has an approved second no cost extension, you have until March 14, 2025 to expend the COVID-19 Relief supplemental funds.***

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is September 1, 2021 – March 24, 2025. Column H should reflect the ARP supplemental funding allotment portion used during the state reporting period.

[3]The expenditure period for the 3rd and 4th allocations of the Bipartisan Safer Communities Act (BSCA) supplemental funding is September 30, 2024 – September 29, 2026 (3rd increment), and September 30, 2025 – September 29, 2027 (4th increment). Column I should reflect the BSCA allotment portion used during the state reporting period.

[4]Column B row 2 should include Early Serious Mental Illness including First Episode Psychosis programs funded through different funding sources, including the MHBG, ARP, and BSCA set aside. States may expend more than 10 percent of their MHBG, ARP, and BSCA allocations.

[5]Row 9 should include Crisis Services programs funded through different funding sources, including the MHBG and BSCA set aside. States may expend more than 5 percent of their MHBG and BSCA allocations.

[6]Per statute, administrative expenditures for MHBG, COVID-19, ARP, and BSCA funds cannot exceed 5 percent of the fiscal year award.

0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

C. State Agency Expenditure Report

MHBG Table 2B (URS Table 7B) MHBG State Agency Early Serious Mental Illness including Psychotic Disorders Expenditure Report

This table collects information on mental health expenditures by sources of funding specifically for Coordinated Specialty Care (CSC) Programs as well as other Early Serious Mental Illness (ESMI) programs through the MHBG 10% set-aside and other funding sources.

Reporting Period From: 7/1/2024 Reporting Period To: 6/30/2025

Activity	Source of Funds									
	A. Mental Health Block Grant	B. Medicaid (Federal, State, and Local)	C. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare), etc.)	D. State Funds	E. Local Funds (excluding local Medicaid)	F. Other	G. COVID-19 Funds (MHBG)[1]	H. ARP Funds (MHBG)[2]	I. BSCA Funds (MHBG)[3]	J. Total
1. Coordinated Specialty Care (CSC) Programs[4]	$1,482,728	$0	$0	$0	$0	$0	$0	$0	$0	**$1,482,728**
2. Training for CSC Practices	$0	$0	$0	$0	$0	$0	$0	$0	$0	**$0**
3. Planning for CSC Practices	$1,146,425	$0	$0	$0	$0	$0	$0	$0	$0	**$1,146,425**
4. Other Early Serious Mental Illnesses (ESMI) programs	$0	$0	$0	$0	$0	$0	$0	$0	$0	**$0**
5. Training for ESMI	$0	$0	$0	$0	$0	$0	$0	$0	$0	**$0**
6. Planning for ESMI	$0	$0	$0	$0	$0	$0	$0	$0	$0	**$0**
7. Other[5]	$0	$0	$0	$0	$0	$0	$0	$0	$0	**$0**
8. Total	**$2,629,153**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$2,629,153**
Comments on Data:										

[1] The 24-month expenditure period for the COVID-19 Relief supplemental funding is March 15, 2021 – March 14, 2023. Column G should reflect the COVID-19 Relief supplemental funding allotment portion used during the state reporting period.**Note: If your state has an approved second no cost extension, you have until March 14, 2025 to expend the COVID-19 Relief supplemental funds.**

[2] The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is September 1, 2021 – March 24, 2025. Column H should reflect the ARP supplemental funding allotment portion used during the state reporting period.

[3] The expenditure period for the 3rd and 4th allocation of the Bipartisan Safer Communities Act (BSCA) supplemental funding is September 30, 2024 – September 29, 2026 (3rd increment) and September 30, 2025 – September 29, 2027 (4th increment). Column I should reflect the BSCA allotment portion used during the state reporting period.

[4] Use row 1 to report only those programs that are providing all components of a CSC model.

[5] Use row 7 if the state uses only certain components of a CSC model.

Note, The Totals for this table should equal the amounts reported on Row 2 (Evidence-Based Practices for Early Serious Mental Illness including Other

Footnotes:

C. State Agency Expenditure Report

MHBG Table 2C (URS Table 7C) - MHBG State Agency Crisis Services Expenditures Report

This table collects information on mental health expenditures specifically for behavioral health crisis response services (BHCS) provided or funded by the state mental health authority through the MHBG 5% set-aside and other funding sources.

Reporting Period Start Date: 7/1/2024 Reporting Period End Date: 6/30/2025

	Source of Funds									
Services	**A. Mental Health Block Grant**	**B. Medicaid (Federal State & Local**	**C. Other Federal Funds (e.g. ACF (TANF), CDC, CMS (Medicare),etc.)**	**D. State Funds**	**E. Local Funds (excluding local Medicaid)**	**F. Other**	**G. COVID-19 Funds (MHBG)**	**H. ARP Funds (MHBG) [2]**	**I. BSCA Funds (MHBG) [3]**	**J. Total**
1. Crisis Contact Centers	$1,411,800	$0	$1,236,014	$18,139,235	$0	$0	$0	$0	$0	$20,787,049
2. 24/7 Mobile Crisis Team	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
3. Crisis Stabilization Programs	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
4. Training and Technical Assistance	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
5. Strategic Planning and Coordination	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total	**$1,411,800**	**$0**	**$1,236,014**	**$18,139,235**	**$0**	**$0**	**$0**	**$0**	**$0**	**$20,787,049**

Comments on Data:

[1]The 24-month expenditure period for the COVID-19 Relief supplemental funding is March 15, 2021 – March 14, 2023. Column H should reflect the COVID -19 Relief supplemental funding allotment portion used during the state reporting period. **Note: If your state has an approved second no cost extension, you have until March 14, 2025 to expend the COVID-19 Relief supplemental funds.**

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is September 1, 2021 – March 24, 2025, which is different from the expenditure period for the "standard" MHBG. Column H should reflect the ARP supplemental funding allotment portion used during the state reporting period.

[3]The expenditure period for the 3rd and 4th allocation of the Bipartisan Safer Communities Act (BSCA) supplemental funding is September 30, 2024 – September 29, 2026 (3rd increment) and September 30, 2025 – September 29, 2027 (4th increment). Column I should reflect the BSCA allotment portion used during the state reporting period.

Note, The Totals for this table should equal the amounts reported on Row 7 (Crisis Services (5 percent set-aside)) on MHBG Table 2a (URS Table 7a).

For definitions, please refer to the ***National Guidelines for Behavioral Health Crisis Care – A Best Practice Toolkit*** .

0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

C. State Agency Expenditure Report

MHBG Table 3 - Set-aside for Children's Mental Health Services

This table collects information on the statewide expenditures for children's mental health services during the last completed SFY. States and jurisdictions are required not to spend less than the amount expended in FY 1994.

Reporting Period Start Date: 7/1/2024 Reporting Period End Date: 6/30/2025

Statewide Expenditures for Children's Mental Health Services			
A **Actual SFY 1994**	**B** **Actual SFY 2024**	**C** **Estimated/Actual SFY 2025**	**Please specify if expenditure amount reported in Column C is actual or estimated**
$20,612,000	$269,024,125	$269,024,125	(●) Actual ( ) Estimated

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

States and jurisdictions are required not to spend less than the amount expended in FY 1994.

0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

The table will be completed upon receipt of the data.

C. State Agency Expenditure Report

MHBG Table 4A (URS Table 8A) Profile of Community Mental Health Block Grant Expenditures for Other Capacity Building/Systems Development Activities

This table collects information on expenditures of MHBG funds including COVID-19, ARP, and BSCA supplemental funds for other capacity building/systems development activities (non-direct service activities) that are funded or conducted by the SMHA during the last completed SFY. Expenditures reported in this table should **not** include administration activities which is capped at 5 percent. Please enter the total amount of the block grant expended for each activity.

Reporting Period From: 7/1/2024 Reporting Period To: 6/30/2025

Non-Direct-Services/System Development					
Activity	**A. MHBG**	**B. COVID Funds[1]**	**C. ARP[2]**	**D. BSCA[3]**	**E. Total**
1. Information Systems	$0	$0	$0	$0	**$0**
2. Infrastructure Support	$0	$0	$0	$0	**$0**
3. Partnerships, Community Outreach and Needs Assessment	$0	$0	$0	$0	**$0**
4. Planning Council Activities	$9,475	$0	$0	$0	**$9,475**
5. Quality Assurance and Improvement	$0	$0	$0	$0	**$0**
6. Research and Evaluation	$0	$0	$0	$0	**$0**
7. Training and Education	$0	$0	$0	$0	**$0**
Total	**$9,475**	**$0**	**$0**	**$0**	**$9,475**
Comments on Data:					

[1] The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**. Column B should reflect the COVID-19 Relief supplemental funding allotment portion used during the state reporting period.
Note: If your state has an approved second no cost extension, you have until March 14, 2025 to expend the COVID-19 Relief supplemental funds.

[2] The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – March 24, 2025**. Column C should reflect the ARP supplemental funding allotment portion used during the state reporting period.

[3] The expenditure period for the 3rd and 4th allocation of the Bipartisan Safer Communities Act (BSCA) supplemental funding is **September 30, 2024 – September 29, 2026** (3rd increment) and September 30, 2025 – September 29, 2027 (4th increment). Column D should reflect the BSCA allotment portion used during the state reporting period.

0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

C. State Agency Expenditure Report

MHBG Table 4B (URS Table 8B) State Agency MHBG Expenditures

This table collects information on MHBG expenditures on direct and other capacity building/systems development (non-direct services), as well as administrative costs during the last completed state fiscal year. Total MHBG expenditures reported for non-direct services must be the same as those reported in MHBG Table 4A (URS Table 8A). Administrative costs should not be more than 5 percent of total MHBG allocation. Please include a brief explanation of expenditures for services with an asterisk in the Comments on Data section of the table below.

Reporting Period From: 7/1/2024 Reporting Period To: 6/30/2025

Services for Adults	
1. EBPs for Adults	$0
2. Crisis Services for Adults	$1,411,800
3. CSC/ESMI program for Adults	$2,629,153
4. *Other outpatient/ambulatory services for adults	$16,001,710
5. *Other Direct Services for Adults	$5,049,058
Subtotal of services for adults	**$25,091,721**
Services for Children	
6. EBPs for Children	$0
7. Crisis Services for Children	$0
8. CSC/ESMI program for Children	$0
9. Other outpatient/ambulatory services for Children	$0
10. *Other Direct Services for Children	$0
Subtotal of services for children	**$0**
Non-Direct Services (other capacity building/systems development)	$9,475
Administrative Costs	$2,828,565
*Any Other Cost	$0
Total	**$27,929,761**
Comments on Data:	

*Please include a brief explanation for services with an asterisk in the Comments on Data or General Data Notes section.
0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

C. State Agency Expenditure Report

MHBG Table 5 (URS Table 10) - Profiles of Agencies Receiving Block Grant Funds Directly from the State Mental Health Authority

This table collects information on payments to recipients of MHBG funds including intermediaries, (e.g., administrative service organizations, and other organizations), which provided mental health services during the last completed SFY, including services for those experiencing early serious mental illness (ESMI), including psychotic disorders, and crisis services. This table is to be used to provide an inventory of providers/agencies who directly receive Block Grant allocations. Only report those programs that receive MHBG funds to provide services. Do not report planning council members reimbursements or other administrative reimbursements related to running the MHBG Program.

Reporting Period Start Date: 7/1/2024 Reporting Period End Date: 6/30/2025

Entity Number	Area Served (Statewide or Sub-State Planning Area)	Provider/Program Name	Street Address	City	State	Zip	Total Block Grant Funds	Adults with Serious Mental Illness	Children with Serious Emotional Disturbance	Set-aside for ESMI including psychotic disorders	Set-aside for crisis services
H01	Statewide	Acenda, Inc	42 Delsea Drive South	Glassboro	NJ	8060	$920,162.42	$920,162.42	$0.00	$0.00	$0.00
A01	Atlantic	AtlantiCare Behavioral Health	6010 Black Horse Pike	Egg Harbor Twp	NJ	8234	$555,291.02	$555,291.02	$0.00	$0.00	$0.00
X03	Statewide	Bridgeway Behavioral Health Services	373 Clermont Terrace	Elizabeth	NJ	7208	$4,303,759.91	$4,303,759.91	$0.00	$0.00	$0.00
B12	Statewide	Care Plus NJ, Inc.	610 Valley Health Plaza	Paramus	NJ	7652	$1,852,757.65	$1,105,529.97	$0.00	$492,166.68	$255,061.00
A40	Atlantic	Career Opportunity Development, Inc.	901 Atlantic Avenue	Egg Harbor	NJ	8215	$537,068.85	$537,068.85	$0.00	$0.00	$0.00
G05	Statewide	Catholic Charities Archdiocese of Newark	590 North 7th Street	Newark	NJ	7107	$31,627.00	$31,627.00	$0.00	$0.00	$0.00
L13	Statewide	Catholic Charities, Diocese of Trenton	383 W. State St., Box 1423	Trenton	NJ	8607	$2,748,300.04	$2,748,300.04	$0.00	$0.00	$0.00
B08	Bergen	Comprehensive Behavioral Healthcare, Inc.	516 Valley Brook Avenue	Lyndhurst	NJ	7071	$487,920.38	$487,920.38	$0.00	$0.00	$0.00
N02	Monmouth	CPC Behavioral Healthcare, Inc.	10 Industrial Way East	Eatontown	NJ	7724	$1,214,330.26	$1,214,330.26	$0.00	$0.00	$0.00
F01	Cumberland, Salem	Cumberland County Guidance Center, Inc.	2038 Carmel Road - Box 808	Millville	NJ	8332	$953,194.61	$953,194.61	$0.00	$0.00	$0.00
S01	Salem	Healthcare Commons Inc. Family Health Services	500 South Pennsville-Auburn Road	Carneys Point	NJ	8069	$197,751.00	$197,751.00	$0.00	$0.00	$0.00
J05	Hudson	Jersey City Medical Center	395 Grand Street, 3rd Floor	Jersey City	NJ	7302	$288,053.09	$288,053.09	$0.00	$0.00	$0.00
A43	Atlantic, Cape May	Jewish Family Service of Atlantic County	607 N. Jerome Avenue	Margate	NJ	8402	$92,579.51	$92,579.51	$0.00	$0.00	$0.00
C01	Burlington, Ocean, Mercer	Legacy Treatment Services	1289 Route 38 West, Suite 203	Hainesport	NJ	8036	$860,083.28	$14,478.77	$0.00	$563,736.34	$281,868.17
G11	Essex	Mental Health Association of Essex and Morris	33 South Fullerton Avenue	Montclair	NJ	7042	$1,374,679.15	$1,374,679.15	$0.00	$0.00	$0.00
R06	Statewide	Mental Health Clinic of Passaic	1451 VanHouten Ave	Clifton	NJ	7013	$39,808.91	$39,808.91	$0.00	$0.00	$0.00
N01	Central	Monmouth Medical Center	300 Second Avenue	Long Branch	NJ	7740	$281,868.17	$0.00	$0.00	$0.00	$281,868.17
C03	Burlington, Camden, Mercer	Oaks Integrated Care, Inc.	770 Woodlane Road	Mt. Holly	NJ	8060	$865,295.23	$865,295.23	$0.00	$0.00	$0.00
Q01	Ocean	Ocean Mental Health	160 Route 9	Bayville	NJ	8721	$1,209,554.03	$1,209,554.03	$0.00	$0.00	$0.00
Q02	Ocean	Preferred Behavioral Health of NJ	700 Airport Road, P.O. Box 2036	Lakewood	NJ	8701	$747,323.91	$747,323.91	$0.00	$0.00	$0.00
G45	Essex	Project Live, Inc.	465-475 Broadway	Newark	NJ	7104	$596,405.93	$596,405.93	$0.00	$0.00	$0.00
M04	Statewide	Rutgers The State Univ of NJ,UBHC	Box 1392 - 671 Hoes Lane	Piscataway	NJ	8855	$1,433,278.32	$363,570.07	$0.00	$787,840.08	$281,868.17
D05	Camden	South Jersey Behavioral Health Resources, Inc.	2500 McClellan Avenue, Suite 300	Pennsauken	NJ	8109	$1,092,840.90	$1,092,840.90	$0.00	$0.00	$0.00
R08	Passaic	St. Joseph's Regional Medical Center	703 Main Street	Paterson	NJ	7503	$538,448.04	$538,448.04	$0.00	$0.00	$0.00
X04	Statewide	Trinitas Regional Medical Center - Bayonne	655 East Jersey Street	Elizabeth	NJ	7206	$176.90	$176.90	$0.00	$0.00	$0.00

Total							$23,222,558.51	$20,278,149.90	$0.00	$1,843,743.10	$1,100,665.51

Footnotes:

C. State Agency Expenditure Report

MHBG Table 6 - Maintenance of Effort for State Expenditures on Mental Health Services

This table collects information on expenditures of all statewide, non-Federal expenditures for authorized activities to treat mental illness during the last completed SFY.

Reporting Period Start Date: 07/01/2024

Reporting Period End Date: 06/30/2025

A Period	B Expenditures	C B1 (2023) + B2 (2024) 2
SFY 2023 (1)	$479,498,570	
SFY 2024 (2)	$509,864,157	$494,681,364
SFY 2025 (3)	$533,992,844	

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

SFY 2023	Yes	X	No
SFY 2024	Yes	X	No
SFY 2025	Yes	X	No

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

0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

D. Population and Services Report

MHBG Table 7 (URS Table 1) - Profile of the State Population by Diagnosis

This table summarizes the estimates of adults residing within the state with serious mental illness (SMI) and children residing within the state with serious emotional disturbance (SED). The table calls for estimates for two time periods, one for the report year and one for three years into the future. This data will be provided to states based on the standardized methodology developed and published in the Federal Register to estimate the state level of adults with SMI and children with SED.

Reporting Period Start Date: Reporting Period End Date:

	Current Report Year	Three Years Forward
Adults with Serious Mental Illness (SMI)		
Children with Serious Emotional Disturbances (SED)		

Note: This table will be completed for the states.

0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

D. Population and Services Report

MHBG Table 8A and MHBG Table 8B (URS Tables 2A and 2B) - Profile of Persons Served, All Programs by Age, Sex and Race/Ethnicity

This table collects information on the unduplicated aggregate profile of persons served in the reporting period. The reporting period should be the latest state fiscal year for which data are available. This profile is based on a client receiving services in programs provided or funded by the state mental health agency. The client profile takes into account all institutional and community services for such programs. States and jurisdictions are to provide this information on all programs by age, sex, and race.

Table 8A

Reporting Period Start Date: 7/1/2024 Reporting Period End Date: 6/30/2025

	Total				American Indian or Alaska Native		
	Female	Male	N/A[1]	Total	Female	Male	N/A[1]
0-5 years	198	285	1	484	0	0	0
6-12 years	3,057	3,915	17	6,989	6	5	0
13-17 years	5,282	4,068	23	9,373	11	8	0
18-20 years	3,351	2,785	42	6,178	14	3	0
21-24 years	4,193	3,880	51	8,124	8	13	0
25-44 years	20,908	19,781	103	40,792	48	42	0
45-64 years	18,214	14,106	22	32,342	41	29	0
65-74 years	5,655	3,830	6	9,491	8	10	0
75+ years	2,395	1,280	7	3,682	6	2	0
Not Available[1]	215	276	4	495	0	1	0
Total	63,468	54,206	276	117,950	142	113	0
Pregnant Women	507		0	507	2		0

	Asian			Black or African American		
	Female	Male	N/A[1]	Female	Male	N/A[1]
0-5 years	1	8	0	39	68	0
6-12 years	33	42	0	524	778	2

13-17 years	122	129	0	877	676	1
18-20 years	122	91	1	507	499	2
21-24 years	148	122	2	837	871	7
25-44 years	526	532	2	4,373	4,547	18
45-64 years	311	250	0	3,270	2,862	5
65-74 years	69	57	0	706	512	0
75+ years	42	26	0	199	94	0
Not Available[1]	2	5	0	46	59	0
Total	1,376	1,262	5	11,378	10,966	35
Pregnant Women	6		0	138		0

	Native Hawaiian or Other Pacific Islander			White		
	Female	Male	N/A[1]	Female	Male	N/A[1]
0-5 years	0	0	0	114	145	0
6-12 years	2	2	0	1,398	1,848	5
13-17 years	6	4	0	2,269	1,739	18
18-20 years	2	7	0	1,458	1,210	21
21-24 years	5	7	0	1,815	1,638	26
25-44 years	24	31	0	9,692	9,085	42
45-64 years	12	12	0	9,577	7,528	8
65-74 years	7	1	0	3,502	2,454	2
75+ years	4	2	0	1,600	892	2
Not Available[1]	0	0	0	98	128	0
Total	62	66	0	31,523	26,667	124

Pregnant Women	0		0	212		0			

	Some Other Race			More Than One Race			Not Available[1]		
	Female	Male	N/A[1]	Female	Male	N/A[1]	Female	Male	N/A[1]
0-5 years	22	43	0	8	11	0	14	10	1
6-12 years	615	663	2	119	143	4	360	434	4
13-17 years	1,048	764	1	212	167	1	737	581	2
18-20 years	556	493	9	138	105	3	554	377	6
21-24 years	627	691	7	171	146	3	582	392	6
25-44 years	2,793	2,664	19	666	695	3	2,786	2,185	19
45-64 years	1,977	1,386	1	371	343	1	2,655	1,696	7
65-74 years	470	252	1	85	67	1	808	477	2
75+ years	185	63	0	43	33	0	316	168	5
Not Available[1]	32	33	0	11	15	0	26	35	4
Total	8,325	7,052	40	1,824	1,725	16	8,838	6,355	56
Pregnant Women	89		0	27		0	33		0

Are these measures unduplicated?

- ☑ Unduplicated
- ☐ Duplicated between hospitals and community
- ☐ Duplicated among community programs
- ☐ Duplicated between children and adults
- ☐ Other, please describe:

Comments on Data (Age):	
Comments on Data (Sex):	
Comments on Data (Race):	"Asian or Pacific Islander" data is listed under the Race Asian. There are 31 Clients with a difference in Race values between the USTF+ and State hospital system. USTF+ providers are requested to review and verify the difference.

Comments on Data (Overall):	DMHAS is currently implementing the USTF+ data system and onboarding the providers. Not all providers are using the system to submit the data. DMHAS continues to train providers on the new client level web-based application.

Table 8B

This table collects information on the unduplicated aggregate profile of persons served in the reporting period. The reporting period should be the latest state fiscal year for which data are available. This profile is based on a client receiving services in programs provided or funded by the state mental health agency. The client profile takes into account all institutional and community services for such programs. States and jurisdictions are to provide this information on all programs by age, sex, and ethnicity. Total persons served would be the same as the total indicated in MHBG Table 8A.

Reporting Period Start Date: 7/1/2024 Reporting Period End Date: 6/30/2025

	Not Hispanic or Latino			Hispanic or Latino		
	Female	Male	N/A[1]	Female	Male	N/A[1]
0-5 years	135	188	0	41	57	0
6-12 years	1,635	2,265	10	923	1,017	3
13-17 years	2,713	2,008	17	1,580	1,272	1
18-20 years	1,783	1,523	20	928	782	12
21-24 years	2,454	2,314	28	1,050	988	12
25-44 years	13,175	13,048	58	4,411	3,798	15
45-64 years	11,791	9,857	13	3,369	2,065	1
65-74 years	3,862	2,839	4	843	384	0
75+ years	1,631	935	2	343	127	1
Not Available[1]	124	168	0	54	44	0
Total	39,303	35,145	152	13,542	10,534	45
Pregnant Women	302		0	149		0

	Not Available[1]			Total			
	Female	Male	N/A[1]	Female	Male	N/A[1]	Total
0-5 years	22	40	1	198	285	1	484

6-12 years	499	633	4	3,057	3,915	17	6,989
13-17 years	989	788	5	5,282	4,068	23	9,373
18-20 years	640	480	10	3,351	2,785	42	6,178
21-24 years	689	578	11	4,193	3,880	51	8,124
25-44 years	3,322	2,935	30	20,908	19,781	103	40,792
45-64 years	3,054	2,184	8	18,214	14,106	22	32,342
65-74 years	950	607	2	5,655	3,830	6	9,491
75+ years	421	218	4	2,395	1,280	7	3,682
Not Available[1]	37	64	4	215	276	4	495
Total	10,623	8,527	79	63,468	54,206	276	117,950
Pregnant Women	56		0	507		0	507

Comments on Data (Age):	
Comments on Data (Sex):	
Comments on Data (Ethnicity):	There are 11 Clients with a difference in Ethnicity values between the USTF+ and State hospital system. USTF+ providers are requested to review and verify the difference.
Comments on Data (Overall):	DMHAS is currently implementing the USTF+ data system and onboarding the providers. Not all providers are using the system to submit the data. DMHAS continues to train providers on the new client level web-based application.

[1] **The 'Not Available' category is to be used only for cases where the requested field in state data systems is null or blank, an invalid value is added, or if the state does not collect information in the state data system.**

0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

D. Population and Services Report

MHBG Table 9 (URS Table 3) - Profile of Persons Served in Community Mental Health Settings, State Psychiatric Hospitals and Other Settings by Age and Sex

This table collects information on the aggregate profile of the number of persons that received public mental health services in community mental health settings, state psychiatric hospitals, other psychiatric inpatient settings, residential treatment centers, and institutions under the justice system. The reporting period should be the latest SFY for which data are available. States and jurisdictions are to provide this information on all programs by age and sex.

Reporting Period Start Date: 7/1/2024 Reporting Period End Date: 6/30/2025

Services Setting	0-5 Years			6-12 Years			13-17 Years			18-20 Years		
	Female	Male	N/A[1]	Female	Male	N/A[1]	Female	Male	N/A[1]	Female	Male	N/A[1]
Community Mental Health Programs	186	270	1	2,901	3,632	17	5,186	3,992	23	3,279	2,701	41
State Psychiatric Hospitals	0	0	0	0	0	0	0	0	0	5	12	0
Other Psychiatric Inpatient	7	6	0	3	13	0	25	22	0	103	181	1
Residential Treatment Centers	0	0	0	0	0	0	0	0	0	0	0	0
Institutions under the Justice System	0	1	0	0	0	0	4	8	0	3	6	0

Services Setting	21-24 Years			25-44 Years			45-64 Years			65-74 Years		
	Female	Male	N/A[1]	Female	Male	N/A[1]	Female	Male	N/A[1]	Female	Male	N/A[1]
Community Mental Health Programs	4,101	3,757	51	20,457	19,184	98	17,954	13,867	21	5,599	3,781	6
State Psychiatric Hospitals	26	67	0	172	689	1	164	444	0	48	86	0
Other Psychiatric Inpatient	186	333	2	1,009	1,636	5	673	628	4	142	118	0
Residential Treatment Centers	0	0	0	0	0	0	0	0	0	0	0	0
Institutions under the Justice System	3	12	0	44	145	0	15	52	0	3	1	0

Services Setting	75 or over			Not Available[1]			Total			
	Female	Male	N/A[1]	Female	Male	N/A[1]	Female	Male	N/A[1]	Total
Community Mental Health Programs	2,375	1,270	7	206	262	4	62,244	52,716	269	115,229

State Psychiatric Hospitals	14	14	0	0	0	0	429	1,312	1	1,742
Other Psychiatric Inpatient	29	17	0	8	15	0	2,185	2,969	12	5,166
Residential Treatment Centers	0	0	0	0	0	0	0	0	0	0
Institutions under the Justice System	0	0	0	0	0	0	72	225	0	297

Note: clients can be duplicated between rows, e.g., the same client may be served in both state psychiatric hospitals and community mental health centers during the same year and thus would be reported in both rows.

Comments on Data (Age):

Comments on Data (Sex):

Comments on Data (Overall):
DMHAS is currently implementing the USTF+ data system and onboarding the providers. Not all providers are using the system to submit the data. DMHAS continues to train providers on the new client level web-based application.

[1] **The 'Not Available' category is to be used only for cases where the requested field in state data systems is null or blank, an invalid value is added, or if the state does not collect information in the state data system.**

0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

D. Population and Services Report

MHBG Table 10A and MHBG Table 10B (URS Tables 5A and 5B) - Profile of Persons Served by Type of Funding Support in All Programs by Sex and Race

Table 10A

This table collects information on the unduplicated aggregate profile of persons served in the reporting period by type of funding support (Medicaid Only, Non-Medicaid Sources Only, Both Medicaid and Non-Medicaid, and Status Not Available). The reporting period should be the latest SFY for which data are available. The client profile takes into account all institutional and community services for all such programs. States and jurisdictions are to provide this information on all programs by sex and race. Persons are to be counted in the Medicaid row if they received a service reimbursable through Medicaid. Total persons served would be the same as the total indicated in MHBG Table 8A.

Reporting Period Start Date: 7/1/2024 Reporting Period End Date: 6/30/2025

	Total				American Indian or Alaska Native		
	Female	Male	N/A[1]	Total	Female	Male	N/A[1]
Medicaid Only	23,846	20,112	82	44,040	56	38	0
Non-Medicaid Sources Only	25,758	22,442	102	48,302	53	50	0
People Served by Both Medicaid and Non-Medicaid	2,268	1,949	5	4,222	6	5	0
Medicaid Status Not Available	11,596	9,703	87	21,386	27	20	0
Total	63,468	54,206	276	117,950	142	113	0

	Asian			Black or African American		
	Female	Male	N/A[1]	Female	Male	N/A[1]
Medicaid Only	387	355	1	5,368	5,144	12
Non-Medicaid Sources Only	678	666	3	3,735	3,657	10
People Served by Both Medicaid and Non-Medicaid	36	23	0	520	456	2
Medicaid Status Not Available	275	218	1	1,755	1,709	11
Total	1,376	1,262	5	11,378	10,966	35

	Native Hawaiian or Other Pacific Islander	White

	Female	Male	N/A[1]	Female	Male	N/A[1]
Medicaid Only	26	25	0	10,774	8,918	40
Non-Medicaid Sources Only	32	33	0	15,112	12,873	61
People Served by Both Medicaid and Non-Medicaid	0	1	0	1,126	1,007	3
Medicaid Status Not Available	4	7	0	4,511	3,869	20
Total	62	66	0	31,523	26,667	124

	Some Other Race			More Than One Race		
	Female	Male	N/A[1]	Female	Male	N/A[1]
Medicaid Only	3,669	2,878	16	744	711	4
Non-Medicaid Sources Only	3,175	2,800	12	801	722	5
People Served by Both Medicaid and Non-Medicaid	311	244	0	49	52	0
Medicaid Status Not Available	1,170	1,130	12	230	240	7
Total	8,325	7,052	40	1,824	1,725	16

	Not Available[1]		
	Female	Male	N/A[1]
Medicaid Only	2,822	2,043	9
Non-Medicaid Sources Only	2,172	1,641	11
People Served by Both Medicaid and Non-Medicaid	220	161	0
Medicaid Status Not Available	3,624	2,510	36
Total	8,838	6,355	56

☐ Data Based on Medicaid Services ☑ Data Based on Medical Eligibility, not Medicaid Paid Services ☑ 'People Served By Both' includes people with any Medicaid

Comments on Race:
"Asian or Pacific Islander" data is listed under the Race Asian. There are 31 Clients with a difference in Race values between the USTF+ and State hospital system. USTF+ providers are requested to review and verify the difference.

Comments on Sex:

Comments on Data (Overall):
DMHAS is currently implementing the USTF+ data system and onboarding the providers. Not all providers are using the system to submit the data. DMHAS continues to train providers on the new client level web-based application.

Each row should have a unique (deduplicated) count of clients: (1) Medicaid Only, (2) Non-Medicaid Only, (3) Both Medicaid and Other Sources funded their treatment, and (4) Medicaid Status Not Available.

If a state is unable to deduplicate counts of people whose care is paid for by Medicaid only or Medicaid and other funds, then all data should be reported into the 'People Served by Both Medicaid and Non-Medicaid Sources' and the 'People Served by Both includes people with any Medicaid' checkbox should be checked.

Table 10B

This table collects information on the unduplicated aggregate profile of persons served in the reporting period by type of funding support (Medicaid Only, Non-Medicaid Sources Only, Both Medicaid and Non-Medicaid, and Status Not Available). The reporting period should be the latest SFY for which data are available. The client profile takes into account all institutional and community services for all such programs. States and jurisdictions are to provide this information on all programs by sex and ethnicity. Persons are to be counted in the Medicaid row if they received a service reimbursable through Medicaid. Total persons served would be the same as the total indicated in MHBG Table 10A.

Reporting Period Start Date: 7/1/2024 Reporting Period End Date: 6/30/2025

	Not Hispanic or Latino			Hispanic or Latino		
	Female	Male	N/A[1]	Female	Male	N/A[1]
Medicaid Only	14,052	12,532	51	6,024	4,564	18
Non-Medicaid Sources Only	17,373	15,562	65	4,683	3,824	18
People Served by Both Medicaid and Non-Medicaid	1,511	1,404	5	431	312	0
Medicaid Status Not Available	6,367	5,647	31	2,404	1,834	9
Total	39,303	35,145	152	13,542	10,534	45

	Not Available[1]			Total			
	Female	Male	N/A[1]	Female	Male	N/A[1]	Total
Medicaid Only	3,770	3,016	13	23,846	20,112	82	44,040
Non-Medicaid Sources Only	3,702	3,056	19	25,758	22,442	102	48,302

People Served by Both Medicaid and Non-Medicaid	326	233	0	2,268	1,949	5	4,222
Medicaid Status Not Available	2,825	2,222	47	11,596	9,703	87	21,386
Total	10,623	8,527	79	63,468	54,206	276	117,950

Comments on Data (Ethnicity):
There are 11 Clients with a difference in Ethnicity values between the USTF+ and State hospital system. USTF+ Providers are requested to review and verify the difference.

Comments on Data (Sex):

Comments on Data (Overall):
DMHAS is currently implementing the USTF+ data system and onboarding the providers. Not all providers are using the system to submit the data. DMHAS continues to train providers on the new client level web-based application.

Each row should have a unique (deduplicated) count of clients: (1) Medicaid Only, (2) Non-Medicaid Only, (3) Both Medicaid and Other Sources funded their treatment, and (4) Medicaid Status Not Available.

If a state is unable to deduplicate counts of people whose care is paid for by Medicaid only or Medicaid and other funds, then all data should be reported into the 'People Served by Both Medicaid and Non-Medicaid Sources' and the 'People Served by Both includes people with any Medicaid' checkbox should be checked

[1] **The 'Not Available' category is to be used only for cases where the requested field in state data systems is null or blank, an invalid value is added, or if the state does not collect information in the state data system.**

0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

D. Population and Services Report

MHBG Table 11 (URS Table 6) - Profile of Client Turnover

This table collects information on the aggregate profile of client turnover in various out-of-home settings (state hospitals, inpatient psychiatric hospitals, residential treatment centers). Information collected by this table includes total served at the beginning of year, admissions and discharge during the year, and lengths of stay. The reporting period should be the latest SFY for which data are available. States and jurisdictions are to provide this information on all programs by age.

Reporting Period Start Date: 7/1/2024 Reporting Period End Date: 6/30/2025

Profile of Service Utilization	Total Served at Beginning of Year (unduplicated)	Admissions During the year (duplicated)	Discharges During the year (duplicated)	Length of Stay (in Days): Discharged Patients		For Clients in Facility for 1 Year or Less: Average Length of Stay (in Days): Residents at end of year		For Clients in Facility More Than 1 Year: Average Length of Stay (in Days): Residents at end of year	
				Average (Mean)	Median	Average (Mean)	Median	Average (Mean)	Median
State Hospital	**1,165**	**722**	**711**	**561**	**300**	**145**	**127**	**1,083**	**771**
0-5 years	0	0	0	0	0	0	0	0	0
6-12 years	0	0	0	0	0	0	0	0	0
13-17 years	0	0	0	0	0	0	0	0	0
18-20 years	6	12	5	157	106	70	67	505	505
21-24 years	48	53	51	296	163	136	133	766	672
25-44 years	562	402	398	512	266	144	127	1,000	762
45-64 years	429	211	212	670	358	151	113	1,209	872
65-74 years	99	36	34	816	461	144	126	1,231	902
75 or over	21	8	11	823	316	164	172	1,614	1,150
Not Available	0	0	0	0	0	0	0	0	0

Profile of Service Utilization	Total Served at Beginning of Year (unduplicated)	Admissions During the year (duplicated)	Discharges During the year (duplicated)	Length of Stay (in Days): Discharged Patients		For Clients in Facility for 1 Year or Less: Average Length of Stay (in Days): Residents at end of year		For Clients in Facility More Than 1 Year: Average Length of Stay (in Days): Residents at end of year	
				Average (Mean)	Median	Average (Mean)	Median	Average (Mean)	Median
Other Psychiactric Inpatient	**714**	**5,428**	**4,966**	**26**	**8**	**12**	**8**	**2,511**	**830**
0-5 years	9	5	1	21	21	21	21	0	0
6-12 years	1	16	2	0	0	0	0	0	0
13-17 years	6	42	16	5	5	5	5	0	0
18-20 years	24	304	277	40	8	13	8	7,314	7,314
21-24 years	77	564	540	42	8	11	8	5,560	7,304
25-44 years	319	2,862	2,622	21	8	12	8	1,861	609
45-64 years	214	1,342	1,242	23	9	13	9	1,530	756
65-74 years	50	234	220	29	11	15	11	1,581	1,581
75 or over	6	44	36	13	10	13	10	0	0
Not Available	8	15	10	8	9	8	9	0	0

Profile of Service Utilization	Total Served at Beginning of Year (unduplicated)	Admissions During the year (duplicated)	Discharges During the year (duplicated)	Length of Stay (in Days): Discharged Patients		For Clients in Facility for 1 Year or Less: Average Length of Stay (in Days): Residents at end of year		For Clients in Facility More Than 1 Year: Average Length of Stay (in Days): Residents at end of year	
				Average (Mean)	Median	Average (Mean)	Median	Average (Mean)	Median
Residential Treatment Centers	**0**	**0**	**0**						
0-5 years	0	0	0	0	0	0	0	0	0
6-12 years	0	0	0	0	0	0	0	0	0
13-17 years	0	0	0	0	0	0	0	0	0
18-20 years	0	0	0	0	0	0	0	0	0
21-24 years	0	0	0	0	0	0	0	0	0
25-44 years	0	0	0	0	0	0	0	0	0
45-64 years	0	0	0	0	0	0	0	0	0
65-74 years	0	0	0	0	0	0	0	0	0
75 or over	0	0	0	0	0	0	0	0	0
Not Available	0	0	0	0	0	0	0	0	0

Profile of Service Utilization	Total Served at Beginning of Year (unduplicated)	Admissions During the year (duplicated)	Discharges During the year (duplicated)	Length of Stay (in Days): Discharged Patients		For Clients in Facility for 1 Year or Less: Average Length of Stay (in Days): Residents at end of year		For Clients in Facility More Than 1 Year: Average Length of Stay (in Days): Residents at end of year	
				Average (Mean)	Median	Average (Mean)	Median	Average (Mean)	Median
Community Programs	**62,144**	**80,251**							
0-5 years	110	385							
6-12 years	2,102	5,217							
13-17 years	3,735	7,007							
18-20 years	2,840	4,486							
21-24 years	3,636	6,367							
25-44 years	20,399	31,100							
45-64 years	20,559	18,939							
65-74 years	6,558	4,310							
75 or over	2,052	2,115							
Not Available	153	325							

Comments on Data (State Hospital):

Comments on Data (Other Inpatient):

Comments on Data (Residential Treatment Centers):

Comments on Data (Community Programs):

Comments on Data (Overall):
DMHAS is currently implementing the USTF+ data system and onboarding the providers. Not all providers are using the system to submit the data. DMHAS continues to train providers on the new client level web-based application.

0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

D. Population and Services Report

MHBG Table 12 (URS Table 12) - State Mental Health Agency Profile

This table collects information that provides context for the data reported in the MHBG tables. This profile includes the populations that receive services operated or funded by the state mental health agency, data reporting capacities, percentage of children and adults that meet the federal definition of SED and SMI, respectively, the percentage of children and adults with co-occurring mental and substance use disorders (M/SUD), as well as other summary administrative information.

Reporting Period Start Date: 7/1/2024 Reporting Period End Date: 6/30/2025

Populations Served

1. Which of the following populations receive services operated or funded by the state mental health agency? Please indicate if they are included in the data provided in the tables. (Check all that apply.)

	Populations Covered		Included in Data	
	State Hospitals	Community Programs	State Hospitals	Community Programs
1. 0 to 5 years	☐ Yes	☐ Yes	☐ Yes	☐ Yes
2. 6 to 12 years	☐ Yes	☐ Yes	☐ Yes	☐ Yes
3. 13-17 years	☐ Yes	☑ Yes	☐ Yes	☑ Yes
4. 18-20 years	☑ Yes	☑ Yes	☑ Yes	☑ Yes
5. 21-24 years	☑ Yes	☑ Yes	☑ Yes	☑ Yes
6. 25-44 years	☑ Yes	☑ Yes	☑ Yes	☑ Yes
7. 45-64 years	☑ Yes	☑ Yes	☑ Yes	☑ Yes
8. 65-74 years	☑ Yes	☑ Yes	☑ Yes	☑ Yes
9. 75 or over	☑ Yes	☑ Yes	☑ Yes	☑ Yes
10. Forensics	☑ Yes	☑ Yes	☑ Yes	☑ Yes
Comments on Data:				

2. Do all of the adults and children served through the state mental health agency meet the federal definitions of serious mental illness and serious emotional disturbances?

☐ Serious Mental Illness
☐ Serious Emotional Disturbances

2.a. If no, please indicate the percentage of persons served for the reporting period who met the federal definitions of serious mental illness and serious emotional disturbance:

2.a.1. Percentage of adults meeting federal definition of SMI: 39.3%

2.a.2. Percentage of children/adolescents meeting federal definition of SED: 33.5%

3. Co-Occurring Mental Health and Substance Use Disorders

3.a. What percentage of persons served by the SMHA for the reporting period have a dual diagnosis of mental and substance use disorders?

3.a.1. Percentage of adults served by the SMHA who also have a substance use disorder: 19%

3.a.2.	Percentage of children/adolescents served by the SMHA who also have a substance use disorder:	3%

3.b. What percentage of persons served in the reporting period who met the federal definitions of adults with SMI and children/adolescents with SED have a dual diagnosis of mental and substance use disorders?

3.b.1.	Percentage of adults meeting federal definition of SMI who also have a substance use disorder:	21%
3.b.2.	Percentage of children/adolescents meeting the federal definition of SED who also have a substance use disorder:	3%
3.b.3.	Please describe how you calculate and count the number of persons with co-occurring mental and substance disorders:	The number of persons with co-occurring disorders is determined by identifying individuals who meet the federal definition of SMI for adults or SED for children, and who also receive a diagnosis of SUD.

4. State Mental Health Agency Responsibilities

a. Medicaid: Does the State Mental Health Agency have any of the following responsibilities for mental health services provided through Medicaid? (Check all that Apply)

1. State Medicaid Operating Agency	☑
2. Setting Standards	☑
3. Quality Improvement/Program Compliance	☐
4. Resolving Consumer Complaints	☐
5. Licensing	☑
6. Sanctions	☑
7. Other	

	b. Managed Care (Mental Health Managed Care)		**Are Data for these programs reported on URS Tables?**
4.b.1	Does the state have a Medicaid Managed Care initiative?	☑ Yes	☐ Yes
4.b.2	Does the State Mental Health Agency have any responsibilities for mental health services provided through Medicaid Managed Care?	☐ Yes	

If yes, please check the responsibilities the SMHA has:

4.b.3	Direct contractual responsibility and oversight of the Managed Care Organizations (MCOs) or specialty Behavioral Health Organizations (BHOs)	☐ Yes
4.b.4	Setting standards for mental health services	☐ Yes
4.b.5	Coordination with state health and Medicaid agencies	☐ Yes
4.b.6	Resolving mental health consumer complaints	☐ Yes
4.b.7	Input in contract development	☐ Yes
4.b.8	Performance monitoring	☐ Yes
4.b.9	Other	

5. Data Reporting: Please describe the extent to which your information systems allow the generation of unduplicated client counts between different parts of your mental health system. Please respond in particular for MHBG Table 8, which requires unduplicated counts of clients served across your entire mental health system.

The data reported in the tables are:

5.a.	**Unduplicated:** counted once even if they were served in both State hospitals and community programs and if they were served in community mental health agencies responsible for different geographic or programmatic areas.	☑
5.b.	**Duplicated:** across state hospital and community programs	☐
5.c.	**Duplicated:** within community programs	☐
5.d.	**Duplicated:** Between child and adult agencies	☐
5.e.	**Plans for reporting unduplicated data:** If you are not currently able to provide unduplicated client counts across all parts of your mental health system, please describe your plans to report unduplicated client counts.	

6. Summary Administrative Data

6.a.	Report Year:	2025
6.b.	State Identifier:	NJ

Summary Information on Data Submitted by SMHA:

6.c.	Year being reported:	From: 7/1/2024 To: 6/30/2025
6.d.	Person Responsible for Submission:	Donna Migliorino

6.e.	Contact Phone Number:	609-438-4295
6.f.	Contact Address:	5 Commerce Way, Suite 100, Hamilton, NJ 08691
6.g.	E-mail:	Donna.Migliorino@dhs.nj.gov

0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

D. Population and Services Report

MHBG Tables 13A and 13B (URS Tables 14A and 14B) Profile of Persons with SMI/SED Served in All Programs by Age, Sex, and Race/Ethnicity

Table 13A

This table collects information on the unduplicated aggregate profile of persons with SMI or SED served in the reporting period. The profile is based on a client receiving services in programs provided or funded by the state mental health agency. States and jurisdictions should report data using the **Federal Definitions of SMI and SED** if they can, if not, please report using the state's definition of SMI and SED and provide information below describing your state's definition. The reporting period should be the latest SFY for which data are available. States and jurisdictions are to provide this information on all programs by age, sex, and race.

Reporting Period Start Date: 7/1/2024 Reporting Period End Date: 6/30/2025

	Total			American Indian or Alaska Native			Asian		
	Female	Male	Not Available[1]	Female	Male	Not Available[1]	Female	Male	Not Available[1]
0-5 years	77	88	0	0	0	0	0	3	0
6-12 years	841	1,033	9	2	1	0	4	7	0
13-17 years	1,458	1,086	8	3	1	0	29	29	0
18-20 years	1,051	1,012	15	4	0	0	33	31	1
21-24 years	1,342	1,544	14	3	5	0	40	48	0
25-44 years	7,100	7,963	35	12	7	0	192	228	0
45-64 years	6,553	5,453	11	11	7	0	130	107	0
65-74 years	2,038	1,421	1	3	4	0	27	21	0
75+ years	854	512	1	1	0	0	22	15	0
Not Available	84	109	3	0	0	0	2	1	0
Total	21,398	20,221	97	39	25	0	479	490	1

	Black or African American			Native Hawaiian or Pacific Islander			White		
	Female	Male	Not Available[1]	Female	Male	Not Available[1]	Female	Male	Not Available[1]
0-5 years	15	22	0	0	0	0	53	46	0
6-12 years	136	209	1	1	1	0	446	569	2
13-17 years	266	186	0	3	3	0	702	537	7
18-20 years	207	222	0	1	1	0	485	445	3
21-24 years	327	385	1	1	3	0	615	652	9
25-44 years	1,686	2,040	2	9	17	0	3,360	3,722	16
45-64 years	1,380	1,241	3	7	4	0	3,503	2,976	3
65-74 years	310	222	0	4	0	0	1,314	939	1
75+ years	90	44	0	3	1	0	593	380	1
Not Available	16	17	0	0	0	0	38	52	0
Total	4,433	4,588	7	29	30	0	11,109	10,318	42

	Some Other Race			More Than One Race			Race Not Available		
	Female	Male	Not Available[1]	Female	Male	Not Available[1]	Female	Male	Not Available[1]
0-5 years	4	8	0	2	4	0	3	5	0
6-12 years	116	136	2	26	30	3	110	80	1
13-17 years	257	203	1	57	35	0	141	92	0
18-20 years	174	193	3	49	44	3	98	76	5
21-24 years	198	296	1	59	62	1	99	93	2
25-44 years	1,072	1,159	8	270	316	0	499	474	9
45-64 years	865	610	1	159	170	0	498	338	4
65-74 years	214	126	0	37	29	0	129	80	0
75+ years	80	29	0	13	16	0	52	27	0
Not Available	10	11	0	7	7	0	11	21	3
Total	2,990	2,771	16	679	713	7	1,640	1,286	24

Comments on Data (Age):	
Comments on Data (Sex):	
Comments on Data (Race):	"Asian or Pacific Islander" data is listed under the Race Asian. There are 31 Clients with a difference in Race values between the USTF+ and State hospital system. USTF+ providers are requested to review and verify the difference.
Comments on Data (Overall):	DMHAS is currently implementing the USTF+ data system and onboarding the providers. Not all providers are using the system to submit the data. DMHAS continues to train providers on the new client level web-based application.

Do the state definitions of SMI/SED match the Federal definition?

(●) Yes ( ) No Adults with SMI, if No describe or attach state definition:

Diagnoses included in the state SMI definition:

(●) Yes ( ) No Children with SED, if No describe or attach state definition:

Diagnoses included in the state SED definition:

Table 13B

This table collects the unduplicated aggregate profile of persons with SMI or SED served in the reporting period. The profile is based on a client receiving services in programs provided or funded by the state mental health agency. States and jurisdictions should report data using the **Federal Definitions of SMI and SED** if they can, if not, please report using the state's definition of SMI and SED and provide information below describing your state's definition. The reporting period should be the latest SFY for your which data are available. States and jurisdictions are to provide this information on all programs by age, sex, and ethnicity. The total persons served who meet the Federal definition of SMI or SED would be the same as the total in MHBG Table 13A.

Reporting Period Start Date: 7/1/2024 Reporting Period End Date: 6/30/2025

	Not Hispanic or Latino			Hispanic or Latino			Not Available[1]		
	Female	Male	Not Available[1]	Female	Male	Not Available[1]	Female	Male	Not Available[1]
0-5 years	60	64	0	11	8	0	6	16	0
6-12 years	489	643	6	215	273	2	137	117	1
13-17 years	803	557	6	453	387	1	202	142	1
18-20 years	601	594	5	308	311	5	142	107	5
21-24 years	856	950	9	322	435	2	164	159	3
25-44 years	4,679	5,517	18	1,603	1,558	7	818	888	10
45-64 years	4,325	3,944	7	1,444	907	1	784	602	3
65-74 years	1,366	1,078	1	429	167	0	243	176	0
75+ years	578	387	1	158	69	0	118	56	0
Not Available	44	66	0	25	11	0	15	32	3
Total	13,801	13,800	53	4,968	4,126	18	2,629	2,295	26

	Total			
	Female	Male	Not Available[1]	Total
0-5 years	77	88	0	165

6-12 years	841	1,033	9	1,883
13-17 years	1,458	1,086	8	2,552
18-20 years	1,051	1,012	15	2,078
21-24 years	1,342	1,544	14	2,900
25-44 years	7,100	7,963	35	15,098
45-64 years	6,553	5,453	11	12,017
65-74 years	2,038	1,421	1	3,460
75+ years	854	512	1	1,367
Not Available	84	109	3	196
Total	21,398	20,221	97	41,716

Comments on Data (Age):	
Comments on Data (Sex):	
Comments on Data (Ethnicity):	There are 11 Clients with a difference in Ethnicity values between the USTF+ and State hospital system. USTF+ providers are requested to review and verify the difference.
Comments on Data (Overall):	DMHAS is currently implementing the USTF+ data system and onboarding the providers. Not all providers are using the system to submit the data. DMHAS continues to train providers on the new client level web-based application.

[1] **The 'Not Available' category is to be used only for cases where the requested field in state data systems is null or blank, an invalid value is added, or if the state does not collect information in the state data system.**
0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

D. Population and Services Report

MHBG Table 14 (URS Table 14C) Profile of Persons with SMI/SED Served in Community Mental Health Settings, State Psychiatric Hospitals, and Other Settings by Age and Sex

This table collects information on the aggregate profile of the number of adults with serious mental illness (SMI) and children with serious emotional disturbance (SED) that received publicly funded mental health services in community mental health settings, state psychiatric hospitals, other psychiatric inpatient programs, residential treatment centers, and institutions under the justice system. The reporting period should be the latest SFY for which data are available. States and jurisdictions are to provide this information on all programs by age and sex.

Reporting Period Start Date: 7/1/2024 Reporting Period End Date: 6/30/2025

Services Setting	0-5 Years			6-12 Years			13-17 Years			18-20 Years		
	Female	Male	N/A	Female	Male	N/A	Female	Male	N/A	Female	Male	N/A
Community Mental Health Programs	69	81	0	770	927	9	1,408	1,048	8	1,014	953	14
State Psychiatric Hospitals	0	0	0	0	0	0	0	0	0	5	12	0
Other Psychiatric Inpatient	4	3	0	1	4	0	15	11	0	70	123	1
Residential Treatment Centers	0	0	0	0	0	0	0	0	0	0	0	0
Institutions under the Justice System	0	0	0	0	0	0	2	5	0	2	3	0

Services Setting	21-24 Years			25-44 Years			45-64 Years			65-74 Years		
	Female	Male	N/A	Female	Male	N/A	Female	Male	N/A	Female	Male	N/A
Community Mental Health Programs	1,291	1,475	14	6,858	7,603	33	6,364	5,300	10	2,005	1,395	1
State Psychiatric Hospitals	26	67	0	172	689	1	164	444	0	48	86	0
Other Psychiatric Inpatient	124	222	1	680	1,078	2	474	427	3	102	73	0
Residential Treatment Centers	0	0	0	0	0	0	0	0	0	0	0	0
Institutions under the Justice System	0	7	0	30	78	0	8	29	0	3	0	0

Services Setting	75 or over			Not Available[1]			Total			
	Female	Male	N/A	Female	Male	N/A	Female	Male	N/A	Total
Community Mental Health Programs	839	507	1	78	102	3	20,696	19,391	93	40,180
State Psychiatric Hospitals	14	14	0	0	0	0	429	1,312	1	1,742
Other Psychiatric Inpatient	20	9	0	5	8	0	1,495	1,958	7	3,460
Residential Treatment Centers	0	0	0	0	0	0	0	0	0	0
Institutions under the Justice System	0	0	0	0	0	0	45	122	0	167

Comments on Data (Age):

Comments on Data (Sex):

Comments on Data (Overall):
DMHAS is currently implementing the USTF+ data system and onboarding the providers. Not all providers are using the system to submit the data. DMHAS continues to train providers on the new client level web-based application.

Note: clients can be duplicated between rows, e.g., the same client may be served in both state psychiatric hospitals and community mental health centers during the same year and thus would be reported in counts for both rows.

[1] **The 'Not Available' category is to be used only for cases where the requested field in state data systems is null or blank, an invalid value is added, or if the state does not collect information in the state data system.**

0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

E. Performance Indicators and Accomplishments

MHBG Table 15A (URS Table 4) - Profile of Adult Clients by Employment Status

This table collects information on the employment status of adult clients served in the reporting period. The focus is on employment for adults recognizing, however, that there are clients who are disabled, retired or who are homemakers, caregivers, etc., and not a part of the labor force. These persons should be reported under the "Not in Labor Force" category. Unemployed refers to persons who are looking for work but have not found employment. Data should be reported for clients in non-institutional settings at time of discharge or last evaluation. The reporting year is the latest SFY for which data are available.

Reporting Period Start Date: 7/1/2024 Reporting Period End Date: 6/30/2025

Adults Served	18-20 Years			21-24 Years			25-44 Years		
	Female	Male	Not Available[1]	Female	Male	Not Available[1]	Female	Male	Not Available[1]
Competitively Employed Full- or Part-Time (including Supported Employment)	608	313	5	1,169	731	10	5,313	3,556	26
Unemployed	549	498	10	776	862	19	4,858	4,600	26
Not in Labor Force (retired, sheltered employment, sheltered workshops, homemaker, student, volunteer, disabled, etc.)	666	537	3	444	414	3	1,719	1,718	7
Not Available	1,362	1,242	23	1,580	1,575	18	8,035	8,449	38
Total	**3,185**	**2,590**	**41**	**3,969**	**3,582**	**50**	**19,925**	**18,323**	**97**

Adults Served	45-64 Years			65-74 Years			75 or Over		
	Female	Male	Not Available[1]	Female	Male	Not Available[1]	Female	Male	Not Available[1]
Competitively Employed Full- or Part-Time (including Supported Employment)	3,039	2,094	2	569	362	0	86	66	0
Unemployed	4,635	3,561	3	1,110	764	2	300	154	1
Not in Labor Force (retired, sheltered employment, sheltered workshops, homemaker, student, volunteer, disabled, etc.)	3,049	2,135	7	1,563	961	0	802	371	1
Not Available	6,807	5,557	8	2,164	1,493	3	964	515	5
Total	**17,530**	**13,347**	**20**	**5,406**	**3,580**	**5**	**2,152**	**1,106**	**7**

Adults Served	Not Available[1]			Total			
	Female	Male	Not Available[1]	Female	Male	Not Available[1]	Total
Competitively Employed Full- or Part-Time (including Supported Employment)	1	1	0	**10,785**	**7,123**	**43**	**17,951**
Unemployed	2	1	0	**12,230**	**10,440**	**61**	**22,731**
Not in Labor Force (retired, sheltered employment, sheltered workshops, homemaker, student, volunteer, disabled, etc.)	3	1	0	**8,246**	**6,137**	**21**	**14,404**
Not Available	1	11	2	**20,913**	**18,842**	**97**	**39,852**
Total	**7**	**14**	**2**	**52,174**	**42,542**	**222**	**94,938**

How Often Does your State Measure Employment Status? ☑ At Admission ☑ At Discharge ☐ Monthly ☐ Quarterly ☐ Other, describe:

What populations are included in reported data?	○ All clients	◉ Only selected groups, describe: Clients in non-institutional settings at discharge or last evaluation are included in the reported data.

Comments on Data (Age):

Comments on Data (Sex):

Comments on Data (Overall):
DMHAS is currently implementing the USTF+ data system and onboarding the providers. Not all providers are using the system to submit the data. DMHAS continues to train providers on the new client level web-based application.

[1] **The 'Not Available' category is to be used only for cases where the requested field in state data systems is null or blank, an invalid value is added, or if the state does not collect information in the state data system.**

0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

E. Performance Indicators and Accomplishments

MHBG Table 15B (URS Table 4A) - Profile of Adult Clients by Employment Status and Primary Diagnosis

This table collects information on the employment status of adult clients served in the reporting period by primary diagnosis. Data should be reported for clients in non-institutional settings at time of discharge or last evaluation. The reporting period is the latest SFY for which data are available. Total persons reported on this table would be the same as the total indicated in MHBG Table 15A.

Reporting Period Start Date: 7/1/2024 Reporting Period End Date: 6/30/2025

Clients Primary Diagnosis	Competitively Employed Full or Part Time (includes Supported Employment)	Unemployed	Not in Labor Force (retired, sheltered employment, sheltered workshops, homemaker, student, volunteer, disabled, etc.)	Employment Status Not Available	Total
Schizophrenia & Related Disorders (F20, F25)	179	847	497	3,189	**4,712**
Bipolar and Mood Disorders (F30, F31, F32, F32.9, F33, F34.0, F34.1)	2,420	2,870	1,401	8,478	**15,169**
Other Psychoses (F22, F23, F24, F29)	33	89	44	1,486	**1,652**
All Other Diagnoses	15,319	18,925	12,462	26,699	**73,405**
No Diagnosis and Deferred Diagnosis (R69, R99, Z03.89)	0	0	0	0	**0**
Diagnosis Total	**17,951**	**22,731**	**14,404**	**39,852**	**94,938**

Comments on Data

DMHAS is currently implementing the USTF+ data system and onboarding the providers. Not all providers are using the system to submit the data. DMHAS continues to train providers on the new client level web-based application.

0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

E. Performance Indicators and Accomplishments

MHBG Table 16 (URS Table 9) - Social Connectedness and Improved Functioning

This table collects information on children/adolescents and adults reporting positively on the improved social connectedness and functioning domains.

Reporting Period Start Date: 7/1/2024 Reporting Period End Date: 6/30/2025

Adult Consumer Survey Results	Number of Positive Responses	Responses	Percent Positive (calculated)
1. Social Connectedness	1,060	1,118	95%
2. Functioning	1,080	1,120	96%
Child/Adolescent Consumer Survey Results	**Number of Positive Responses**	**Responses**	**Percent Positive (calculated)**
3. Social Connectedness	191	266	72%
4. Functioning	135	280	48%
Comments on Data:			

Adult Social Connectedness and Functioning Measures

1. Did you use the recommended Social Connectedness Domain Questions? (●) Yes ( ) No

2. Did you use the recommended Functioning Domain Questions? Measure used (●) Yes ( ) No

3. Did you collect these as part of your MHSIP Adult Consumer Survey? Measure used (●) Yes ( ) No

If No, what source did you use?

(●) Yes ( ) No

Child/Family Social Connectedness and Functioning Measures

4. Did you use the recommended Social Connectedness Domain Questions? Measure used

5. Did you use the recommended Functioning Domain Questions? (●) Yes ( ) No

6. Did you collect these as part of your YSS-F Survey? Measure used (●) Yes ( ) No

If No, what source did you use?

0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

E. Performance Indicators and Accomplishments

MHBG Table 17A (URS Table 11) - Summary Profile of Client Evaluation of Care

This table collects information that evaluates the "experience" of care for individuals that participate in the public mental health system. Specifically, the evaluation focuses on several areas including access, quality and appropriateness of services, outcomes, participation in treatment planning, cultural sensitivity of staff, and general satisfaction with services. Please enter the number of persons responding positively to the questions and the number of total responses within each group. Percent positive will be calculated from these data.

Reporting Period Start Date: 7/1/2024 Reporting Period End Date: 6/30/2025

Adult Consumer Survey Results:	Number of Positive Responses	Responses	Confidence Interval*
1. Reporting Positively about Access.	1,153	1,158	See comments on data
2. Reporting Positively about Quality and Appropriateness.	1,154	1,158	See comments on data
3. Reporting Positively about Outcomes.	1,035	1,100	See comments on data
4. Adults Reporting on Participation In Treatment Planning.	1,145	1,158	See comments on data
5. Adults Positively about General Satisfaction with Services.	1,147	1,158	See comments on data

Child/Adolescent Consumer Survey Results:	Number of Positive Responses	Responses	Confidence Interval*
1. Reporting Positively about Access.	203	289	
2. Reporting Positively about General Satisfaction.	178	291	
3. Reporting Positively about Outcomes.	136	280	
4. Family Members Reporting on Participation In Treatment Planning.	211	291	
5. Family Members Reporting High Cultural Sensitivity of Staff.	236	291	

Comments on Data:
Confidence Intervals: Adults: Access 0.035, Qualty & Approp. 0.037, Outcomes 0.049, Part in Tx Plannning 0.035, General Satisfaction 0.038.

**** Please report Confidence Intervals at the 95% level. See directions below regarding the calculation of confidence intervals.***

Adult Consumer Surveys

1. Was the Official 28 Item MHSIP Adult Outpatient Consumer Survey Used? ○ Yes ◉ No

1.a. If no, which version:

1. Original 40 Item Version ◉ Yes
2. 21-Item Version ○ Yes
3. State Variation of MHSIP ○ Yes
4. Other Consumer Survey ○ Yes

1.b. If other, please attach instrument used.

1.c. Did you use any translations of the MHSIP into another language? ☑ 1. Spanish

2. Other Language:

Adult Survey Approach

2. Populations covered in survey? (Note all surveys should cover all regions of state)
   - ○ 1. All Consumers In State
   - ◉ 2. Sample of MH Consumers

2.a. If a sample was used, what sample methodology was used?
   - ○ 1. Random Sample
   - ◉ 2. Stratified / Random Stratified Sample
   - ○ 3. Convenience Sample
   - ○ 4. Other Sample:

2.b. Do you survey only people currently in services, or do you also survey persons no longer in service?
   - ☑ 1. Persons Currently Receiving Services
   - ☐ 2. Persons No Longer Receiving Services

2.c. If yes, please describe how you survey persons no longer receiving services

3. Please describe the populations included in your sample: (e.g., all adults, only adults with SMI, etc.)
   - ☐ 1. All Adult Consumers In State
   - ☐ 2. Adults With Serious Mental Illness
   - ☐ 3. Adults Who Were Medicaid Eligible Or In Medicaid Managed Care
   - 4. Other (for example, if you survey anyone served in the last 3 months, describe that here):

4. Methodology of collecting data? (Check all that apply)

	Self-Administered	Interview
Phone	☐ Yes	☐ Yes
Mail	☐ Yes	
Face-to-face	☐ Yes	☐ Yes
Web-Based	☑ Yes	☐ Yes

4.a. Who administered the survey? (check all that apply)
   - ☐ 1. MH Consumers
   - ☐ 2. Family Members
   - ☐ 3. Professional Interviewers
   - ☑ 4. MH Clinicians
   - ☑ 5. Non Direct Treatment Staff
   - 6. Other, describe:

5. Are Responses Anonymous, Confidential and/or Linked to other Patient Databases?
   - [x] 1. Responses are Anonymous
   - [x] 2. Responses are Confidential
   - [ ] 3. Responses are Matched to Client Databases

6. Sample Size and Response Rate

6.a. How Many surveys were Attempted (sent out or calls initiated)?	4,380
6.b. How many survey Contacts were made? (surveys to valid phone numbers or addresses)?	4,380
6.c. How many surveys were completed? (survey forms returned or calls completed)	1,158
6.d. What was your response rate? (number of Completed surveys divided by number of Contacts)	26.4%

6.e. If you receive "blank" surveys back from consumers (surveys with no responses on them), did you count these surveys as "completed" for the calculation of response rates? ○ Yes ◉ No

7. Who Conducted the survey

7.a. SMHA Conducted or contracted for the survey (survey done at state level) ◉ Yes ○ No

7.b. Local Mental Health Providers/County mental health providers conducted or contracted for the survey (survey was done at the local or regional level) ○ Yes ○ No

7.c. Other, describe: The SMHA distributed the survey to its provider agencies with explicit guidance on survey administration.

* Report Confidence Intervals at the 95% confidence level

Note: The confidence interval is the plus-or-minus figure usually reported in newspaper or television opinion poll results. For example, if you use a confidence interval of 4 and 47% percent of your sample picks an answer you can be "sure" that if you had asked the question of the entire relevant population between 43% (47-4) and 51% (47+4) would have picked that answer. The confidence level tells you how sure you can be. It is expressed as a percentage and represents how often the true percentage of the population who would pick an answer lies within the confidence interval. The 95% confidence level means you can be 95% certain; the 99% confidence level means you can be 99% certain. Most researchers use the 95% confidence level. When you put the confidence level and the confidence interval together, you can say that you are 95% sure that the true percentage of the population is between 43% and 51%. (From www.surveysystem.com)

Child / Family Consumer Surveys

1. Was the MHSIP Youth Services Survey for Families (YSS-F) used? ☐ Yes

   If no, what survey was used?

   If no, please attach instrument used.

1.c. Did you use any translations of the Child MHSIP into another language?
   - [ ] 1. Spanish
   - 2. Other Language:

Child Survey Approach

2. Populations covered in survey? (Note all surveys should cover all regions of state) ◉ 1. All Consumers In State ○ 2. Sample of MH Consumers

2.a. If a sample was used, what approach was used?
   - ○ 1. Random Sample
   - ○ 2. Stratified / Random Stratified Sample
   - ○ 3. Convenience Sample

4. Other Sample:

2.b. Do you survey only people currently in services, or do you also survey persons no longer in service?

- ☐ 1. Persons Currently Receiving Services
- ☑ 2. Persons No Longer Receiving Services

2.c. If yes, please describe how you survey persons no longer receiving services

3. Please describe the populations included in your sample (e.g.,all children, only children with SED, etc.)

- ☑ 1. All Child Consumers In State
- ☐ 2. Children with Serious Emotional Disturbances
- ☐ 3. Children who were Medicaid Eligible or in Medicaid Managed Care
- 4. Other (for example, if you survey anyone served in the last 3 months, describe that here):

4. Please check all of the methods used to collect the data:

	Self-Administered	Interview
Phone	☐ Yes	☐ Yes
Mail	☐ Yes	
Face-to-face	☐ Yes	☐ Yes
Web-Based	☑ Yes	☐ Yes

4.a. Who administered the survey? (check all that apply)

- ☐ 1. MH Consumers
- ☐ 2. Family Members
- ☐ 3. Professional Interviewers
- ☐ 4. MH Clinicians
- ☐ 5. Non Direct Treatment Staff
- ☑ 6. Other, describe:

5. Are Responses Anonymous, Confidential and/or Linked to other Patient Databases?

- ☑ 1. Responses are Anonymous
- ☐ 2. Responses are Confidential
- ☐ 3. Responses are Matched to Client Databases

6. Sample Size and Response Rate

6.a. How Many surveys were Attempted (sent out or calls initiated)? 13,353

6.b. How many survey Contacts were made? (surveys to valid phone numbers or addresses)?	13,353
6.c. How many surveys were completed? (survey forms returned or calls completed)	291
6.d. What was your response rate? (number of Completed surveys divided by number of Contacts)	2.0%

6.e. If you received "blank" surveys back from consumers (surveys with no responses on them), did you count these surveys as "completed" for the calculation of response rates? ○ Yes ◉ No

7. Who Conducted the survey

7.a.	SMHA Conducted or contracted for the survey (survey done at state level)	◉ Yes ○ No
7.b.	Local Mental Health Providers/County mental health providers conducted or contracted for the survey (survey was done at the local or regional level)	○ Yes ◉ No
7.c.	Other, describe:	

0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

E. Performance Indicators and Accomplishments

MHBG Table 17B (URS Table 11A) - Consumer Evaluation of Care by Race and Ethnicity (Optional Reporting Table)

This table requests information that evaluates the "experience" of care for individuals that participate in the public mental health system, broken down by race, ethnicity, and age category (adult or child/adolescent). Please enter the number of persons responding positively to the questions and the number of total responses within each group. Percent positive will be calculated from these data.

Reporting Period Start Date: 7/1/2024 Reporting Period End Date: 6/30/2025

Adult Consumer Survey Results:

Indicators	Total		American Indian / Alaska Native		Asian		Black / African American		Hawaiian / Pacific Islander		White		Some Other Race		More than One Race		Not Available		Hispanic Origin	
	# Positive	Responses	# Positive	Responses	# Positive	Responses	# Positive	Responses	# Positive	Responses	# Positive	Responses	# Positive	Responses	# Positive	Responses	# Positive	Responses	# Positive	Responses
1. Reporting Positively About Access	1,153	1,158	10	10	30	30	243	245	3	3	446	446	117	118	60	61	244	245	197	198
2. Reporting Positively About Quality and Appropriateness	1,154	1,158	10	10	29	30	245	245	3	3	444	446	118	118	60	61	245	245	198	198
3. Reporting Positively About Outcomes	1,035	1,100	10	10	27	29	225	239	3	3	406	431	109	116	52	57	203	215	186	194
4. Reporting Positively About Participation in Treatment Planning	1,145	1,158	9	10	30	30	243	245	3	3	440	446	118	118	59	61	243	245	197	198
5. Reporting Positively about General Satisfaction	1,147	1,158	10	10	30	30	243	245	3	3	442	446	117	118	60	61	242	245	197	198
6. Social Connectedness	1,060	1,118	10	10	29	30	231	243	3	3	420	441	110	116	53	60	204	215	187	195
7. Functioning	1,080	1,120	10	10	29	30	235	241	3	3	422	440	113	117	57	60	211	219	189	197

Child/Adolescent Family Survey Results:

Indicators	Total		American Indian / Alaska Native		Asian		Black / African American		Hawaiian / Pacific Islander		White		Some Other Race		More than One Race		Not Available		Hispanic Origin	
	# Positive	Responses	# Positive	Responses	# Positive	Responses	# Positive	Responses	# Positive	Responses	# Positive	Responses	# Positive	Responses	# Positive	Responses	# Positive	Responses	# Positive	Responses
1. Reporting Positively About Access	203	289	0	0	7	9	37	49	1	2	87	126	16	21	10	15	45	67	70	86
2. Reporting Positively About General Satisfaction	178	291	0	0	6	9	29	50	1	2	82	127	14	21	7	15	39	67	58	86
3. Reporting Positively About Outcomes	136	280	0	0	3	9	27	50	1	2	61	126	14	21	4	15	26	57	49	86
4. Reporting Positively About																				

Participation in Treatment Planning	211	291	0	0	5	9	39	50	1	2	90	127	17	21	10	15	49	67	65	86
5. Reporting Positively About Cultural Sensitivity of Staff	236	291	0	0	7	9	40	50	1	2	104	126	18	21	12	16	54	67	77	86
6. Social Connectedness	191	266	0	0	5	9	38	50	1	2	90	126	17	21	12	16	28	42	63	86
7. Functioning	135	280	0	0	4	9	26	50	1	2	60	126	14	21	4	15	26	57	48	86

Comments on Data:

0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

E. Performance Indicators and Accomplishments

MHBG Table 18 (URS Table 15) - Living Situation Profile

This table collects information on the living situation of persons served in the reporting period. Living situation categories include, but are not limited to, private residence, foster care, residential care, jail/correctional facility, homeless shelter, etc. Data should be based on the most recent assessment in the reporting period. Specifically, information is collected on the individual's living situation at time of discharge or last evaluation. The reporting period should be the latest SFY for which data are available.

Reporting Period Start Date: 7/1/2024 Reporting Period End Date: 6/30/2025

	Private Residence	Foster Home	Residential Care	Crisis Residence	Residential Treatment	Institutional Setting	Jail / Correctional Facility	Homeless / Shelter	Other	Not Available	Total
0-5 years	436	1	1	1	0	8	2	8	3	24	484
6-12 years	6330	17	10	38	10	54	5	8	19	498	6,989
13-17 years	7899	20	22	141	44	132	17	14	54	1030	9,373
18-20 years	4785	6	32	5	6	234	16	80	83	931	6,178
21-24 years	6241	0	71	0	1	331	43	220	90	1127	8,124
25-44 years	28943	7	815	1	6	1524	310	2316	545	6325	40,792
45-64 years	21602	11	1223	2	5	1160	101	1850	551	5837	32,342
65-74 years	6344	8	449	0	1	478	6	196	143	1866	9,491
75 or over	2498	1	73	0	0	432	1	28	41	608	3,682
Not Available[1]	326	0	11	0	0	28	1	35	5	89	495
TOTAL	**85,404**	**71**	**2,707**	**188**	**73**	**4,381**	**502**	**4,755**	**1,534**	**18,335**	**117,950**
Female	47324	44	1053	122	39	2048	125	1785	657	10271	63,468
Male	37884	26	1651	65	34	2329	376	2961	875	8005	54,206
N/A	196	1	3	1	0	4	1	9	2	59	276
TOTAL	**85,404**	**71**	**2,707**	**188**	**73**	**4,381**	**502**	**4,755**	**1,534**	**18,335**	**117,950**
American Indian/Alaska Native	195	0	12	0	0	2	0	13	2	31	255

Asian	2076	0	44	2	0	97	7	55	30	332	2,643
Black/African American	15707	22	888	33	24	913	200	1879	390	2323	22,379
Native Hawaiian or Pacific Islander	109	0	3	0	0	6	0	4	1	5	128
White	44172	35	1347	96	29	2491	169	1887	721	7367	58,314
Some Other Race	11863	7	179	41	14	497	82	506	136	2092	15,417
More Than One Race	2561	2	98	12	3	200	22	200	43	424	3,565
Not Available[1]	8721	5	136	4	3	175	22	211	211	5761	15,249
TOTAL	**85,404**	**71**	**2,707**	**188**	**73**	**4,381**	**502**	**4,755**	**1,534**	**18,335**	**117,950**

	Private Residence	Foster Home	Residential Care	Crisis Residence	Residential Treatment	Institutional Setting	Jail / Correctional Facility	Homeless / Shelter	Other	Not Available	Total
Hispanic or Latino	55034	56	2179	117	44	3187	324	3525	1149	8985	74,600
Not Hispanic or Latino	19278	5	279	57	14	703	128	748	251	2658	24,121
Not Available[1]	11092	10	249	14	15	491	50	482	134	6692	19,229
TOTAL	**85,404**	**71**	**2,707**	**188**	**73**	**4,381**	**502**	**4,755**	**1,534**	**18,335**	**117,950**

Comments on Data:	
How Often Does your State Measure Living Situation?	☑ At Admission ☑ At Discharge ☐ Monthly ☐ Quarterly ☐ Other, please describe:

[1] **The 'Not Available' category is to be used only for cases where the requested field in state data systems is null or blank, an invalid value is added, or if the state does not collect information in the state data system.**

0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

E. Performance Indicators and Accomplishments

MHBG Table 19A (URS Table 16A) Profile of Adults with Serious Mental Illnesses and Children with Serious Emotional Disturbances Receiving Specific Services

This table collects information on the aggregate profile of adults with SMI and children with SED receiving specific evidence-based practices in the reporting year. In addition, the table captures information on if and how states and jurisdictions monitor fidelity for the evidence-based services. The reporting period should be the latest SFY for which data are available. The total unduplicated number of adults with SMI and children with SED should be the same as those reported in MHBG Tables 13A and 13B.

Reporting Period Start Date: 7/1/2024 Reporting Period End Date: 6/30/2025

Age	Adults with Serious Mental Illness (SMI)				Children with Serious Emotional Disturbance (SED)			
	N Receiving Supported Housing	N Receiving Supported Employment	N Receiving Assertive Community Treatment	Total unduplicated N - Adults with SMI Served	N Receiving Therapeutic Foster Care	N Receiving Multi-Systemic Therapy	N Receiving Family Functional Therapy	Total unduplicated N - Children with SED
0-5 Years					0	0	0	6,833
6-12 Years					0	16	44	24,994
13-17 Years					0	86	101	22,467
18-20 Years	5	9	6	2,078	0	0	1	2,693
21-24 Years	16	12	22	2,900				
25-44 Years	252	62	229	15,098				
45-64 Years	565	50	292	12,017				
65-74 Years	177	8	116	3,460				
75 or Over	15	1	25	1,367				
Total	1,030	142	690	36,920	0	102	146	56,987

Sex	Adults with Serious Mental Illness (SMI)				Children with Serious Emotional Disturbance (SED)			
	N Receiving Supported Housing	N Receiving Supported Employment	N Receiving Assertive Community Treatment	Total unduplicated N - Adults with SMI Served	N Receiving Therapeutic Foster Care	N Receiving Multi-Systemic Therapy	N Receiving Family Functional Therapy	Total unduplicated N - Children with SED
Female	496	62	284	18,938	0	40	73	25,863
Male	534	78	408	17,905	0	62	72	31,158

N/A	4,812	1,272	1,669	273	0	0	1	5

Race	Adults with Serious Mental Illness (SMI)				Children with Serious Emotional Disturbance (SED)			
	N Receiving Supported Housing	N Receiving Supported Employment	N Receiving Assertive Community Treatment	Total unduplicated N - Adults with SMI Served	N Receiving Therapeutic Foster Care	N Receiving Multi-Systemic Therapy	N Receiving Family Functional Therapy	Total unduplicated N - Children with SED
American Indian or Alaska Native	3	0	1	57	0	0	0	57
Asian	20	4	17	894	0	0	2	1,598
Black or African American	377	37	258	8,154	0	48	21	13,949
Native Hawaiian or Pacific Islander	0	0	1	51	0	0	0	23
White	477	68	296	18,984	0	17	90	22,029
Some Other Race	73	27	90	5,016	0	26	18	11,289
More Than One Race	19	3	7	1,224	0	4	11	3,958
Not Available[1]	4,873	1,273	1,691	2,736	0	7	4	4,123

Ethnicity	Adults with Serious Mental Illness (SMI)				Children with Serious Emotional Disturbance (SED)			
	N Receiving Supported Housing	N Receiving Supported Employment	N Receiving Assertive Community Treatment	Total unduplicated N - Adults with SMI Served	N Receiving Therapeutic Foster Care	N Receiving Multi-Systemic Therapy	N Receiving Family Functional Therapy	Total unduplicated N - Children with SED
Hispanic or Latino	119	39	84	7,711	0	45	35	24,803
Not Hispanic or Latino	846	97	580	24,875	0	51	104	29,770
Not Available[1]	4,877	1,276	1,697	4,530	0	6	7	2,453

	Adults with Serious Mental Illness (SMI)				Children with Serious Emotional Disturbance (SED)			
	N Receiving Supported Housing	N Receiving Supported Employment	N Receiving Assertive Community Treatment	Total unduplicated N - Adults with SMI Served	N Receiving Therapeutic Foster Care	N Receiving Multi-Systemic Therapy	N Receiving Family Functional Therapy	Total unduplicated N - Children with SED
Do you monitor fidelity for this service?	○ Yes ◉ No	○ Yes ◉ No	○ Yes ◉ No		○ Yes ○ No	○ Yes ◉ No	○ Yes ◉ No	

IF YES,								
What fidelity measure do you use?								
Who measures fidelity?								
How often is fidelity measured?								
Is the federal EBP Toolkit used to guide EBP Implementation?	○ Yes ◉ No	○ Yes ◉ No	○ Yes ◉ No		○ Yes ○ No	○ Yes ◉ No	○ Yes ◉ No	
Have staff been specifically trained to implement the EBP?	○ Yes ◉ No	○ Yes ◉ No	○ Yes ◉ No		○ Yes ○ No	◉ Yes ○ No	◉ Yes ○ No	

Comments on Data (overall):
Total number matches the total number of adults with SMI in table 14A.

Comments on Data (Supported Housing):
Data is from NJ's Quarterly Contract Monitoring Report Data System.

Comments on Data (Supported Employment):
Data is from NJ's Quarterly Contract Monitoring Report Data System.

Comments on Data (Assertive Community Treatment):
Data is from NJ's Quarterly Contract Monitoring Report Data System.

Comments on Data (Therapeutic Foster Care):

Comments on Data (Multisystemic Therapy):

Comments on Data (Family Functional Therapy):

[1]**The 'Not Available' category is to be used only for cases where the requested field in state data systems is null or blank, an invalid value is added, or if the state does not collect information in the state data system.**
0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

E. Performance Indicators and Accomplishments

MHBG Table 19B (URS Table 16B) - Profile of Adults with Serious Mental Illness Receiving Specific Services During the Year

This table collects information on the aggregate profile of adults with SMI receiving family psychoeducation, integrated treatment for co-occurring disorders, illness self-management and recovery, and medication management. In addition, this table provides information on if, and how, states and jurisdictions monitor the fidelity for the evidence-based services. The reporting period should be the latest SFY for which data are available.

Reporting Period Start Date: 7/1/2024 Reporting Period End Date: 6/30/2025

	ADULTS WITH SERIOUS MENTAL ILLNESS			
	Receiving Family Psychoeducation	**Receiving Integrated Treatment for Co-occurring Disorders (M/SUD)**	**Receiving Illness Self Management and Recovery**	**Receiving Medication Management**
Age				
18-20 years	0	0	0	0
21-24 years	0	0	0	0
25-44 years	0	0	0	0
45-64 years	0	0	0	0
65-74 years	0	0	0	0
75 or over	0	0	0	0

Not Available[1]	0	0	3,900	0
TOTAL	**0**	**0**	**3,900**	**0**

Sex				
Female	0	0	0	0
Male	0	0	0	0
Not Available[1]	0	0	3,900	0

Race				
American Indian or Alaska Native	0	0	0	0
Asian	0	0	0	0
Black or African American	0	0	0	0
Native Hawaiian or Pacific Islander	0	0	0	0
White	0	0	0	0
Some Other Race	0	0	0	0
More Than One Race	0	0	0	0
Not Available[1]	0	0	3,900	0

Ethnicity				
Hispanic or Latino	0	0	0	0
Not Hispanic or Latino	0	0	0	0
Not Available[1]	0	0	3,900	0

Do you monitor fidelity for this service?	○ Yes ○ No	○ Yes ○ No	○ Yes ◉ No	○ Yes ○ No
IF YES,				
What fidelity measure do you use?				
Who measures fidelity?				
How often is fidelity measured?				
Is the federal EBP Toolkit used to guide EBP implementation?	○ Yes ○ No	○ Yes ○ No	○ Yes ◉ No	○ Yes ○ No
Have staff been specifically trained to implement the EBP?	○ Yes ○ No	○ Yes ○ No	○ Yes ◉ No	○ Yes ○ No

Comments on Data (overall):
Comments on Data (Family Psychoeducation): After consulting with NRI, as of 3/23/21, NJ decided not to report the number of family members receiving family psychoeducation services in Table 16B.

Comments on Data (Integrated Treatment for Co-occurring Disorders): NJ data system does not provide the capacity to collect this data.
Comments on Data (Illness Self-Management and Recovery): See General Comments.
Comments on Data (Medication Management): NJ data system does not provide the capacity to collect this data.

[1] The 'Not Available' category is to be used only for cases where the requested field in state data systems is null or blank, an invalid value is added, or if the state does not collect information in the state data system.

0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

E. Performance Indicators and Accomplishments

MHBG Table 19C (URS Table 16C) - Profile of Adults with Serious Mental Illnesses and Children with Serious Emotional Disturbances Receiving Coordinated Specialty Care Services

This table collects information on the number of adults with SMI and children with SED that were admitted into and received Coordinated Specialty Care (CSC) services, the number of clients successfully discharged from CSC services, the number of clients who discontinued CSC services, and the number of clients that received CSC services. In addition, the table collects information on if, and how, states and jurisdictions monitor fidelity for the CSC program. The reporting period should be the latest SFY for which data are available.

Reporting Period Start Date: 7/1/2024 Reporting Period End Date: 6/30/2025

Program Name	Number of Admissions into CSC Services During FY										Number of Clients Successfully Discharged from CSC Services During the FY									
	0-5 Years	6-12 Years	13-17 Years	18-20 Years	21-24 Years	25-44 Years	45-64 Years	65-74 Years	75 or Over	NA	0-5 Years	6-12 Years	13-17 Years	18-20 Years	21-24 Years	25-44 Years	45-64 Years	65-74 Years	75 or Over	NA
Care Plus NJ, Inc.	0	0	6	2	2	1	0	0	0	0	0	0	1	0	0	0	0	0	0	0
Legacy Treatment Services	0	0	0	2	2	14	11	0	0	0	0	0	0	0	1	1	2	0	0	0
University Behavioral Health	0	0	11	27	27	19	1	0	0	1	0	0	2	11	11	5	2	0	0	0

Program Name	Number of Clients who Discontinued CSC Services Prior to Discharge During the FY										Number of Clients Receiving CSC Services During the FY									
	0-5 Years	6-12 Years	13-17 Years	18-20 Years	21-24 Years	25-44 Years	45-64 Years	65-74 Years	75 or Over	NA	0-5 Years	6-12 Years	13-17 Years	18-20 Years	21-24 Years	25-44 Years	45-64 Years	65-74 Years	75 or Over	NA
Care Plus NJ, Inc.	0	0	2	2	1	0	0	0	0	0	0	0	27	23	15	10	0	0	0	0
Legacy Treatment Services	0	0	0	0	1	1	0	0	0	0	0	0	0	5	4	25	25	2	0	0
University Behavioral Health	0	0	4	10	7	6	0	0	0	0	2	0	30	73	79	50	2	0	0	4

Program Name	Do you monitor fidelity for this service?	What fidelity measure do you use?	Who measures fidelity?	How often is fidelity measured?	Has staff been specifically trained to implement the CSC EBP?
Care Plus NJ, Inc.	Yes ○ No ◉				Yes ◉ No ○
Legacy Treatment Services	Yes ○ No ◉				Yes ◉ No ○
University Behavioral Health	Yes ○ No ◉				Yes ◉ No ○

0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

E. Performance Indicators and Accomplishments

MHBG Table 19D (URS Table 16D) Adults with Serious Mental Illnesses and Children with Serious Emotional Disturbances Receiving Coordinated Specialty Care Services who Experienced No Psychiatric Hospitalization or Arrest

This table collects information on the percentage of adults with SMI and children with SED enrolled in Coordinated Specialty Care (CSC) who experienced no psychiatric hospitalization in the current fiscal year and the percentage of adults with SMI and children with SED enrolled in CSC services who experienced no arrest in the current fiscal year by age groups. The reporting period should be the latest state fiscal year for which data are available.

Reporting Period Start Date: 7/1/2024 Reporting Period End Date: 6/30/2025

Percentage of Clients Enrolled in CSC Services who Experienced No Psychiatric Hospitalization in the FY[1]										
Program Name	**0-5 Years**	**6-12 Years**	**13-17 Years**	**18-20 Years**	**21-24 Years**	**25-44 Years**	**45-64 Years**	**65-74 Years**	**75 or Over**	**Not Available**
University Behavioral Health	0	0	50.00%	67.86%	56.00%	65.22%	100.00%	0	0	100.00%
Care Plus NJ, Inc.	0	0	60.00%	50.00%	100.00%	100.00%	0	0	0	75.00%
Legacy Treatment Services	0	0	0	100.00%	0	100.00%	100.00%	100.00%	0	60.00%

Percentage of Clients Enrolled in CSC Services who Experienced No Arrest in the FY[2]										
Program Name	**0-5 Years**	**6-12 Years**	**13-17 Years**	**18-20 Years**	**21-24 Years**	**25-44 Years**	**45-64 Years**	**65-74 Years**	**75 or Over**	**Not Available**
University Behavioral Health	0	0	87.50%	78.57%	84.00%	78.26%	0	0	0	76.00%
Care Plus NJ, Inc.	0	0	100.00%	50.00%	100.00%	100.00%	0	0	0	50.00%
Legacy Treatment Services	0	0	0	100.00%	100.00%	94.73%	93.75%	100.00%	0	100.00%

1 Report the percentage of individuals who experienced no psychiatric hospitalization while enrolled in the CSC program during the fiscal year.

2 Report the percentage of individuals who experienced no arrest while enrolled in the CSC program during the fiscal year.

0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

E. Performance Indicators and Accomplishments

MHBG Table 20 (URS Table 17) - Profile of Persons Receiving Crisis Response Services

This table collects information on the number of persons that received crisis response services by age groups. In addition, this table also collects information on the estimated percentage of the state population with access to crisis response services. The reporting period should be the latest SFY for which data are available.

Reporting Period Start Date: Reporting Period End Date:

	Actual Number of Persons Served										Estimated Percentage of State Population with Access to Service									
Service	**0-5 Years**	**6-12 Years**	**13-17 Years**	**18-20 Years**	**21-24 Years**	**25-44 Years**	**45-64 Years**	**65-74 Years**	**75 or over**	**Not Available**	**0-5 Years**	**6-12 Years**	**13-17 Years**	**18-20 Years**	**21-24 Years**	**25-44 Years**	**45-64 Years**	**65-74 Years**	**75 or over**	**Not Available**
Crisis Contact Centers	0	0	0	0	0	0	0	0	0	83,114	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
24/7 Mobile Crisis Team	0	0	0	5	14	46	33	20	4	41	0.0%	0.0%	0.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Crisis Stabilization Programs	0	0	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Comments on Data:	Crisis Stabilization Program data is not available in FY 2025. Five awards have been made; however, the centers are not open and operational. For 24/7 Mobile Crisis team, the data source is reflective from March to June 2025.																			

0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

E. Performance Indicators and Accomplishments

MHBG Table 21 (URS Table 19A) - Profile of Criminal Justice or Juvenile Justice Involvement

This table collects information on the number of children/youth and adults with an arrest in T1 (prior 12 months) and T2 (most recent 12 months) to measure the change in arrests over time. Information required includes information on arrests and impact of services.

1.The National Outcome Measure for Criminal Justice or Juvenile Justice measures change in arrests over time.

2. If your SMHA has data on arrest records from alternative sources, you may also report that here. If you only have data for arrests for consumers in this year, please report that in the T2 column. If you can calculate the change in arrests from T1 to T2, please use the "T1 to T2 change" columns.

3. Please complete the checkboxes at the bottom of the table to help explain the data sources that you have used to complete the table.

4. Please tell us anything else that would help us to understand your indicator (e.g., list surveys or MIS questions; describe linking methodology and data sources; specify time period for criminal or juvenile justice involvement; explain whether treatment data are collected).

Reporting Period Start Date: 7/1/2024 Reporting Period End Date: 6/30/2025

For Consumers in Service for at least 12 months

	T1			T2			T1 to T2 Change						Assessment of the Impact of Services					
	"T1" Prior 12 months (more than 1 year ago)			"T2" Most Recent 12 months (this year)			If Arrested at T1 (Prior 12 Months)			If Not Arrested at T1 (Prior 12 Months)			Over the last 12 months, my encounters with the police have...					
	Arrested	Not Arrested	No Response	Arrested	Not Arrested	No Response	# with an Arrest in T2	# with No Arrest at T2	No Response	# with an Arrest in T2	# with No Arrest at T2	No Response	# Reduced (fewer encounters)	# Stayed the Same	# Increased	# Not Applicable	No Response	Total Responses
Total	**54**	**477**	**2**	**42**	**431**	**64**	**22**	**30**	**2**	**20**	**397**	**60**	**74**	**35**	**8**	**422**	**4**	**543**
Total Children/Youth (under age 18)	**0**	**29**	**0**	**0**	**29**	**0**	**0**	**0**	**0**	**0**	**29**	**0**	**3**	**0**	**3**	**21**	**2**	**29**
Female	0	16	0	0	16	0	0	0	0	0	16	0	2	0	0	13	1	16
Male	0	13	0	0	13	0	0	0	0	0	13	0	1	0	3	8	1	13
Not Available [1]	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Adults (age 18 and over)	**54**	**448**	**2**	**42**	**402**	**64**	**22**	**30**	**2**	**20**	**368**	**60**	**71**	**35**	**5**	**401**	**2**	**514**
Female	22	227	2	15	202	38	6	15	1	9	184	34	23	17	1	215	1	257
Male	29	205	0	25	184	25	14	14	1	11	169	25	44	17	4	172	1	238
Not Available [1]	3	16	0	2	16	1	2	1	0	0	15	1	4	1	0	14	0	19

For Consumers Who Began Mental Health Services during the past 12 months

	T1			T2			T1 to T2 Change						Assessment of the Impact of Services					
	"T1" 12 months prior to beginning services			"T2" Since Beginning Services (this year)			If Arrested at T1 (Prior 12 Months)			If Not Arrested at T1 (Prior 12 Months)			Since starting to receive MH Services, my encounters with the police have...					
	Arrested	Not Arrested	No Response	Arrested	Not Arrested	No Response	# with an Arrest in T2	# with No Arrest at T2	No Response	# with an Arrest in T2	# with No Arrest at T2	No Response	# Reduced (fewer encounters)	# Stayed the Same	# Increased	# Not Applicable	No Response	Total Responses
Total	**44**	**471**	**2**	**24**	**488**	**1**	**14**	**29**	**1**	**11**	**448**	**12**	**32**	**74**	**8**	**76**	**0**	**190**
Total Children/Youth (under age 18)	**20**	**161**	**0**	**14**	**167**	**1**	**8**	**12**	**0**	**6**	**154**	**1**	**31**	**70**	**7**	**74**	**0**	**182**
Female	11	70	0	6	90	0	5	6	0	1	69	0	16	35	3	28	0	82
Male	9	90	0	8	76	1	3	6	0	5	84	1	15	35	4	45	0	99
Not Available [1]	0	1	0	0	1	0	0	0	0	0	1	0	0	0	0	1	0	1
Total Adults (age 18 and over)	**24**	**310**	**2**	**10**	**321**	**0**	**6**	**17**	**1**	**5**	**294**	**11**	**1**	**4**	**1**	**2**	**0**	**8**
Female	4	177	2	1	181	0	1	3	0	0	171	6	1	2	0	2	0	5
Male	19	123	0	9	130	0	4	14	1	5	113	5	0	2	1	0	0	3
Not Available [1]	1	10	0	0	10	0	1	0	0	0	10	0	0	0	0	0	0	0

Please Describe the Sources of your Criminal Justice Data

Source of adult criminal justice information:

- [x] 1. Consumer survey (recommended questions)
- [ ] 2. Other Consumer Survey: Please send copy of questions
- [ ] 3. Mental health MIS
- [ ] 4. State criminal justice agency
- [ ] 5. Local criminal justice agency
- [ ] 6. Other (specify)

Sources of children/youth criminal justice information:

- [ ] 1. Consumer survey (recommended questions)
- [x] 2. Other Consumer Survey: Please send copy of questions
- [ ] 3. Mental health MIS
- [ ] 4. State criminal/juvenile justice agency
- [ ] 5. Local criminal/juvenile justice agency
- [ ] 6. Other (specify)

Measure of adult criminal justice involvement:

- (●) 1. Arrests
- ( ) 2. Other (specify)

Measure of children/youth criminal justice involvement:

- (●) 1. Arrests
- ( ) 2. Other (specify)

Mental health programs included:

- [ ] 1. Adults with SMI only
- [ ] 2. Other adults (specify)
- [x] 3. Both (all adults)
- [ ] 1. Children with SED only
- [x] 2. Other Children (specify) Incl. kids with SED, substance use & IDD
- [ ] 3. Both (all Children)

Region for which adult data are reported: (●) 1. The whole state ( ) 2. Less than the whole state (please describe)

Region for which children/youth data are reported: (●) 1. The whole state ( ) 2. Less than the whole state (please describe)

What is the Total Number of Persons Surveyed or for whom Criminal Justice Data Are Reported

	Child/Adolescents	Adults
1. If data is from a survey, what is the total number of people from which the sample was drawn?	13,353	84,924
2. What was your sample size? (How many individuals were selected for the sample)?	13,353	4,380
3.How many survey Contracts were made (surveys to valid phone numbers or addresses)?	13,353	4,380
4. How many surveys were completed (survey forms returned or calls completed), if data source was not a Survey. How many persons were CJ data available for?	291	1,158
5. What was your response rate (number of completed surveys divided by number of contracts)?	2.0%	26.0%

State Comments/Notes:

Instructions: If you have responses to a survey by person not in the expected age group, you should include those responses with other responses from the survey (e.g., if a 16 or 17 year old responds to the Adult MHSIP survey, please include their responses in the Adult categories, since that was the survey they used)."

[1] **The 'Not Available' category is to be used only for cases where the requested field in state data systems is null or blank, an invalid value is added, or if the state does not collect information in the state data system.**

0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

E. Performance Indicators and Accomplishments

MHBG Table 22 (URS Table 19B) - Profile of Change in School Attendance

This table collects information on the number of children with suspension and expulsion from school in T1 (prior 12 months) and T2 (most recent 12 months) to measures the change in school attendance over time. Information required includes information on suspensions/expulsions, and impact of services.

1. The National Outcome Measure for School Attendance measures the change in school attendance over time.
2. If your SMHA has data on school attendance from alternative sources, you may also report that here. If you only have data for school attendance for consumers in this year, please report that in the T2 column, if you can calculate the change in attendance from T1 to T2, please use the T1 to T2 Change columns.
3. Please complete the checkboxes at the bottom of the table to help explain the data sources that you used to complete this table.
4. Please tell us anything else that would help us to understand your indicator (e.g., list surveys or MIS questions; describe linking methodology and data sources; specify time period for school attendance; explain whether treatment data are collected).

Reporting Period Start Date: 7/1/2024 Reporting Period End Date: 6/30/2025

For Consumers in Service for at least 12 months

	T1			T2			T1 to T2 Change						Impact of Services					
	"T1" Prior 12 months (more than 1 year ago)			"T2" Most Recent 12 months (this year)			If Suspended at T1 (Prior 12 Months)			If Not Suspended at T1 (Prior 12 Months)			Since starting to receive MH Services, the number of days my child was in school have					
	# Suspended or Expelled	# Not Suspended or Expelled	No Response	# Suspended or Expelled	# Not Suspended or Expelled	No Response	# with an Expulsion or Suspension in T2	# with no Expulsion or Suspension in T2	No Response	# with an Expulsion or Suspension in T2	# with no Expulsion or Suspension in T2	No Response	# Greater (Improved)	# Stayed the Same	# Fewer days (gotten worse)	# Not Applicable	No Response	Total Responses
Total	**7**	**31**	**0**	**9**	**29**	**0**	**5**	**2**	**0**	**4**	**27**	**0**	**13**	**12**	**7**	**6**	**0**	**38**
Sex																		
Female	4	19	0	5	18	0	3	1	0	2	17	0	7	9	4	3	0	23
Male	3	12	0	4	11	0	2	1	0	2	10	0	6	3	3	3	0	15
Not Available[1]	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Age																		
Under 18	6	23	0	2	7	0	4	2	0	3	20	0	10	9	6	4	0	29

For Consumers Who Began Mental Health Services during the past 12 months

	T1			T2			T1 to T2 Change						Impact of Services					
	"T1" Prior 12 months (more than 1 year ago)			"T2" Most Recent 12 months (this year)			If Suspended at T1 (Prior 12 Months)			If Not Suspended at T1 (Prior 12 Months)			Since starting to receive MH Services, the number of days my child was in school have					
	# Suspended or Expelled	# Not Suspended or Expelled	No Response	# Suspended or Expelled	# Not Suspended or Expelled	No Response	# with an Expulsion or Suspension in T2	# with no Expulsion or Suspension in T2	No Response	# with an Expulsion or Suspension in T2	# with no Expulsion or Suspension in T2	No Response	# Greater (Improved)	# Stayed the Same	# Fewer days (gotten worse)	# Not Applicable	No Response	Total Responses
Total	**22**	**167**	**1**	**7**	**172**	**0**	**10**	**12**	**0**	**6**	**160**	**1**	**32**	**74**	**8**	**75**	**0**	**189**
Sex																		
Female	11	75	1	6	81	0	5	6	0	1	74	0	17	37	3	30	0	87
Male	11	91	0	1	91	0	5	6	0	5	85	1	15	37	5	45	0	102
Not Available[1]	0	1	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0
Age																		
Under 18	20	161	1	14	166	0	8	12	0	6	154	1	31	70	7	73	0	181

Sources of School Attendance Information:
- [x] 1. Consumer survey (recommended questions)
- [ ] 2. Other Survey: Please send copy of questions
- [ ] 3. Mental health MIS
- [ ] 4. State Education Department
- [ ] 5. Local Schools/Education Agencies
- [ ] 6. Other (specify)

Measure of School Attendance:
- (•) 1. School Attendance
- ( ) 2. Other (specify):

Mental health programs include:
- [ ] 1. Children with SED only
- [x] 2. Other Children (specify): Incl. kids with SED, substance use & IDD
- [ ] 3. Both (all Children)

Region for which data are reported:
- (•) 1. The whole state
- ( ) 2. Less than the whole state (please describe):

What is the Total Number of Persons Surveyed or for whom School Attendance Data Are Reported?

	Child/Adolescents:
1. If data is from survey, what is the total number of people from which the sample was drawn?	13,353
2. What was your sample size? (How many individuals were selected for the sample)?	13,353
3. How many survey contacts were made? (surveys to valid phone numbers or addresses)?	13,353
4. How many surveys were completed? (survey forms returned or calls completed) If data source was not a Survey, how many persons were data available for?	291
5. What was your response rate? (number of Completed surveys divided by number of Contacts)?	2%

Comments on Data:

[1] The 'Not Available' category is to be used only for cases where the requested field in state data systems is null or blank, an invalid value is added, or if the state does not collect information in the state data system.

0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

E. Performance Indicators and Accomplishments

MHBG Table 23A (URS Table 20A) - Profile of Non-Forensic (Voluntary and Civil-Involuntary) Patients Readmission to Any State Psychiatric Inpatient Hospital within 30/180 Days of Discharge

This table collects information on the total number of civil discharges within the year, the number of readmissions within 30-days and 180-days, and the percent readmitted by age, sex, race, and ethnicity. The reporting period should be the latest SFY for which data are available.

	Total number of Discharges in Year	Number of Readmissions to ANY STATE Hospital within		Percent Readmitted	
		30 days	180 days	30 days	180 days
TOTAL	**420**	**7**	**35**	**1.67%**	**8.33%**
Age					
0-5 years	0	0	0	**0.00%**	**0.00%**
6-12 years	0	0	0	**0.00%**	**0.00%**
13-17 years	0	0	0	**0.00%**	**0.00%**
18-20 years	2	0	1	**0.00%**	**50.00%**
21-24 years	35	0	0	**0.00%**	**0.00%**
25-44 years	231	3	19	**1.30%**	**8.23%**
45-64 years	116	3	14	**2.59%**	**12.07%**
65-74 years	26	1	1	**3.85%**	**3.85%**
75+ years	10	0	0	**0.00%**	**0.00%**
Not Available	0	0	0	**0.00%**	**0.00%**
Gender					
Female	132	3	13	**2.27%**	**9.85%**
Male	287	4	22	**1.39%**	**7.67%**
Gender Not Available	1	0	0	**0.00%**	**0.00%**
Race					
American Indian/Alaska Native	1	0	0	**0.00%**	**0.00%**
Asian	9	1	3	**11.11%**	**33.33%**

Black/African American	165	2	14	**1.21%**	**8.48%**
Hawaiian/Pacific Islander	1	0	0	**0.00%**	**0.00%**
White	241	4	18	**1.66%**	**7.47%**
Some Other Race	0	0	0	**0.00%**	**0.00%**
More than one race	0	0	0	**0.00%**	**0.00%**
Race Not Available	3	0	0	**0.00%**	**0.00%**
Hispanic/Latino Origin					
Hispanic/Latino Origin	54	1	3	**1.85%**	**5.56%**
Non Hispanic/Latino	360	6	32	**1.67%**	**8.89%**
Hispanic/Latino Origin Not Available	6	0	0	**0.00%**	**0.00%**

Are Forensic Patients Included? ○ Yes ◉ No

Comments on Data:

**Hispanic: Only use the "Hispanic" row under Race if data for Hispanic as a Ethnic Origin are not available*

0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

E. Performance Indicators and Accomplishments

MHBG Table 23B (URS Table 20B) - Profile of Forensic Patients Readmission to any State Psychiatric Inpatient Hospital within 30/180 Days of Discharge

This table collects information on the total number of forensic discharges within the year, the number of readmissions within 30-days and 180-days, and the percent readmitted by age, sex, race, and ethnicity. The reporting year should be the latest SFY for which data are available.

Reporting Period Start Date: 7/1/2024 Reporting Period End Date: 6/30/3025

	Total number of Discharges in Year	Number of Readmissions to ANY STATE Hospital within		Percent Readmitted	
		30 days	180 days	30 days	180 days
TOTAL	**293**	**3**	**11**	**1.02%**	**3.75%**
Age					
0-5 years	0	0	0	**0.00%**	**0.00%**
6-12 years	0	0	0	**0.00%**	**0.00%**
13-17 years	0	0	0	**0.00%**	**0.00%**
18-20 years	3	0	0	**0.00%**	**0.00%**
21-24 years	15	0	0	**0.00%**	**0.00%**
25-44 years	170	3	10	**1.76%**	**5.88%**
45-64 years	96	0	1	**0.00%**	**1.04%**
65-74 years	8	0	0	**0.00%**	**0.00%**
75 and over	1	0	0	**0.00%**	**0.00%**
Not Available[1]	0	0	0	**0.00%**	**0.00%**
Sex					
Female	50	0	0	**0.00%**	**0.00%**
Male	243	3	11	**1.23%**	**4.53%**
Not Available[1]	0	0	0	**0.00%**	**0.00%**
Race					
American Indian or Alaska Native	1	0	0	**0.00%**	**0.00%**

Asian	5	0	0	**0.00%**	**0.00%**
Black or African American	167	1	8	**0.60%**	**4.79%**
Native Hawaiian or Pacific Islander	1	0	0	**0.00%**	**0.00%**
White	118	2	3	**1.69%**	**2.54%**
Some Other Race	0	0	0	**0.00%**	**0.00%**
More than One Race	0	0	0	**0.00%**	**0.00%**
Not Available[1]	1	0	0	**0.00%**	**0.00%**
Hispanic or Latino Origin					
Hispanic or Latino	54	0	1	**0.00%**	**1.85%**
Not Hispanic or Latino	237	3	10	**1.27%**	**4.22%**
Not Available[1]	2	0	0	**0.00%**	**0.00%**

Comments on Data:

---

[1] The 'Not Available' category is to be used only for cases where the requested field in state data systems is null or blank, an invalid value is added, or if the state does not collect information in the state data system.
0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

E. Performance Indicators and Accomplishments

MHBG Table 24 (URS Table 21) Profile of Non-Forensic (Voluntary and Civil-Involuntary Patients) Readmission to Any Psychiatric Inpatient Care Unit (State Operated or Other Psychiatric Inpatient Unit) Within 30/180 Days of Discharge (Optional Table)

This table collects information on the total number of discharges from inpatient care units within the year, the number of readmissions within 30-days and 180-days, and the percent readmitted by age, sex, race, and ethnicity. The reporting year should be the latest SFY for which data are available.

Reporting Period Start Date: 7/1/2024 Reporting Period End Date: 6/30/2025

	Total number of Discharges in Year	Number of Readmissions to Any State Hospital within		Percent Readmitted	
		30 days	180 days	30 days	180 days
TOTAL	**0**	**0**	**0**	**0.00**	**0.00**
Age					
0-5 years	0	0	0	**0.00%**	**0.00%**
6-12 years	0	0	0	**0.00%**	**0.00%**
13-17 years	0	0	0	**0.00%**	**0.00%**
18-20 years	0	0	0	**0.00%**	**0.00%**
21-24 years	0	0	0	**0.00%**	**0.00%**

25-44 years	0	0	0	**0.00%**	**0.00%**
45-64 years	0	0	0	**0.00%**	**0.00%**
65-74 years	0	0	0	**0.00%**	**0.00%**
75 and over	0	0	0	**0.00%**	**0.00%**
Not Available[1]	0	0	0	**0.00%**	**0.00%**
Sex					
Female	0	0	0	**0.00%**	**0.00%**
Male	0	0	0	**0.00%**	**0.00%**
Not Available[1]	0	0	0	**0.00%**	**0.00%**
Race					
American Indian or Alaska Native	0	0	0	**0.00%**	**0.00%**
Asian	0	0	0	**0.00%**	**0.00%**
Black or African American	0	0	0	**0.00%**	**0.00%**
Native Hawaiian or Pacific Islander	0	0	0	**0.00%**	**0.00%**

White	0	0	0	**0.00%**	**0.00%**
Some Other Race	0	0	0	**0.00%**	**0.00%**
More Than One Race	0	0	0	**0.00%**	**0.00%**
Not Available[1]	0	0	0	**0.00%**	**0.00%**
Ethnicity					
Hispanic or Latino	0	0	0	**0.00%**	**0.00%**
Not Hispanic or Latino	0	0	0	**0.00%**	**0.00%**
Not Available[1]	0	0	0	**0.00%**	**0.00%**

1. Does this table include readmission from state psychiatric hospitals? ○ Yes ○ No

2. Are forensic patients included? ○ Yes ○ No

Comments on Data:

[1] The 'Not Available' category is to be used only for cases where the requested field in state data systems is null or blank, an invalid value is added, or if the state does not collect information in the state data system.

0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

F. State General Data Notes

State General Data Notes

Expenditure Period Start Date: Expenditure Period End Date:

MHBG Table Number	General Data Note
21	NJ has never populated Table 21 before and is working toward populating this table by FY 2028.
17	Crisis Contact Centers: Data is based on reports from the 988 Network Administrator. NJ 988 was routed 85,380 calls of which 69,454 were answered and 33,528 chats/texts were routed of which 13,660 were answered. The total number of calls, chats and texts routed was 118,908 of which 83,114 were answered. Number of contacts does not represent the number of unduplicated help seekers. Additionally, age of help seeker is not routinely collected and not available at this time. The Contact Centers are available statewide for the entire state population. Crisis Stabilization Program data is not available in FY 2025. Five awards have been made; however, the centers are not open and operational. For 24/7 Mobile Crisis Team, the data source is reflective from March to June 2025. The 24/7 Mobile Crisis Team services is not available to clients ages 0-17 years. For crisis stabilization programs, the estimated percentage of State population with access to service is 0% for those under 18 and for those over 18, 100%.
16B	IMR: The decrease of approximately 25% reflects a reduction in the number of programs reporting data which decreased from 49 programs in FY24 down to 44 programs in FY25. This also reflects the reported loss of IMR trained staff. More importantly, the increase in total programs from 124 to 135 suggests that some newer programs may not have reported, are still in the process of being trained, or were still ramping up services during FY25. MST services are utilized by a small volume of youth every year, so change in percentage from year to year appears large. While a 73% increase may seem significant, it is only reflective of an increase of forty-three (43) youth, across multiple providers. This may reflect a small shift towards increased capacity for these providers. But, given the small volume, NJ cannot draw any reliable conclusions.
16A	The SMI/SED and EBP "not available" values are not comparable. The overall SMI and SMI by demographics are from Tables 14A and 14B, which have few missing values. The EBP numbers came from the QCMR report and the new USTF+ system. The "not available" values are much higher for EPBs. DMHAS is currently implementing the new USTF+ data system and onboarding the providers. Not all providers are using the system to submit the data. DMHAS continues to train providers on the new client-level web-based application.
8A	Total MHBG Expenditures for Non-Direct Service Activities: Salary adjustments were processed in the last quarter of the grant, which is after the dates of these reports.
7C	Total Mental Health Block Grant Funds: The increase is related to greater funding. For Total Other Federal Funds, Total State Funds, and Call Centers, 2025 reflects the increase in amount of services provided compared to 2024. Crisis Stabilization Programs: The Crisis Stabilization Homes had certification delays, so openings were pushed back.
7B	Total CSC-Evidence-Based Practices for First Episode Psychosis Expenditures: 2025 reflects the increase in amount of services provided compared to 2024. Total Mental Health Block Grant Funds: The increase is related to greater funding. Planning for CSC Practices: 2025 reflects the increase in amount of services provided compared to 2024. In 2024, New Jersey expanded its CSC program for First Episode Psychosis to include individuals experiencing Affective Psychosis. To address the need for a broader CSC continuum of care, the CSC Community Integration (CSC CI) program was introduced and provided a stepped-care approach that allows individuals to remain engaged with their existing CSC team while adjusting the intensity and frequency of services based on clinical need. New Jersey awarded two additional teams, increasing the total from three to five teams, which currently serve 18 counties statewide, with a sixth region remaining unserved. Staffing levels for each team were increased from 5.8 to 12.0 FTEs to support program expansion, enabling providers to grow their caseloads from 70 individuals to 200 individuals.
7A	Total MHBG Expenditures increase is related to greater funding. Total Other Funds Expenditure increase is related to greater spending in Ambulatory Non-24-Hour Care expenditures and getting back to normal after Covid. For Total EBP for ESMI Expenditures, Total Administration Expenditures, Total COVID-19 Relief Funds Expenditures, Total ARP Funds Expenditures, and Total Crisis Services (5 percent set-aside): 2025 reflects the increase in amount of services provided compared to 2024. Total Bipartisan Safer Communities Funds: 2025 reflects the temporary decrease in services provided.
2A, 3, 4, 5A, 6, 12, 14A, 14C, 15, 16A	DMHAS implemented the new USTF+ data system in SFY 2024 and onboarded providers into the updated platform. Since the launch of USTF+, DMHAS has conducted extensive outreach to providers and provider administrators to address low compliance, and there is an increase in USTF+ data submission for SFY 2025. Greater provider engagement, enhanced compliance with reporting requirements, and the onboarding of additional providers and programs have

	collectively led to more data submission and clients reported as served. New Jersey's estimate is for approximately 85% of providers to transition to the new USTF+ system by the end of calendar year 2027, with training and onboarding continuing through the transition period.

Footnotes: