

New Jersey

UNIFORM APPLICATION

FY 2024 SUPTRS Block Grant Report

SUBSTANCE ABUSE PREVENTION AND TREATMENT
BLOCK GRANT

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Center for Substance Abuse Prevention
Division of Primary Prevention

Center for Substance Abuse Treatment
Division of State and Community Systems (DSCS)

I: State Information

State Information

I. State Agency for the Block Grant

Agency Name Division of Mental Health and Addiction Services

Organizational Unit Office of Planning, Research, Evaluation, Prevention and Olmstead

Mailing Address PO Box 362

City Trenton

Zip Code 08625-0362

II. Contact Person for the Block Grant

First Name Valerie

Last Name Mielke

Agency Name Division of Mental Health and Addiction Services

Mailing Address PO Box 362

City Trenton

Zip Code 08625-0362

Telephone (609) 438-4352

Fax (609) 341-2302

Email Address Valerie.Mielke@dhs.nj.gov

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State Expenditure Period

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V. Contact Person Responsible for Report Submission

First Name Helen

Last Name Staton

Telephone (609) 438-4159

Fax

Email Address Helen.Staton@dhs.nj.gov

VI. Contact Person Responsible for Substance Use Disorder Data

First Name Suzanne

Last Name Borys, Ed.D.

Telephone 609-438-4360

Email Address Suzanne.Borys@dhs.nj.gov

Footnotes:

For prevention data:

Donald Hallcom, Ph.D.

Email: Donald.Hallcom@dhs.nj.gov

Phone: 609-438-4187

II: Annual Update

Table 1 Priority Area and Annual Performance Indicators - Progress Report

Priority #: 1

Priority Area: Pregnant Women/Women with Dependent Children

Priority Type: SAT

Population(s): PWWDC

Goal of the priority area:

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

Objective:

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

Strategies to attain the goal:

- **Annual Provider Meetings:** These meetings are held with licensed contracted women's treatment providers, system partners representing NJ Department of Children and Families (DCF), Division of Family Development (DFD), Work First New Jersey Substance Abuse Initiative (WFNJ-SAI), the Maternal Wrap Around Program (MWRAP) providers, and Integrated Opioid Treatment and Substance Exposed Infants (IOT-SEI) providers. Meetings address a variety of topics ranging from information sharing, best practices, continuum of care, medication assisted treatment, referrals and access to services, recovery supports, Plans of Safe Care, systems collaboration, Substance Exposed Infants (SEI) and Neonatal Abstinence Syndrome (NAS), challenges, and training needs.
- **Professional Development:** Contracted licensed women's treatment providers that receive funding through the women's set aside block grant are required to address the full continuum of treatment services: family-centered treatment, evidence-based parenting programs, trauma-informed and trauma-responsive treatment using Seeking Safety, Strengthening Families, evidence-based parenting classes, recovery supports, etc. and assist women with housing supports by linking women to transitional, permanent and/or supportive or sober living homes such as an Oxford House. All providers who have DMHAS contracts for specialty services ranging from prevention, treatment and recovery supports for pregnant and parenting women (PPW) with opioid use disorder are required to have new staff successfully complete the National Center on Substance Abuse and Child Welfare (NCSACW) online tutorials "Understanding Child Welfare and the Dependency Court: A Guide for Substance Abuse Treatment Professionals" and document completion of tutorials in their employee personnel files.
- **Plans of Safe Care:** All women's treatment and pregnant and parenting specialty services (MWRAP and IOT-SEI Initiatives) provider contract language requires Plans of Safe Care for pregnant and postpartum women. Plans of Safe Care will address the needs of the mother, infant and family to ensure coordination of, access to, and engagement in services. For a pregnant woman, the Plan shall be developed prior to the birth event whenever possible and in collaboration with treatment providers, health care providers, early childhood service providers, and other members of the multidisciplinary team as appropriate. Documentation of the Plan must be included in the woman's file.
- **Interim Services:** In 2019 NJ DMHAS added language to Fee for Service (FFS) Network Annex A's to ensure all FFS funded treatment agencies provide Interim Services as an engagement service at all levels of care to ensure priority PPW consumers awaiting admission to their assessed level of care anywhere in the state could receive interim services within 48 hours at facilities closer to home. Interim services for PPW consumers is designed to reduce the adverse health effects of substance use, promote individual health, and reduce the risk of transmitting disease to sexual partners and their infants by providing individualized education, case management, referrals and MAT if needed, while awaiting admission. Statewide technical assistance on interim services was provided to all provider contractees.
- **In Depth Technical Assistance (IDTA) Neonatal Abstinence Syndrome and Substance Exposed Infants (NAS SEI):** As a SAMHSA Prescription Drug Abuse Policy Academy State, NJ applied for a unique technical assistance opportunity through the SAMHSA supported NCSACW to address the multi-faceted problems of NAS and SEI. NJ DHS/DMHAS as the lead State agency, partnered with DCF and DOH, and submitted a successful application (no funding attached). The IDTA goal was to develop uniform policies/guidelines that address the entire spectrum of NAS and SEI from pre-pregnancy, prevention, early intervention, assessment and treatment, postpartum and early childhood. The IDTA provided technical assistance to NJ to strengthen collaboration and linkages across multiple systems such as addictions treatment, child welfare, and medical communities to improve services for pregnant women with opioid and other substance use disorders and outcomes for their babies. The Core Team included over 60 individuals representing multiple State Departments and Divisions, community stakeholders, treatment providers, and the medical community. Three goals were established (1) Increase perinatal SEI screening at multiple intervention points (2) Leverage existing programs and policy mechanisms to collaboratively increase the rate at which women screening positive on the 4P's Plus get connected for a comprehensive assessment by establishing formal warm-handoffs and other safety net measures; (3) Leverage existing programs and policy mechanisms to collaboratively increase the rate at which women delivering SEIs and their babies and any other eligible children, receive early support services for which they are eligible. Workgroups were formed.

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

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

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

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

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

- Data Collection (MWRAP and IOT-SEI): DMHAS Researcher is collecting and analyzing data to understand the impact of each program on outcomes for the mother and her child, to evaluate program effectiveness, make recommendations for program improvement and sustainability. As of July 2020 COVID19 specific data is also being collected; the purpose of this data is to understand how individual participants are being affected and what specific steps are being taken to address COVID19 related challenges – Data is on impact of social determinants of health on health outcomes in the time of COVID 19 such as housing, transportation and healthcare.

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

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

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

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

- New Jersey was recently awarded technical assistance through the National Center on Substance Abuse and Child Welfare's (NCSACW) 2023 Policy Academy: Advancing Collaborative Practice and Policy: Promoting Healthy Development and Family Recovery for Infants, Children, Parents, and Caregivers Affected by Prenatal Substance Exposure. The Department of Health is the lead State Department and NJ Policy Academy State representatives include the Departments of Children and Families, Human Services, and the Governor's Office. The DMHAS Women's Treatment Coordinator represents the Department of Human Services. The overall goal is to increase awareness of pregnant women and SUD, through increased education and maximizing messaging through the perinatal work force; increase awareness and access to treatment, Plans of Safe Care, and improving screenings in hospitals and healthcare providers.
- Project ECHO series with new curriculums took place early Spring 2022 and concluded late Summer. The new MCH PPW-OD ECHO series will commence 2023 with 18 sessions.
- Fall 2022, the MWRAP provided training to ReachNJ, the statewide 24/7 addictions hotline that provides screening, referral to treatment, care coordination and warm hand-offs to providers for eligible individuals. The MWRAP is another resource for pregnant women with a SUD across the state and can provide immediate case management and recovery supports.
- Sober Living: New Jersey contracts with Oxford House Inc. which has dedicated women's homes and women with children homes. The contract has been expanded to develop additional homes for special populations including women with children. Women and Children Oxford Houses are required to provide lockboxes to each for medication storage. Residents in Oxford Houses is responsible for their individual medication lock boxes. Outreach staff conduct annual training (Overdose Specific) at each Chapter meeting at the annual state workshop. Currently, there are 14 Oxford House Chapters throughout the state. This is in response to the heroin overdose epidemic in the state of New Jersey and its effects related to Oxford House. Each home is required to maintain Naloxone kits on site.
- Advertising Campaign: New Jersey continues its statewide advertising campaign centered around opioid use and bringing public awareness to call ReachNJ, the 24/7 Addiction Hotline, for treatment. New messaging, beginning in August 2022, has added pregnant women, along with student athletes and older adults, as target groups. This is a statewide campaign that utilizes television and radio advertisements, bus wraps, billboards and social media to encourage New Jerseyans to access treatment. Recently the TV ad aired on NBC during the Macy's Thanksgiving Day Parade and later that evening during an NFL football game.

Annual Performance Indicators to measure goal success

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

The number of pregnant women and women with children from SFY 2021 – 2023 will be tracked by the SSA's New Jersey Substance Abuse Monitoring System (NJSAMS).

New Data Source(if needed):

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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)

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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:

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Report of Progress Toward Goal Attainment

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

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

SFY 2021: 27,210 admissions

SFY 2022: 25,694 admissions

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

In 2019, New Jersey rolled out the Office Based Addictions Treatment (OBAT) Initiative. Hospital-based programs, MAT-waivered physicians, and other community office-based treatment providers provide services to pregnant women and are not required to enter this data into NJSAMS. Treatment data from OBAT Initiative providers is not captured in NJSAMS or shared with DMHAS. Thus, it is likely that OBAT Initiative providers provided treatment to pregnant and parenting women with opioid use disorder, more so during the COVID-19 pandemic. This population was reluctant to enter treatment during the pandemic. They may have had more anxiety due to fear of the virus, childcare issues, remote learning and public transportation restrictions. Also, our licensed treatment facilities had restrictions on number of individuals permitted into the facilities.

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

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

How first year target was achieved (optional):

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

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

SFY 2022: 25,694 admissions

SFY 2023: 23,317 admissions

There were 2,377 less admissions in SFY 2023 compared to SFY 2022, a decrease of 9.25%.

According to the Treatment Episode Data Set (TEDS) 2021 to 2022 data, there is a decrease in admissions, and decreases in pregnant women, MOUD and IVDU. Our treatment admissions data reflects the national data.

In 2019, New Jersey rolled out the Office Based Addictions Treatment (OBAT) Initiative. Hospital-based programs, MAT-waivered physicians, and other community office-based treatment providers provide services to pregnant women and are not required to enter this data into NJSAMS. Treatment data from OBAT Initiative providers is not captured in NJSAMS or shared with DMHAS. Thus, it is likely

that OBAT Initiative providers provided treatment to pregnant and parenting women with opioid use disorder, more so during the COVID-19 pandemic. This population was reluctant to enter treatment during the pandemic. They may have had more anxiety due to fear of the virus, childcare issues, remote learning and public transportation restrictions. Also, our licensed treatment facilities had restrictions on number of individuals permitted into the facilities.

The numbers of private practitioners has steadily increased across the state over the last few years. DMHAS has seen a decline in the number of pregnant and parenting women with SUD seeking treatment through the licensed NJ SUD treatment providers. Pregnant and parenting women with OUD are choosing private practitioners, and the trend appears to be that individuals are choosing multiple pathways to recovery. The MCH: PPW- OUD ECHO Program's overall goal is to help ensure that NJ mothers can give birth safely with the treatment and support they receive within their community. To accomplish this overarching goal the focus was to: 1) increase the ability of providers/practitioners who offer either prenatal or postpartum care to recognize signs of substance use and what it means to provide optimal treatment for pregnant and parenting women with an OUD and its impact on their newborn infants using a family-centered, empowering, and culturally relevant approach; 2) explore how to build a more trusting, empowering relationship with women with an OUD; 3) learn to implement best practices for treatment in the care setting and linkages to supportive community resources. Series 4 Project ECHO MCH: PPW- OUD training focused on educating private practitioners on best practices for pregnant women with OUD and other substances. The target audience was a special evening time for practitioners to learn and discuss the latest, FDA approved techniques for MAT, integrated care, and wraparound services for pregnant and postpartum individuals. The curriculum covered screening for SUD; new guidelines for prescribing buprenorphine; Starting treatment: the patient contract, pharmacy partner, and social services; managing buprenorphine treatment and follow-up; and hot topics.

Improving maternal child health outcomes is a major agenda for New Jersey through the adoption of Nurture NJ, led by First Lady Tammy Murphy. Nurture NJ is a statewide, multi-agency campaign dedicated to this issue. 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. Access to care should be a safe, high-quality equitable system of care with services from prenatal to postpartum care provided in a supportive community environment. The MWRAP and IOT-SEI Initiatives focus on the impact of SUD on maternal child health by providing an array of services. Services range from treatment, recovery supports, wraparound services and case management with the overall goal to promote maternal health, improve birth outcomes and reduce the risks and adverse consequences of prenatal substance exposure and to support the woman's recovery. The pregnant and postpartum/parenting women who participate in these initiatives are engaged in treatment, however, treatment may not necessarily be with one of the NJ licensed SUD facilities. Providers are required to submit separate data to DMHAS, and SUD treatment is reported. To date, the MWRAP and IOT-SEI initiatives have catered for a cumulative unduplicated total of 948 women. Five MWRAP providers catered for a total of 458 unduplicated women, and five IOT-SEI providers catered for a total of 490 unduplicated women. Methadone was the most commonly used at intake and at the birth event for MWRAP and buprenorphine for IOT-SEI. To date a cumulative total of 380 pregnant women were engaged in SUD treatment with the vast majority utilizing outpatient services; 464 utilized MAT at intake. Methadone was the most commonly used at intake and at the birth event for MWRAP and buprenorphine for IOT-SEI.

Although treatment admissions reflect a decrease for pregnant and parenting women, the process of recovery is highly personal and occurs via multiple pathways. NJ has Community Peer Recovery Centers in every county supported with State Opioid Response funding and two state funded Recovery Centers. The Community Peer Recovery Centers provided peer support services to 12,885 unduplicated individuals from 9/30/2022 to 9/29/2023, which is 150% higher than the 21 CPRC's original goal of 9,217 per year. Many of the 12,885 unduplicated individuals took advantage of the wide range of services that the 21 CPRC's offered, which equated to 38,959 duplicated individuals being served during this funding period. The CPRCs are among the most accessible resources in NJ, that are rooted in empowering people in recovery to be agents of change in the communities that they serve. The CPRCs serve as vital local hubs for the recovery community providing peer coaching, mutual support meetings, telephone recovery, social events and activities, wellness activities, and linkages to all supportive services needed by the recoveree such as co-occurring behavioral health treatment, medication assisted treatment, and harm reduction. Pregnant and parenting women have access to their local CPRCs, and these women may choose the CPRCs as their pathway to recovery.

Stigma is one of the biggest barriers to effective treatment for pregnant and parenting women who have a SUD. Pregnant women who use substances often do not seek prenatal care due to fear of child welfare involvement and losing their children. They may face mistreatment, stereotyping or negative bias from individuals in healthcare such as prenatal clinics, labor and delivery settings. These challenges may prevent them from seeking treatment and may contribute to isolation. In an effort to reduce the stigma associated with SUD, the Division will be launching an anti-stigma campaign that produces and disseminates media messaging. The campaign will appear on broadcast television, streaming services, radio, outdoor advertising, and digital and social media. By reducing the stigma associated with SUD, through the campaign more pregnant and parenting women will opt to seek treatment and move towards their recovery.

"DMHAS is participating in the 2023 National Academy for State Health Policy (NASHP) Maternal and Child Health Policy Innovation Program (MCH-PIP) Alumni Policy Academy. NASHP held the first MCH PIP in 2019 with NJ Medicaid as the lead with DMHAS, DCF and DOH participation. The focus was on maternal depression-related issues. Accomplishments included statewide maternal health related initiatives as part of NJ's NurtureNJ work led by First Lady Tammy Murphy, which has included standing up Medicaid coverage for community doula care, postpartum coverage for a year and universal home visiting. The 2023 MCH PIP Alumni Policy Academy includes NJ DHS Medicaid, DMHAS, DOH and DCF. The Alumni Policy Academy will focus on improving integration with community based behavioral resources, addressing the perinatal workforce including expanding capacity for clinical and non-clinical staff to improve

state capacity to address the social determinants of health (SDOH) needs impacting NJs perinatal populations.”

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

How second year target was achieved (optional):

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Priority #:

2

Priority Area:

Persons Who Inject Drugs (PWID)

Priority Type:

SAT

Population(s):

Goal of the priority area:

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

Objective:

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

Strategies to attain the goal:

- Expand low threshold buprenorphine induction programming at all statewide Harm Reduction Centers (HRCs) while also continuing to encourage collaboration and affiliation agreements between the HRCs and substance use disorder agencies to ensure referral to comprehensive treatment programs, when clinically indicated. Providing services in convenient locations, specifically continuing to utilize and start-up new mobile medication programming, in order to reduce barriers and engage individuals in care as easily as possible.
- Development and expansion of its expanded hour Opioid Treatment Program (OTP) initiative in efforts to provide increased (i.e. evening) hours that are not typically provided in efforts to assist individuals with easier access to services. Promoting the use of medication assisted treatment (MAT) (e.g., methadone, buprenorphine, injectable naltrexone) for individuals with an opioid use disorder (OUD) who seek treatment at any level of care.
- Providing substance use disorder treatment services for individuals who are Deaf and hard of hearing and whose primary language is American Sign Language (ASL) and have a primary diagnosis of an opioid use disorder or stimulant use disorder. The goal is to provide regional services that are both culturally and linguistically accessible and utilize substance use counselors, case managers, and qualified ASL interpreters at three (3) site locations and refer to MAT programming, when appropriate.
- Educating providers, individuals with an OUD, family members and the public about the benefits of MAT through its public awareness campaign that was launched in 2020, as well as providing public presentations, in-person or virtually, on this topic.
- Contracts with three regional Opioid Overdose Prevention Program (OOPP) providers and an Opioid Overdose Prevention Network (OOPN) provider to continue to offer community education and trainings for individuals at-risk for an opioid use disorder, their families, friends and loved ones to recognize an opioid overdose and to subsequently provide naloxone kits to individuals in attendance. A component of these trainings have been and will continue to be to discuss treatment, including MAT.
- Increase the number of naloxone trainings specifically for underserved populations, such as schools, jails, licensed substance use disorder (SUD) treatment providers, Offices of Emergency Management, Emergency Medical Services teams, fire departments, homeless shelters and community health clinics.
- Linking individuals reversed from an opioid overdose, who are seen bedside by recovery specialists and patient navigators at emergency departments, via the 21 county Opioid Overdose Recovery Programs (OOPP) to treatment and/or recovery support services in their communities.
- Statewide contracts awarded to providers in all 21 counties for a Support Team for Addiction Recovery (STAR) program to provide case management and wraparound services for individuals with an OUD. Goals include linking clients to needed services, housing, primary care and treatment to include MAT.
- Maternal Wrap Around Program (MWRAP) – MWRAP is a statewide program located in six regions with each region serving approximately 30 unduplicated opioid dependent pregnant women, their infants and families. MWRAP provides intensive case management and recovery support services for opioid dependent pregnant and postpartum women. Opioid dependent women are eligible for services during pregnancy and up to one year after the birth event. The MWRAP goal is to alleviate barriers to services for pregnant opioid dependent women through comprehensive care coordination that is implemented within the five major timeframes when intervention in the life of the SEI can reduce potential harm of prenatal substance exposure: pre-pregnancy, prenatal, birth, neonatal and early childhood. MWRAP is intended to promote maternal health, improve birth outcomes, and reduce the risks and adverse consequences of prenatal substance exposure. The onset of the COVID-19 pandemic resulted in many significant safety precautions at the national and state level. The stay-at-home orders, such as closures of businesses, schools, restrictions in gatherings has had an impact on the social determinants of health (food, security, employment, income, access to medical care, etc.). Pregnant and parenting women with a history of substance use disorder could be at risk for increase in substance use or experience relapse due to feelings of isolation, lack of family supports, or social support systems. Their mental health could be adversely affected exhibiting depression during pregnancy and postpartum. State fiscal year, 2022 the MWRAP statewide initiative eligibility criteria will be expanded to include pregnant women with substance

use disorder, not exclusive to opioid dependency and providers will serve a total of 50 (fifty) unduplicated women per region.

- In September 2016, DMHAS was awarded a "Strategic Prevention Framework for Prescription Drugs (SPF Rx)" five-year grant from SAMHSA to implement the NJAssessRx initiative. NJAssessRx expands interagency sharing of the state's Prescription Drug Monitoring Program data and gives DMHAS the capability to use data analytics to identify prescribers, prescriber groups and patients at high risk for inappropriate prescribing and nonmedical use of opioid drugs. Informed by the data, DMHAS and its prevention partners will strategically target communities and populations needing services, education or other interventions. The target population is youth (ages 12-17) and adults (18 years of age and older) who are being prescribed opioid pain medications, controlled drugs, or human growth hormone (HGH), and are at risk for their nonmedical use.
- In FY 2020, New Jersey received a total of \$120.3 million through SOR for a two-year period. In FY 2021, NJ received \$65.97 million through SOR 2.0. The goal of the SOR is to address the State's opioid crisis as well as a rising issue of stimulant use disorder by providing treatment, family and peer recovery support, community prevention and education programs and training. The key objectives of funding are to increase access to medication-assisted treatment (MAT), reduce unmet treatment need, reduce opioid-related deaths, and provide services to address individuals who have a stimulant use disorder.
- As part of SOR and state funding, DMHAS collaborates with 20 of 21 counties in NJ who have established MAT programs or enhanced existing MAT services for inmates with OUD at county correctional facilities. DMHAS will utilize funds to have its Centers of Excellence provide technical assistance to correctional facilities to assist them in the provision of these services. In addition, DMHAS has worked with county correctional facilities to establish justice involved re-entry services for detainees where case managers at county jails conduct intake assessments and establish pre-release plans for needed services in the community.
- Interim Services is a requirement of DMHAS provider contracts. A new initiative developed in October 2019 has allowed DMHAS to pay for these services through a fee-for-service (FFS) mechanism. The Interim Services initiative provides funding to all contracted FFS agencies to support individuals awaiting admission to treatment following a substance use disorder (SUD) assessment. Interim Services are an engagement level of service intended to link individuals to services they may not be able to access due to lack of provider capacity. This service has been designed to be provided by agencies contracted for any licensed ASAM level of care. Interim services have been made available to any individual eligible for treatment within the public system who cannot be admitted for the assessed level of care within 72 hours. Prior to this initiative, agencies enrolled in the Block Grant initiatives were required to provide this service.
- DMHAS is proposing to increase access to buprenorphine and other ancillary services for individuals with a substance use disorder through current programming available at homeless shelters. It is proposed that providers will develop the capacity to provide low threshold medication as well as other support services for individuals who reside or drop in at the shelters, linking them to treatment services when appropriate.
- DMHAS will continue a train-the-trainer program through Rutgers University on MAT and NJ-specific treatment and recovery resources for graduate students. The goal of this project is to educate, support, and mentor graduate students to give free educational talks to community groups throughout the State.
- DMHAS will be issuing a Request for Proposal (RFP) which will fund cultural competence training that will be provided to narrow the treatment gap experienced by Black/African Americans (AA) who are diagnosed with opioid and stimulant use disorders and who are statistically less likely to receive or access services. A second goal of this initiative is to increase access to MAT through increased prescribing to the Black/AA community.
- DMHAS to develop a pilot program to fund one of its university partners to develop a few pilot paramedicine programs in the State to administer buprenorphine for opioid withdrawal symptoms and provide next day linkage to care to community MAT providers.
- The Division of Medical Assistance and Health Services, in collaboration with DMHAS, launched a program to cover and support MAT and Office Based Addiction Treatment (OBAT). This program coordinates the delivery of multiple reimbursable services provided by primary care providers and community behavioral health specialists to NJ FamilyCare members with an addiction diagnosis. OBAT providers link patients to OTP or other treatment services when appropriate.

Edit Strategies to attain the objective here:

(if needed)

- Telephone Recovery Support (TRS) program that calls high risk participants with an OUD, for up to four months, longer if needed, to provide encouragement, support and information.
- Long-Term Residential Incentive Payment. A new innovation is paying long term residential providers for providing MAT to clients. Effective June 1, 2020, the Long-term Residential (LTR) reimbursement rate was increased, as well as the ability to pay for Medication Assisted Treatment (MAT) and MAT related services. Beginning July 1, 2020, additional incentive payments became available for the utilization of MAT and MAT capacity in LTR. The incentive rate creates the capacity to prescribe and administer MAT, which minimally includes Buprenorphine, but also may include Naltrexone and other FDA-approved products for Opioid Use Disorder (OUD) and for Alcohol Use Disorder (AUD). The rates and incentives are divided into three (3) tiers that are structured as follows:
 - 1) Tier 1 rate: The increased base LTR per diem rate for treatment plus Room and Board.
 - 2) Tier 2 rate: Licensed LTR provider sites that receive Department of Health (DOH) Certificate of Need and Licensing (CN&L) approval for MAT will have the base rate raised by \$5.00 per unit of service plus Room and Board. To qualify for Tier 2, providers will be required to submit the MAT certification

letter that has been issued by CN&L. If the provider loses its licensed approval for MAT, they will not qualify for the Tier 2 rate and will be reimbursed for the base LTR rate.

3) When an LTR provider site has least 40% of eligible clients receiving an approved medication for treatment of an OUD or an AUD, the provider's rate will increase by \$10.00 per unit of service. This incentive threshold applies to medications arranged for using an external provider (e.g., Methadone from an OTP; Buprenorphine from OBAT) and provided by the LTR Provider.

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

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

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

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

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

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

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

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

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Increase the number of PWID entering treatment.
Baseline Measurement:	SFY 2021: 21,921 admissions
First-year target/outcome measurement:	Increase the number of PWID entering treatment by 1%.
Second-year target/outcome measurement:	Increase the number of PWID entering treatment by 2% by the end of SFY 2023. The change in SFY 2023 will be measured by calculating the percent difference from SFY 2020 to SFY 2023.
New Second-year target/outcome measurement(if needed):	Maintain the number of PWID who entered treatment in SFY 2022 (20,275) by the end of SFY 2023.

Data Source:

The number of PWID in SFY 2021 through SFY 2023 will be tracked by the SSA's New Jersey Substance Abuse Monitoring System (NJSAMS).

New Data Source(if needed):



Description of Data:

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

New Description of Data:(if needed)☐**Data issues/caveats that affect outcome measures:**

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

New Data issues/caveats that affect outcome measures:☐**Report of Progress Toward Goal Attainment**

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

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

SFY 2021: 21,957 admissions

SFY 2022: 20,075 admissions

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

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

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

How first year target was achieved (optional):

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

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

SFY 2022: 20,075 admissions

SFY 2023: 16,765 admissions

There were 3,310 less admissions in SFY 2023 compared to SFY 2022, a decrease of 16.49%.

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

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

Although treatment admissions reflect a decrease for PWID, the process of recovery is highly personal and occurs via multiple pathways. NJ has Community Peer Recovery Centers (CPRCs) in every county supported with State Opioid Response funding and two state funded Recovery Centers. The CPRCs provided peer support services to 12,885 unduplicated individuals from 9/30/2022 to 9/29/2023, which is 150% higher than the 21 CPRC's original goal of 9,217 per year. Many of the 12,885 unduplicated individuals took advantage of the wide range of services that the 21 CPRC's offered, which equated to 38,959 duplicated individuals being served during this funding period. The CPRCs are among the most accessible resources in NJ, that are rooted in empowering people in recovery to be agents of change in the communities that they serve. The CPRCs serve as vital local hubs for the recovery community providing peer coaching, mutual support meetings, telephone recovery, social events and activities, wellness activities, and linkages to all supportive services needed by the recoveree such as co-occurring behavioral health treatment, medication assisted treatment, and harm reduction. PWID have access to local CPRCs, and these PWID may choose the CPRCs as their pathway to recovery.

How second year target was achieved (optional):☐

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

Baseline Measurement: SFY 2021: 39,771 admissions

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

Second-year target/outcome measurement: Increase number of opiate dependent individuals entering treatment by 2% by the end of SFY 2023. The change in SFY 2023 will be measured by calculating the percent difference from SFY 2021 to SFY 2023.

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

Data Source:

The number of opiate dependent individuals from SFY 2021 - 2023 will be tracked by the SSA's New Jersey Substance Abuse Monitoring System (NJSAMS).

New Data Source(if needed):

☐

Description of Data:

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

New Description of Data:(if needed)

☐

Data issues/caveats that affect outcome measures:

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

New Data issues/caveats that affect outcome measures:

☐

Report of Progress Toward Goal Attainment

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

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

SFY 2021: 39, 839 admissions

SFY 2022: 39,523 admissions

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

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

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

How first year target was achieved (optional):

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

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

SFY 2022: 39,523 admissions

SFY 2023: 35,630 admissions

There were 3,893 less admissions in SFY 2022 compared to SFY 2021, a decrease of 9.85%.

Various options to receive medications for OUD now exist (i.e., Federally Qualified Healthcare Centers, Office Based Addiction Treatment

programs and new innovative low threshold buprenorphine programming) that are not licensed SUD treatment programs, and therefore, are not required to enter data into the NJSAMS reporting system.

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

How second year target was achieved (optional):

Priority #: 3
Priority Area: Heroin/Opioid Users
Priority Type: SAT
Population(s): Other ()

Goal of the priority area:

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

Objective:

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

Strategies to attain the goal:

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

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

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

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

2) Tier 2 rate: Licensed LTR provider sites that receive Department of Health (DOH) Certificate of Need and Licensing (CN&L) approval for MAT will have the base rate raised by \$5.00 per unit of service plus Room and Board. To qualify for Tier 2, providers will be required to submit the MAT certification letter that has been issued by CN&L. If the provider loses its licensed approval for MAT, they will not qualify for the Tier 2 rate and will be reimbursed for the base LTR rate.

3) When an LTR provider site has least 40% of eligible clients receiving an approved medication for treatment of an OUD or an AUD, the provider's rate will increase by \$10.00 per unit of service. This incentive threshold applies to medications arranged for using an external provider (e.g., Methadone from an OTP; Buprenorphine from OBAT) and provided by the LTR Provider.

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

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

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

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

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

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

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

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Increase the number of heroin/other opiate admissions for whom MAT was planned.
Baseline Measurement:	SFY 2021: 21,227 heroin/other opiate admissions for whom MAT was planned.
First-year target/outcome measurement:	Increase the number of heroin/other opiate admissions for whom MAT is planned by 1%
Second-year target/outcome measurement:	Increase the number of heroin/other opiate admissions for whom MAT is planned by 2%. The change in SFY 2023 will be measured by calculating the percent difference from SFY 2021 to SFY 2023.

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

The number of heroin/other opiate admissions for whom MAT was planned from SFY 2021 - 2023 will be tracked by the SSA's New Jersey Substance Abuse Monitoring System (NJSAMS).

New Data Source(if needed):☐**Description of Data:**

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

New Description of Data(if needed)☐**Data issues/caveats that affect outcome measures:**

None

New Data issues/caveats that affect outcome measures:☐

Report of Progress Toward Goal Attainment

First Year Target:

☒

Achieved

☐

Not Achieved (if not achieved, explain why)

Reason why target was not achieved, and changes proposed to meet target:**How first year target was achieved (optional):**

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

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

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

The NJ Department of Health, Certificate of Need & Licensing (CN&L) continues to license new Opioid Treatment Programs (OTPs) throughout the State. In SFY 2021 (during the COVID-19 pandemic), CN&L licensed four (4) new ambulatory OTPs. Statewide licensed ambulatory OTPs now total 46, with a minimum of one in each of the State's 21 counties, ensuring better access of medications to be planned in an individual's treatment episode. DMHAS also continues to fund a public awareness campaign through State Opioid Response (SOR) grant funds, to focus on reducing stigma and discrimination for the use of medications in treatment of Opioid Use Disorder (OUD). This is a statewide campaign that utilizes television and radio advertisements, billboards and social media to promote the use of medication to support an individual's recovery. The target audience for the campaign are individuals with a substance use disorder, as well as their families and friends.

Second Year Target:

☐

Achieved

☒

Not Achieved (if not achieved, explain why)

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

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

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

SFY 2023: 20,432 heroin/other opiate admissions for whom MAT was planned.

There were 852 less admissions in SFY 2023 compared to SFY 2021, a decrease of 4%.

Various options to receive medications for OUD now exist (i.e., Federally Qualified Healthcare Centers, Office Based Addiction Treatment programs and new innovative low threshold buprenorphine programming) that are not licensed SUD treatment programs, and therefore, are not required to enter data into the NJSAMS reporting system. Some types of low threshold programming that exist are now located at statewide harm reduction centers and various homeless shelters.

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

How second year target was achieved (optional):

Priority #: 4
Priority Area: TB
Priority Type: SAT
Population(s): TB

Goal of the priority area:

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

Objective:

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

Strategies to attain the goal:

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

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

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Annual Site Monitoring Report of DMHAS' SAPT Block Grant contracted agency indicating that client was offered a tuberculosis evaluation.
Baseline Measurement: According to SFY 2021 Annual Site Monitoring Reports of DMHAS' SAPT Block Grant contracted agencies, 83% of the agencies that were monitored (30 of 36 agencies) were in compliance with offering every client a tuberculosis evaluation.
First-year target/outcome measurement: An increase of 5% above the baseline measure.
Second-year target/outcome measurement: An additional increase of 5% above the first-year target measure.
New Second-year target/outcome measurement(if needed): No change from SFY 2022 first year outcome measurement. For SFY 2023, 100% of monitored agencies will continue to be in compliance with offering every client a tuberculosis evaluation.

Data Source:

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

New Data Source(if needed):

Description of Data:

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

New Description of Data:(if needed)

Data issues/caveats that affect outcome measures:

None

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

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

How first year target was achieved (optional):

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

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

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

According to SFY 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.

The two agencies were found to be not in compliance with several admissions requirements, including offering a TB evaluation. A plan of correction was required from the agency, and follow up will be conducted quarterly to ensure compliance for SFY 2024.

How second year target was achieved (optional):

Priority #: 5
Priority Area: Tobacco
Priority Type: SAP
Population(s): Other (Persons aged 12 – 17)

Goal of the priority area:

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

Objective:

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

Strategies to attain the goal:

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

Environmental Strategies

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

Individual Strategies

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

Legislation

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

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

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

☐

Annual Performance Indicators to measure goal success

Indicator #: 1

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

Baseline Measurement: According to 2018-2019 NSDUH data, 2.96 percent of the target population reported tobacco product use (any) during the month prior to participating in the survey.

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

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

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

Data Source:

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

New Data Source(if needed):

☐

Description of Data:

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

New Description of Data:(if needed)

☐

Data issues/caveats that affect outcome measures:

None

New Data issues/caveats that affect outcome measures:

☐

Report of Progress Toward Goal Attainment

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

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

How first year target was achieved (optional):

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

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

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

☐

How second year target was achieved (optional):

According to 2021 NSDUH data, 1.97 percent of the target population reported using any tobacco product during the month prior to participating in the survey.

Priority Area: Alcohol

Priority Type: SAP

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

Goal of the priority area:

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

Objective:

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

Strategies to attain the goal:

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

Environmental Strategies

- Enhance Access/Reduce Barriers – Enhance access to effective prevention strategies and information through the use of a social media campaign and the development of human capital and networks of support.
- Enhance Barriers/Reduce Access - Increase education among merchants, bars, and restaurants who sell alcoholic beverages. Also, provide education to parents and guardians.
- Change Consequences/Enhance Access/Reduce Barriers – Work with municipal and county government to assure that underage drinking laws are enforced at the local level.
- Change Physical Design – Through the compliance check report and GIS mapping, provide municipalities and state Alcoholic Beverage Commission with details regarding how outlet density and location impact tobacco availability to youth.
- Modify/Change Policies – Enhance or create policies related to underage drinking among 12-20 years olds on a countywide level.

Individual Strategies

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

Edit Strategies to attain the objective here:

(if needed)

☐

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Binge Alcohol Use in the Past Month by persons aged 12-20.
Baseline Measurement:	According to 2018-2019 NSDUH data, 12.63 percent of the target population reported binge drinking during the month prior to participating in the survey.
First-year target/outcome measurement:	A reduction of .50% below the baseline measure.
Second-year target/outcome measurement:	An additional reduction of .10% below the baseline measure.
New Second-year target/outcome measurement(if needed):	An additional reduction of .05% below the baseline measure.
Data Source:	Alcohol Use and Binge Alcohol Use in the Past Month among Individuals Aged 12 to 20, by Age Group and State: Percentages, Annual Averages Based on 2018-2019 NSDUH data for New Jersey
New Data Source(if needed):	☐
Description of Data:	Data from the NSDUH provide national and state-level estimates on the use of tobacco products, alcohol, illicit drugs (including non-medical use of prescription drugs) and mental health in the United States.

New Description of Data:(if needed)

Data issues/caveats that affect outcome measures:

None

New Data issues/caveats that affect outcome measures:

Cannot determine if Second Year Target was achieved. 2021 NSDUH data do not include rates of binge drinking among 12-20 year olds. Data are available for persons 12-17 (4.65%) and 18-25 (31.80%).

Report of Progress Toward Goal Attainment

First Year Target:

☒

Achieved

☐

Not Achieved (if not achieved, explain why)

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

How first year target was achieved (optional):

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

Second Year Target:

☐

Achieved

☐

Not Achieved (if not achieved, explain why)

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

How second year target was achieved (optional):

Priority #:

7

Priority Area:

Marijuana

Priority Type:

SAP

Population(s):

Other (Persons aged 12-17)

Goal of the priority area:

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

Objective:

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

Strategies to attain the goal:

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

Environmental Strategies

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

Individual Strategies

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

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

Annual Performance Indicators to measure goal success

Indicator #: 1

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

Baseline Measurement: According to 2018-2019 NSDUH data, 11.48 percent of the target population reported marijuana use during the year prior to participating in the survey.

First-year target/outcome measurement: A reduction of .05% below the baseline measure.

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

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

Data Source:

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

New Data Source(if needed):

☐

Description of Data:

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

New Description of Data(if needed)

☐

Data issues/caveats that affect outcome measures:

None

New Data issues/caveats that affect outcome measures:

☐

Report of Progress Toward Goal Attainment

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

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

How first year target was achieved (optional):

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

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

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

☐

How second year target was achieved (optional):

According to 2021 NSDUH data, 8.13 percent of the target population reported marijuana use during the year prior to participating in the survey.

Second Year Target was achieved through intensive education for youth in this age range provided by DMHAS' regional prevention coalitions and agencies, Municipal Alliances and DFC coalitions.

Priority #: 8

Priority Area: Prescription Drugs

Priority Type: SAP

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

Goal of the priority area:

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

Objective:

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

Strategies to attain the goal:

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

Edit Strategies to attain the objective here:

(if needed)

☐

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Opioid Dispensations in New Jersey.

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

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

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

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

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):

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Description of Data:

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

New Description of Data(if needed)

☐

Data issues/caveats that affect outcome measures:

None

New Data issues/caveats that affect outcome measures:

☐

Report of Progress Toward Goal Attainment

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

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

How first year target was achieved (optional):

According to data from NJ CARES – A Realtime Dashboard of Opioid-Related Data and Information (maintained by the Office of the New Jersey Attorney General), in 2021, 3,537,890 prescriptions for opioids were provided in New Jersey.

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

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

☐

How second year target was achieved (optional):

According to data from NJ CARES – A Realtime Dashboard of Opioid-Related Data and Information (maintained by the Office of the New Jersey Attorney General), in 2022, 3,353,110 prescriptions for opioids were provided in New Jersey.

Priority #: 9
Priority Area: Heroin
Priority Type: SAP
Population(s): Other (Persons aged 12-17)

Goal of the priority area:

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

Objective:

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

Strategies to attain the goal:

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

Environmental Strategies

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

Individual Strategies

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

Edit Strategies to attain the objective here:

(if needed)

☐**Annual Performance Indicators to measure goal success**

Indicator #: 1
Indicator: Perceptions of Great Risk from Trying Heroin Once or Twice among persons aged 12-17.
Baseline Measurement: According to 2018-2019 NSDUH data, 66.82 percent of the target population reported Perceptions of Great Risk from Trying Heroin Once or Twice.
First-year target/outcome measurement: An increase of .25% above the baseline measure
Second-year target/outcome measurement: An additional increase of .10% above the first year measure
New Second-year target/outcome measurement(if needed): An increase of .02% above the first year measure.

Data Source:

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

New Data Source(if needed):

☐**Description of Data:**

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

New Description of Data:(if needed)☐**Data issues/caveats that affect outcome measures:**

None

New Data issues/caveats that affect outcome measures:☐

Report of Progress Toward Goal Attainment

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

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

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

How first year target was achieved (optional):

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

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

According to 2021 NSDUH data, 60.96 percent of the target population reported Perceptions of Great Risk from Trying Heroin Once or Twice.

Since 2020, many additional healthcare providers registered to use the PDMP. As such, the number of individuals reporting on the PDMP increased.

How second year target was achieved (optional):☐

Priority #: 10

Priority Area: Housing Services in Community Support Services

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

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

Objective:

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

Strategies to attain the goal:

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

The SMHA will utilize a number of strategies to help attain the objective.

1. The Office of Planning, Research, Evaluation, Prevention and Olmstead works collaboratively with provider agencies, state hospital key personnel, DMHAS staff and other Divisions across the state to implement an overall paradigm of community integration.

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

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

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

☐

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Consumers who remain in Community Support Services (CSS) during the fiscal year as a proportion of total consumers served in Community Support Services.

Baseline Measurement: The total number of clients served in CSS in SFY 2020 was 5535 with 651 individuals terminated. The percentage for SFY 2020 was 88.24%. The total number of clients served in CSS in SFY 2021 was 4,952 with 796 terminated. The percentage for SFY 2021 was 83.9%.

First-year target/outcome measurement: The percentage of consumers who remain in Community Support Services during SFY 2022 will be no less than 88% of total consumers served in Community Support Services.

Second-year target/outcome measurement: The percentage of consumers who remain in Community Support Services during SFY 2023 will be no less than 88% of total consumers served in Community Support Services.

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

Data Source:

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

New Data Source(if needed):

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Description of Data:

The QCMR Database collects quarterly, cumulative, program-specific data from each of the service providers contracted by DMHAS. The current QCMR for Community Support Services contains 50 data elements. The key data fields relevant for this performance indicator are "Ending Active Caseload (Last Day of Quarter)" and Number of terminations in the Quarter. In SFY 2020, 37 agencies contracted by the SMHA to provide QCMR data for Community Support Services.

New Description of Data:(if needed)

☐

Data issues/caveats that affect outcome measures:

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

negotiations. Data will be maintained through the QCMR database.

New Data issues/caveats that affect outcome measures:

☐

Report of Progress Toward Goal Attainment

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

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

☐

How first year target was achieved (optional):

☐

Priority #: 11

Priority Area: Olmstead Access to Service/Occupancy Rate

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

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

Objective:

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

Strategies to attain the goal:

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

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

☐

Annual Performance Indicators to measure goal success

Indicator #: 1

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

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

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

Second-year target/outcome measurement: In SFY 2023, the occupancy rate (i.e., occupied CSS housing units and those units with an assignment) is expected to be 97%.

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

Data Source:

The 2020 baseline value was generated from newer and slightly improved Provider Weekly Reports (PWR). The 2020 values were

calculated by dividing the sum of the reported number of requested assignments, by the sum of the reported capacities at each program. The SMHA collected this data from 33 CSS providers at the end of SFY20.

New Data Source(if needed):

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Description of Data:

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

New Description of Data:(if needed)

☐

Data issues/caveats that affect outcome measures:

The reporting of occupancy strictly among CSS provider agencies necessitated the use of the Provider Weekly Reports (PWRs). The rollout of the standardized PWRs came late in SFY19, so there is a small number of providers who have yet to submit their data in the proscribed fashion. This performance indicator is expressed as a proportion, and therefore it is unlikely that the SFY19 occupancy rate of 95.9% would be materially different if/when all of the data was reported.

New Data issues/caveats that affect outcome measures:

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Report of Progress Toward Goal Attainment

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

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

☐

How first year target was achieved (optional):

☐

Priority #: 12

Priority Area: Early Serious Mental Illness (ESMI)

Priority Type: MHS

Population(s):

Goal of the priority area:

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

Objective:

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

Strategies to attain the goal:

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

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

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

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

Edit Strategies to attain the objective here:

(if needed)

☐

Annual Performance Indicators to measure goal success

Indicator #: 1

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

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

First-year target/outcome measurement: In SFY 2022, it is anticipated that at least 88% of the client who are taking or in need of antipsychotic medication adhere to the medication regimen.

Second-year target/outcome measurement: In SFY 2023, it is anticipated that at least 88% of the client who are taking or in need of antipsychotic medication adhere to the medication regimen.

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

Data Source:

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

New Data Source(if needed):

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Description of Data:

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

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

New Description of Data:(if needed)

☐

Data issues/caveats that affect outcome measures:

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

New Data issues/caveats that affect outcome measures:

☐

Report of Progress Toward Goal Attainment

First Year Target:

☐

Achieved

☐

Not Achieved (if not achieved, explain why)

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

☐

How first year target was achieved (optional):

☐

Priority #: 13

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

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

System wide assessment for delivering services to diverse populations

Objective:

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

Strategies to attain the goal:

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

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

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

Edit Strategies to attain the objective here:

(if needed)

☐

Annual Performance Indicators to measure goal success

Indicator #: 1

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

Baseline Measurement: The baseline variable is the number of provider agencies that complete their self-assessments and have a written Cultural Competency Plan containing at least three of the areas needed to enhance cultural competency. The establishment of a baseline is still in process and is expected to be completed in SFY 2022. The MSAC will complete the "Center for Cultural Competency Excellence" designation for agencies.

First-year target/outcome measurement: In SFY 2022, seventy-five percent (75%) percent of all providers will have written Cultural Competence Plans which include at least three areas identified in their self-assessment. Agencies will apply for "Center for Cultural Competency Excellence" designation.

Second-year target/outcome measurement: In SFY 2023, one hundred percent (100%) of all providers will have written Cultural Competence Plans which include at least three areas identified in their self-assessment. Agency "Center for Cultural Competency Excellence" designations will be reviewed and awarded.

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

Data Source:

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

New Data Source(*if needed*):

☐

Description of Data:

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

New Description of Data(*if needed*)

☐

Data issues/caveats that affect outcome measures:

n/a

New Data issues/caveats that affect outcome measures:

☐

Report of Progress Toward Goal Attainment

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

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

☐

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

☐

Priority #: 14

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

Priority Type: MHS

Population(s): SED

Goal of the priority area:

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

Objective:

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

Strategies to attain the goal:

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

Edit Strategies to attain the objective here:

(if needed)

☐**Annual Performance Indicators to measure goal success****Indicator #:**

1

Indicator:

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

Baseline Measurement:

0

First-year target/outcome measurement:

85% (approximately 408) of direct service staff in all MRSS programs will receive training.

Second-year target/outcome measurement:

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

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

Internal Data

New Data Source(if needed):☐**Description of Data:**

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

New Description of Data:(if needed)☐**Data issues/caveats that affect outcome measures:**

None.

New Data issues/caveats that affect outcome measures:☐**Report of Progress Toward Goal Attainment**

First Year Target:

☐

Achieved

☐Not Achieved *(if not achieved, explain why)***Reason why target was not achieved, and changes proposed to meet target:**☐**How first year target was achieved (optional):**☐

Indicator #: 2

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

Baseline Measurement: 0

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

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

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

Data Source:

Internal Data

New Data Source(if needed):

☐

Description of Data:

We will count clinicians who complete the training.

New Description of Data:(if needed)

☐

Data issues/caveats that affect outcome measures:

None.

New Data issues/caveats that affect outcome measures:

☐

Report of Progress Toward Goal Attainment

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

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

☐

How first year target was achieved (optional):

☐

Priority #: 15

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

Priority Type: MHS

Population(s): SED

Goal of the priority area:

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

Objective:

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

Strategies to attain the goal:

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

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

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

☐

Annual Performance Indicators to measure goal success

Indicator #: 1

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

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

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

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

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

Data Source:

To be determined by a quality improvement process.

New Data Source(if needed):

☐

Description of Data:

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

New Description of Data:(if needed)

☐

Data issues/caveats that affect outcome measures:

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

New Data issues/caveats that affect outcome measures:

☐

Report of Progress Toward Goal Attainment

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

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

☐

How first year target was achieved (optional):

☐

Indicator #: 2

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

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

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

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

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

To be determined by a quality improvement process.

New Data Source(if needed):☐**Description of Data:**

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

New Description of Data:(if needed)☐**Data issues/caveats that affect outcome measures:**

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

New Data issues/caveats that affect outcome measures:☐**Report of Progress Toward Goal Attainment**

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

Reason why target was not achieved, and changes proposed to meet target:☐**How first year target was achieved (optional):**☐

Priority #: 16

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

Priority Type: MHS

Population(s): SED

Goal of the priority area:

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

Objective:

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

Strategies to attain the goal:

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

**Edit Strategies to attain the objective here:
(if needed)**☐**Annual Performance Indicators to measure goal success**

Indicator #: 1

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

Baseline Measurement: 0 clinicians trained

First-year target/outcome measurement: 10 clinicians trained

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

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

Data Source:

Internal Data

New Data Source(if needed):

☐

Description of Data:

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

New Description of Data:(if needed)

☐

Data issues/caveats that affect outcome measures:

None.

New Data issues/caveats that affect outcome measures:

☐

Report of Progress Toward Goal Attainment

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

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

☐

How first year target was achieved (optional):

☐

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Footnotes:

For #6 Priority Area: Alcohol, cannot determine if Second Year Target was achieved. 2021 NSDUH data do not include rates of binge drinking among 12-20 year olds. Data are available for persons 12-17 (4.65%) and 18-25 (31.80%).

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

Priory Areas #10 to #16 are not applicable to this Report.

FY 21 SABG ARP COVID Testing and Mitigation Supplemental Funding:
FY 23 Annual Report
Period 10/1/2022 - 9/30/2023

#	FY 23 Date of Expenditure	FY 23 Item/Activity Description	FY 23 Amount of Expenditure
1	10/27/2022	JSAS HEALTHCARE INC. -Testing	730.00
2	11/23/2022	NEW HOPE FOUNDATION -Testing	4,816.50
3	12/21/2022	NEWBRIDGE SERVICES INC. -Testing	2,496.00
4	12/21/2022	DISCOVERY INSTITUTE -Testing	20,000.00
5	12/21/2022	IRON RECOVERY AND WELLNESS CEN -Testing	2,027.00
6	1/27/2023	IRON RECOVERY AND WELLNESS CEN -Testing	235.00
7	2/3/2023	IRON RECOVERY AND WELLNESS CEN -Testing	160.00
8	2/3/2023	PARTNERS IN PREVENTION -Testing	2,344.50
9	2/9/2023	TURNING POINT -Testing	8,474.25
10	2/9/2023	JSAS HEALTHCARE INC. -Testing	828.00
11	3/8/2023	NEW HOPE FOUNDATION -Testing	9,633.00
12	4/26/2023	JSAS HEALTHCARE INC. -Testing	828.00
13	4/26/2023	IRON RECOVERY AND WELLNESS CEN -Testing	1,893.00
14	5/17/2023	THE CENTER FOR GREAT EXPECTATI -Testing	397.60
15	8/18/2023	STRAIGHT AND NARROW INC. -Testing	4,170.00
16			
17			
18			
19			
20			
21			
22			
23			
24			

25			
26			
27			
28			
29			
30			
		Total	59,032.85

III: Expenditure Reports

Table 2 - State Agency Expenditure Report

This table provides a report of SUPTRS BG and state expenditures by the SSA during the SFY immediately preceding the FFY for which the state is applying for funds for authorized activities to prevent and treat SUDs. For detailed instructions, refer to those in the WebBGAS. Please note that this expenditure period is different from that on SUPTRS BG Table 4.

Expenditure Period Start Date: 7/1/2022 Expenditure Period End Date: 6/30/2023

Activity (See instructions for entering expenses in Row 1)	A. SUPTRS BG	B. MHBG	C. Medicaid (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. COVID-19 ¹	I. ARP ²
1. Substance Use Prevention (Other than Primary Prevention), Treatment, and Recovery ³	\$38,343,028.00		\$248,734,219.00	\$37,849,015.00	\$110,912,492.00	\$0.00	\$0.00	\$3,726,423.00	\$646,080.00
a. Pregnant Women and Women with Dependent Children	\$6,394,367.00		\$0.00	\$0.00	\$1,698,996.00	\$0.00	\$0.00	\$558,177.00	\$0.00
b. Recovery Support Services	\$0.00		\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
c. All Other	\$31,948,661.00		\$248,734,219.00	\$37,849,015.00	\$109,213,496.00	\$0.00	\$0.00	\$3,168,246.00	\$646,080.00
2. Substance Use Disorder Primary Prevention	\$12,115,952.00		\$0.00	\$33,008,059.00	\$1,537,103.00	\$0.00	\$0.00	\$2,813,249.00	\$394,730.00
3. Tuberculosis Services	\$0.00		\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
4. Early Intervention Services Regarding the Human Immunodeficiency Virus (EIS/HIV) ⁴	\$0.00		\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
5. State Hospital									
6. Other 24 Hour Care									
7. Ambulatory/Community Non-24 Hour Care									
8. Mental Health Primary Prevention									
9. Evidenced Based Practices for First Episode Psychosis (10% of the state's total MHBG award)									
10. Administration (Excluding Program and Provider Level)	\$3,145,679.00		\$0.00	\$1,109,755.00	\$589,158.00	\$0.00	\$0.00	\$383,881.00	\$0.00
11. Total	\$53,604,659.00	\$0.00	\$248,734,219.00	\$71,966,829.00	\$113,038,753.00	\$0.00	\$0.00	\$6,923,553.00	\$1,040,810.00

¹The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the "standard" SUPTRS BG and MHBG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SUPTRS BG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds. However, grantees are requested to annually report SUPTRS BG COVID-19 Supplemental Funding expenditures in accordance with requirements included in their current Notice of Award Terms and Conditions (NoA). Per the instructions, the standard SUPTRS BG expenditures are for the state planned expenditure period of July 1, 2023 – June 30, 2025 for most states.

²The expenditure period for ARP supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. Per the instructions, the planning period for standard MHBG/SUPTRS BG expenditures is July 1, 2023 – June 30, 2025.

³Prevention other than primary prevention

⁴Only designated states as defined in 42 U.S.C. § 300x-24(b)(2) and 45 CFR § 96.128(b) for the applicable federal fiscal year should enter information in this row. This may include a state or states that were previously considered "designated states" during any of the three prior FFYs for which a state was applying for a grant. See EIS/HIV policy change in SUPTRS BG Annual Report instructions.

Please indicate the expenditures are actual or estimated.

☒ Actual ☐ Estimated

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Footnotes:

The State Substance Abuse Authority spent zero dollars on TB services in the state for SFY23 (whether SABG or state funds).

III: Expenditure Reports

Table 3a – Syringe Services Program (SSP)

Expenditure Start Date: 07/01/2022 Expenditure End Date: 06/30/2023

				SSP Expenditures			
SSP Agency Name	SSP Main Address	SUD Treatment Provider (Yes or No)	# Of locations (Include any mobile locations)	SUPTRS BG Funds	COVID-19 ¹ Funds	ARP ² Funds	Actions
No Data Available							

¹ The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the "standard" SUPTRS BG and MHBG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SUPTRS BG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds. However, grantees are requested to annually report SUPTRS BG COVID-19 Supplemental Funding expenditures in accordance with requirements included in their current Notice of Award Terms and Conditions.

² The expenditure period for The ARP supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. Per the instructions, the planning period for standard MHBG/SUPTRS BG expenditures is July 1, 2023 – June 30, 2025.

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Footnotes:

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

III: Expenditure Reports

Table 3b - Syringe Services Program

Expenditure Start Date: 07/01/2022 Expenditure End Date: 06/30/2023

SUPTRS							
Syringe Services Program Name	# of Unique Individuals Served		HIV Testing (Please enter total number of individuals served)	Treatment for Substance Use Conditions (Please enter total number of individuals served)	Treatment for Physical Health (Please enter total number of individuals served)	STD Testing (Please enter total number of individuals served)	Hep C (Please enter total number of individuals served)
	0	ONSITE Testing	0	0	0	0	0
		REFERRAL to testing	0	0	0	0	0
COVID-19 ¹							
Syringe Services Program Name	# of Unique Individuals Served		HIV Testing (Please enter total number of individuals served)	Treatment for Substance Use Conditions (Please enter total number of individuals served)	Treatment for Physical Health (Please enter total number of individuals served)	STD Testing (Please enter total number of individuals served)	Hep C (Please enter total number of individuals served)
	0	ONSITE Testing	0	0	0	0	0
		REFERRAL to testing	0	0	0	0	0
ARP ²							
Syringe Services Program Name	# of Unique Individuals Served		HIV Testing (Please enter total number of individuals served)	Treatment for Substance Use Conditions (Please enter total number of individuals served)	Treatment for Physical Health (Please enter total number of individuals served)	STD Testing (Please enter total number of individuals served)	Hep C (Please enter total number of individuals served)
	0	ONSITE Testing	0	0	0	0	0
		REFERRAL to testing	0	0	0	0	0

¹ The 24-month expenditure period for the COVID-19 Relief supplemental funding is March 15, 2021 – March 14, 2023, which is different from the expenditure period for the “standard” SUPTRS BG and MHBG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SUPTRS BG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds. However, grantees are requested to annually report SUPTRS BG COVID-19 Supplemental Funding expenditures in accordance with requirements included in their current Notice of Award Terms and Conditions.

² The expenditure period for ARP supplemental funding is September 1, 2021 – September 30, 2025, which is different from the expenditure period for the “standard” MHBG/SUPTRS BG. Per the instructions, the planning period for standard MHBG/SUPTRS BG expenditures is July 1, 2023 – June 30, 2025.

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Footnotes:

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

III: Expenditure Reports

Table 3c – Harm Reduction Activities

Expenditure Period Start Date: 07/01/2022 Expenditure Period End Date: 06/30/2023

Harm Reduction Activities								Expenditures		
Provider/Program Name	Main Address	SSP (Yes/No)	Number of Naloxone Kits Purchased	Number of Naloxone Kits Distributed	Number of Overdose Reversals	Number of Fentanyl Test Strips Purchased	Number of Fentanyl Test Strips Distributed	SUPTRS BG Funds	COVID-19 ¹ Funds	ARP ² Funds
No Data Available										

¹The 24-month expenditure period for the COVID-19 Relief supplemental funding is March 15, 2021 - March 14, 2023, which is different from the expenditure period for the "standard" SUPTRS BG and MHBG. However, grantees are requested to annually report SUPTRS BG COVID-19 Supplemental Funding expenditures in accordance with requirements included in their current Notice of Award Terms and Conditions.

²The expenditure period for ARP supplemental funding is September 1, 2021 - September 30, 2025, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. Per the instructions, the planning period for standard MHBG/SUPTRS BG expenditures is July 1, 2023 - June 30, 2025.
0930-0168 Approved: 06/15/2023 Expires: 06/30/2025

Footnotes:

III: Expenditure Reports

Table 4 - State Agency SUPTRS BG Expenditure Compliance Report

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

Expenditure Period Start Date: 10/1/2020 Expenditure Period End Date: 9/30/2022

Expenditure Category	FY 2021 SA Block Grant Award
1. Substance Use Prevention ¹ , Treatment, and Recovery	\$35,994,610.00
2. Substance Use Primary Prevention	\$10,460,601.00
3. Early Intervention Services Regarding the Human Immunodeficiency Virus (EIS/HIV) ²	\$0.00
4. Tuberculosis Services	\$0.00
5. Administration (excluding program/provider level)	\$1,419,466.00
Total	\$47,874,677.00

¹Prevention other than Primary Prevention

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

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Footnotes:

III: Expenditure Reports

SUPTRS BG Table 5a - Primary Prevention Expenditures

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

Expenditure Period Start Date: Expenditure Period End Date:

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

Community-Based Process	Selective					
Community-Based Process	Indicated					
Community-Based Process	Universal					
Community-Based Process	Unspecified					
Community-Based Process	Total	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Environmental	Selective					
Environmental	Indicated					
Environmental	Universal					
Environmental	Unspecified					
Environmental	Total	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Section 1926 (Synar)-Tobacco	Selective					
Section 1926 (Synar)-Tobacco	Indicated					
Section 1926 (Synar)-Tobacco	Universal					
Section 1926 (Synar)-Tobacco	Total	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Other	Universal Direct	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Other	Universal Indirect	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Other	Selective	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Other	Indicated	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Other	Total	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	Grand Total					

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

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

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Footnotes:

III: Expenditure Reports

Table 5b - SUPTRS BG Primary Prevention Targeted Priorities (Required)

The purpose of the first table is for the state or jurisdiction to identify the substance and/or categories of substances it identified through its needs assessment and then addressed with primary prevention set-aside dollars from the FY 2021 SUPTRS BG NoA. The purpose of the second table is to identify each special population the state or jurisdiction selected as a priority for primary prevention set-aside expenditures.

Expenditure Period Start Date: 10/1/2020 Expenditure Period End Date: 9/30/2022

SUPTRS BG Award	
Prioritized Substances	
Alcohol	☒
Tobacco	☒
Marijuana	☒
Prescription Drugs	☒
Cocaine	☒
Heroin	☒
Inhalants	☒
Methamphetamine	☒
Synthetic Drugs (i.e. Bath salts, Spice, K2)	☒
Fentanyl	☒
Prioritized Populations	
Students in College	☒
Military Families	☒
LGBTQ+	☒
American Indians/Alaska Natives	☒
African American	☒
Hispanic	☒
Homeless	☒
Native Hawaiian/Other Pacific Islanders	☒
Asian	☒

Rural	☒
Other Underserved Racial and Ethnic Minorities	☒

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Footnotes:

III: Expenditure Reports

Table 6 - Non Direct Services/System Development

Expenditure Period Start Date: 10/1/2020 Expenditure Period End Date: 9/30/2022

Activity	A. SUPTRS BG Treatment	B. SUPTRS BG Prevention	C. SUPTRS BG Integrated ¹
1. Information Systems	\$1,025,373.00	\$0.00	\$0.00
2. Infrastructure Support	\$0.00	\$0.00	\$0.00
3. Partnerships, community outreach, and needs assessment	\$298,848.00	\$26,919.00	\$0.00
4. Planning Council Activities (MHBG required, SUPTRS BG optional)	\$0.00	\$0.00	\$0.00
5. Quality Assurance and Improvement	\$0.00	\$0.00	\$0.00
6. Research and Evaluation	\$1,826,351.00	\$1,478,557.00	\$0.00
7. Training and Education	\$354,018.00	\$0.00	\$0.00
8. Total	\$3,504,590.00	\$1,505,476.00	\$0.00

¹Integrated refers to funds both treatment and prevention portions of the SUPTRS BG for overarching activities.

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Footnotes:

III: Expenditure Reports

Table 7 - Statewide Entity Inventory

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

Expenditure Period Start Date: 10/01/2020 Expenditure Period End Date: 9/30/2022

Source of Funds Substance Use Block Grant																	
	Entity Number	I-BHS ID (formerly I-SATS)		Area Served (Statewide or SubState Planning Area)	Provider / Program Name	Street Address	City	State	Zip	A. All SUPTRS BG Funds	B. Prevention (other than primary prevention) and Treatment Services	C. Pregnant Women and Women with Dependent Children	D. Primary Prevention	E. Early Intervention Services for HIV	F. Syringe Services Program	G ¹ . Opioid Treatment Programs (OTPs)	H. Office- based opioid treatment (OBOTs)
*	300103	NJ300103		01	JOHN BROOKS RECOVERY CENTER	1315 Pacific Avenue	Atlantic City	NJ	08401	\$38,073.00	\$38,073.00	\$38,862.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
*	100156	NJ100156		13	JSAS HEALTHCARE INC.	685 Neptune Boulevard Suite 101	Neptune	NJ	07753	\$130,021.00	\$130,021.00	\$132,476.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
*	100404	NJ100404		07	LENNARD CLINIC INC.	164 Blanchard Street	Newark	NJ	07105	\$180,962.00	\$180,962.00	\$181,356.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
*	302026	NJ302026		12	New Brunswick Counseling Center	320 Suydam Street	New Brunswick	NJ	08901	\$55,297.00	\$55,297.00	\$56,134.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
*	100495	NJ100495		16	Paterson Counseling Center Inc	319-321 Main Street	Paterson	NJ	07505	\$99,163.00	\$99,163.00	\$99,313.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
*	999074	NJ102679		16	STRAIGHT & NARROW INC	508 Straight Street, P.O. Box 2738	Paterson	NJ	07501	\$1,554,986.00	\$1,554,986.00	\$1,555,279.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	2000840	NJ103071		99	Acenda, Inc- 2000840	340 WEST HANOVER AVENUE	MORRISTOWN	NJ	07960	\$244.00	\$244.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	2000841	NJ103071		99	Acenda, Inc- 2000841	6 GAUNTT PLACE, BLDG #2	FLEMINGTON	NJ	08822	\$244.00	\$244.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	2000842	NJ103071		99	Acenda, Inc- 2000842	128 Crest Haven Road	Cape May Court House	NJ	08210	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	2000843	NJ103071		99	Acenda, Inc- 2000843	9 HARDING HIGHWAY	PITTSBORO	NJ	08319	\$1,949.00	\$1,949.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	1000088	NJ103071		99	Acenda, Inc. - 1000155	42 Delsea Dr. South	Glassboro	NJ	08028	\$200,235.00	\$200,235.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	2000813	NJ103071		99	Acenda, Inc. - 2000813	128 CREST HAVEN ROAD	CAPE MAY COURT HOUSE	NJ	08210	\$1,968.00	\$1,968.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	2000693	NJ102946		99	Adult Family Health Services - 2000693	53 Orchard Street	Clifton	NJ	07013	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	1000019	NJ902437		99	Alfre, Inc. d.b.a. Mrs. Wilson's - 1000019	56 Mount Kemble Ave	Morristown	NJ	07960	\$278,743.00	\$278,743.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	2000074	NJ902437		99	Alfre, Inc. d.b.a. Mrs. Wilson's - 2000074	56 Mount Kemble Ave	Morristown	NJ	07960	\$49.00	\$49.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	1000090	NJ106872		99	Anderson House, A Turning Point Program - 1000090	532 ROUTE 523	WHITEHOUSE STATION	NJ	08889	\$299,923.00	\$299,923.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	100776	NJ101850		01	Atlantic Prevention Resources Inc - Individual and Group Counseling	1416 North Main Street	Pleasantville	NJ	08232	\$244,400.00	\$0.00	\$0.00	\$244,400.00	\$0.00	\$0.00	\$0.00	\$0.00
	100883	NJ101680		01	ATLANTICARE BEHAVIORAL HEALTH	6010 Black Horse Pike Suite B-10	Egg Harbor Township	NJ	08234	\$283,399.00	\$283,399.00	\$35,056.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	2000615	NJ101970		99	Behavioral Crossroads Recovery - 2000615	205 West Parkway Drive Suite 2	Egg Harbor Township	NJ	08234	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	2000071	NJ101656		99	C-LINE COMMUNITY OUTREACH - 2000071	110 MARTIN LUTHER KING DRIVE	JERSEY CITY	NJ	07305	\$197.00	\$197.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	2000511	NJ100774		99	C-Line Counseling Center - 2000511	P.O. Box 15802	Jersey City	NJ	07305	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	306175	NJ101797		04	CAMDEN COUNTY COUNCIL ON	1 Alpha Avenue Suite 22	Voorhees	NJ	08043	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	750133	NJ750133		05	Cape May Council on - Alcoholism and Drug Abuse Inc	3819 New Jersey Avenue	Wildwood	NJ	08260	\$436,240.00	\$0.00	\$0.00	\$436,240.00	\$0.00	\$0.00	\$0.00	\$0.00
	102403	NJ102403		05	Cape Regional Medical Center	2 Stone Harbor Blvd.	CAPE MAY COURT HOUSE	NJ	08210	\$58,668.00	\$58,668.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	1024030	NJ102403		05	Cape Regional Medical Center	2 Stone Harbor Blvd	Cape May Court House	NJ	08210	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00

	900247	NJ102278	✗	11	CATHOLIC CHARITIES	383 WEST STATE STREET	TRENTON	NJ	08618	\$111,700.00	\$0.00	\$0.00	\$111,700.00	\$0.00	\$0.00	\$0.00	\$0.00
	900247	NJ102278	✗	Mercer County	CATHOLIC CHARITIES	383 WEST STATE STREET	TRENTON	NJ	08618	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	2000313	NJ102684	✗	99	Catholic Charities Alcoholism/Addictions Program - 2000313	10 Southard Street	Trenton	NJ	08609	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	2000312	NJ102684	✗	99	Catholic Charities, Diocese of Trenton, Project Free/New Choices - 2000312	10 SOUTHARD STREET	TRENTON	NJ	08609	\$54,249.00	\$54,249.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	NJ000121	NJ000121	✓	99	Center for Family Services	108 SOMERDALE ROAD	VOORHEES	NJ	08043	\$5,071.00	\$5,071.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	NJ100603	NJ100603	✓	99	Center for Family Services	601 South Blackhorse Pike	WILLIAMSTOWN	NJ	08094	\$3,449.00	\$3,449.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	NJ101537	NJ101537	✓	99	Center for Family Services	594 Benson Street	Camden	NJ	08103	\$2,222.00	\$2,222.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	NJ102073	3400186	✗	04	Center for Family Services	584 Benson Street	Camden	NJ	08103	\$1,325,493.00	\$1,325,493.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	100853	NJ100853	✓	19	Center for Prevention and Counseling	61 Spring Street	Newton	NJ	07860 -2072	\$708,644.00	\$379,944.00	\$0.00	\$328,700.00	\$0.00	\$0.00	\$0.00	\$0.00
	100853	NJ100853	✓	Sussex County	Center for Prevention and Counseling	61 Spring Street	Newton	NJ	07860 -2072	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	101804	NJ101804	✗	Warren County	COMMUNITY PREVENTION RESOURCES	20 West Washington Avenue	WASHINGTON	NJ	07882	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	NJ101804	NJ101804	✗	21	Community Prevention Resources	20 West Washington Avenue	Washington	NJ	07882	\$142,700.00	\$0.00	\$0.00	\$142,700.00	\$0.00	\$0.00	\$0.00	\$0.00
	NJ300715	NJ300715	✓	99	Corner House Behavioral Health	1 Monument Drive	Princeton	NJ	08540	\$20,360.00	\$20,360.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	NJ100392	NJ100392	✓	99	CPC Behavioral Healthcare	270 Highway 35	Red Bank	NJ	07701	\$16,560.00	\$16,560.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	2000679	NJ102895	✗	99	CPC Howell Counseling Center - 2000679	4535, 4537 & 4539 US HIGHWAY 9	HOWELL	NJ	07731	\$6,476.00	\$6,476.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	NJ102779	NJ102779	✓	99	CPC Integrated Health	1088 Highway 34	Aberdeen	NJ	07747	\$4,287.00	\$4,287.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	NJ102886	NJ102886	✓	99	CPC Integrated Health	22 Court Street	Freehold	NJ	07728	\$599.00	\$599.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	NJ103191	NJ103191	✓	99	CPC Integrated Health	72 Morris Avenue	Neptune City	NJ	07753	\$360.00	\$360.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	NJ107532	NJ107532	✗	99	CURA Inc	729 E LANDIS AVE	VINELAND	NJ	08360	\$33,644.00	\$33,644.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	NJ107870	NJ107870	✓	99	CURA Inc	61 Lincoln Park	Newark	NJ	07102	\$23,683.00	\$23,683.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	NJ100868	NJ100868	✓	99	CURA Inc	595 County Avenue	Secaucus	NJ	07094	\$125,118.00	\$125,118.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	NJ100756	NJ100756	✓	07	CURA Inc	P.O. Box 180	Newark	NJ	07101 -0180	\$296,164.00	\$296,164.00	\$185,046.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	1000050	NJ306159	✗	99	Damon House, Inc. - 1000050	105 JOYCE KILMER AVE	NEW BRUNSWICK	NJ	08901	\$50.00	\$50.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	2000084	NJ100936	✓	99	Delaware Valley Medical	7980 South Crescent Boulevard Route 130	Pennsauken	NJ	08109	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	NJ100477	NJ100477	✓	99	Discovery Institute for	P.O. Box 177	Marlboro	NJ	07746	\$18,104.00	\$18,104.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	NJ101721	NJ101721	✓	99	Discovery Institute for	80 Conover Road	Marlboro	NJ	07746	\$178,136.00	\$178,136.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	1000063	NJ301028	✗	99	Dismas House for Drug Rehabilitation	396 STRAIGHT ST	PATERSON	NJ	07501	\$26,625.00	\$26,625.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	NJ300806	NJ300806	✓	99	East Orange Substance Abuse Trt Prog	110 South Grove Street	East Orange	NJ	07018 -4102	\$45,356.00	\$45,356.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	NJ300806	NJ300806	✓	07	East Orange Substance Abuse Trt Prog	110 South Grove Street	East Orange	NJ	07018 -4102	\$21,590.00	\$21,590.00	\$21,590.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	2000336	NJ100521	✗	99	Epiphany House - 2000336	1110 GRAND AVE	ASBURY PARK	NJ	07712	\$134,950.00	\$134,950.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	1000105	NJ103193	✗	99	Epiphany House, Inc.- Long Branch - 1000105	373 BRIGHTON AVE	LONG BRANCH	NJ	07740	\$198,240.00	\$198,240.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	101329	NJ101329	✓	16	Evas Village	393 Main Street	Paterson	NJ	07501	\$2,143,153.00	\$2,143,153.00	\$306,696.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	300855	NJ300855	✓	07	Family Connections Inc	395 South Center Street	Orange	NJ	07050	\$430,000.00	\$0.00	\$0.00	\$430,000.00	\$0.00	\$0.00	\$0.00	\$0.00
	2000318	NJ300855	✗	99	Family Connections, Inc. - 2000318	395 South Center Street	Orange	NJ	07050	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00

	902635	NJ902635	✖	Warren County	Family Guidance Center of Warren Cnty	492 Route 57 West	Washington	NJ	07882	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	902635	NJ902635	✖	21	Family Guidance Center of Warren Cnty	492 Route 57 West	Washington	NJ	07882	\$31,336.00	\$31,336.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	2000005	NJ107359	✖	99	Family Guidance Center of Warren County - 2000005	370 MEMORIAL PKWY	PHILLIPSBURG	NJ	08865	\$481.00	\$481.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	2000411	NJ902635	✖	99	Family Guidance Center of Warren County - 2000411	492 RT 57 W	WASHINGTON	NJ	07882	\$1,274.00	\$1,274.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	101162	NJ101162	✖	Hunterdon County	FREEDOM HOUSE	2004 State Route 31 Suite 9	Clinton	NJ	08809-2040	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	101162	NJ101162	✖	10	FREEDOM HOUSE	2004 State Route 31 Unit 1	Clinton	NJ	08809	\$48,879.00	\$48,879.00	\$48,879.00	\$0.00	\$0.00	\$0.00	\$0.00
	1000023	NJ106864	✖	99	Freedom House - 1000023	200 SANITORIUM ROAD	GLEN GARDNER	NJ	08826	\$845,671.00	\$845,671.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	2000518	NJ100516	✖	99	Freedom House - 2000518	2004 ROUTE 31, NORTH	CLINTON	NJ	08809	\$206,186.00	\$206,186.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	2000650	NJ103267	✖	99	Freedom House Outpatient Services - 2000650	427-429 SOUTH MAIN STREET	PHILLIPSBURG	NJ	08865	\$12,164.00	\$12,164.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	2000153	NJ101478	✖	99	Genesis Counseling Center - 2000153	1000 ATLANTIC AVE	CAMDEN	NJ	08105	\$15,720.00	\$15,720.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	2000146	NJ101899	✖	99	Genesis Counseling Center, Inc. - 2000146	566 Haddon Avenue	Collingswood	NJ	08108	\$3,994.00	\$3,994.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	2000171	NJ101573	✖	99	Genesis Counseling Center, Marlton - 2000171	2003 C LINCOLN DR , WEST	MARLTON	NJ	08053	\$6,691.00	\$6,691.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	101477	NJ101477	✖	Hunterdon County	Good News Home for Women	33 Bartles Corner Road	Flemington	NJ	08822	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	101477	NJ101477	✖	10	Good News Home for Women	33 Bartles Corner Road	Flemington	NJ	08822	\$582,542.00	\$582,542.00	\$582,542.00	\$0.00	\$0.00	\$0.00	\$0.00
	2000133	NJ104612	✖	99	Guided Life Structures - 2000133	286 Main Street	Somerville	NJ	08876	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	2000490	NJ102027	✖	99	Habit Opco - 2000490	111 State Route 35 Suite 7	Cliffwood	NJ	07721-1515	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	1000003	NJ101677	✖	01	Hansen House	411 Aloe Street	Egg Harbor City	NJ	08215	\$686,531.00	\$686,531.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	1000007	NJ105270	✖	99	Hendricks House, Inc. - 1000007	542 N West Blvd	Vineland	NJ	08360	\$642,388.00	\$642,388.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	2000218	NJ306357	✖	99	Hispanic Family Center of Southern New Jersey - 2000218	P.O. Box 1590	Camden	NJ	08105-0590	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	306357	NJ306357	✖	04	Hispanic Family Center of Southern NJ - New Jersey Substance Abuse Services	2700 Westfield Avenue	Camden	NJ	08105	\$272,000.00	\$0.00	\$0.00	\$272,000.00	\$0.00	\$0.00	\$0.00
	2000184	NJ306241	✖	99	Hunterdon Drug Awareness Program, Inc. - 2000184	8 Main St	Flemington	NJ	08822	\$7,212.00	\$7,212.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	104232	NJ750216	✖	Hunterdon County	HUNTERDON PREVENTION RESOURCES	4 Walter Foran Boulevard Suite 410	Flemington	NJ	08822-1128	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	104232	NJ750216	✖	10	HUNTERDON PREVENTION RESOURCES	4 Walter Foran Boulevard Suite 410	Flemington	NJ	08822	\$319,500.00	\$0.00	\$0.00	\$319,500.00	\$0.00	\$0.00	\$0.00
	2000631	NJ103517	✖	99	Integrity House - 2000631	310 MAIN STREET	TOMS RIVER	NJ	08753	\$32,112.00	\$32,112.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	100420	NJ100420	✖	07	Integrity House Inc - Mens Facility	105 Lincoln Park	Newark	NJ	07102	\$650,999.00	\$650,999.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	1000022	NJ107706	✖	99	Integrity, Inc. - 1000022	99 LINCOLN PARK	NEWARK	NJ	07102	\$91,432.00	\$91,432.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	1000036	NJ103390	✖	99	Integrity, Inc. - 1000036	595 COUNTY AVENUE, BUILDING #6	SECAUCUS	NJ	07094	\$226,144.00	\$226,144.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	1000070	NJ107722	✖	99	Integrity, Inc. - 1000070	43 LINCOLN PARK	NEWARK	NJ	07102	\$56,183.00	\$56,183.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	1000072	NJ000163	✖	99	Integrity, Inc. - 1000072	101 LINCOLN PARK	NEWARK	NJ	07102	\$246,290.00	\$246,290.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	1000081	NJ100420	✖	99	Integrity, Inc. - 1000081	105 LINCOLN PARK	NEWARK	NJ	07102	\$85,800.00	\$85,800.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	1000123	NJ103556	✖	99	Integrity, Inc. - 1000123	595 COUNTY AVENUE, BUILDING 7	SECAUCUS	NJ	07094	\$37,606.00	\$37,606.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	1000146	NJ103556	✖	99	Integrity, Inc. - 1000146	97 LINCOLN PARK	NEWARK	NJ	07102	\$274,279.00	\$274,279.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00

	2000154	NJ103556	✖	99	Integrity, Inc. - 2000154	595 COUNTY AVE	SECAUCUS	NJ	07094	\$27,443.00	\$27,443.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	2000333	NJ107821	✖	99	Integrity, Inc. - 2000333	26-28 LONGWORTH ST	NEWARK	NJ	07102	\$47,584.00	\$47,584.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	2000530	NJ103518	✖	99	Integrity, Inc. - 2000530	360-398 Martin Luther King Boulevard	Jersey City	NJ	07305	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	2000613	NJ103519	✖	99	Integrity, Inc. - 2000613	30-32 Central Avenue	Jersey City	NJ	07306	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	2000635	NJ103556	✖	99	Integrity, Inc. - 2000635	415 SPEEDWELL AVENUE	MORRIS PLAINS	NJ	07950	\$21,581.00	\$21,581.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	1000119	NJ103556	✖	99	Integrity, Inc., Halfway House - 1000119	595 COUNTY AVE	SECAUCUS	NJ	07094	\$496,980.00	\$496,980.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	2000435	NJ100594	✖	99	Inter County Council on Drug and Alcohol Abuse - 2000435	480 KEARNY AVE	KEARNY	NJ	07032	\$95,737.00	\$95,737.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	306209	NJ306209	✖	09	Inter County Council on Drug/Alc Abuse - Administration/Drug Free Counseling	480 Kearny Avenue	Kearny	NJ	07032	\$21,589.00	\$21,589.00	\$21,589.00	\$0.00	\$0.00	\$0.00	\$0.00
	100461	NJ100461	✖	11	IRON RECOVERY AND WELLNESS CEN	132 Perry Street	Trenton	NJ	08618	\$87,687.00	\$87,687.00	\$74,052.00	\$0.00	\$0.00	\$0.00	\$0.00
	100461	NJ100461	✖	Mercer County	IRON RECOVERY AND WELLNESS CEN	132 Perry Street	Trenton	NJ	08618	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	2000519	NJ102035	✖	99	Jewish Family and Children's Service of Greater Monmouth County - 2000519	705 SUMMERFIELD AVE	ASBURY PARK	NJ	07712	\$6,642.00	\$6,642.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	1000044	NJ101989	✖	99	John Brooks Recovery Center - 1000044	15 South Tennessee Avenue	Atlantic City	NJ	08401	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	1000048	NJ000081	✖	99	John Brooks Recovery Center - 1000048	1455 PINWOOD BOULEVARD	MAYS LANDING	NJ	08330	\$5,365.00	\$5,365.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	2000275	NJ101038	✖	99	John Brooks Recovery Center - 2000275	660 Black Horse Pike	Pleasantville	NJ	08232	\$318,360.00	\$318,360.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	2000637	NJ102037	✖	99	John Brooks Recovery Center - OTP Bacharach Blvd. - 2000637	1931 BACHARACH BLVD.	ATLANTIC CITY	NJ	08401	\$109,981.00	\$109,981.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	100156	NJ100156	✖	Monmouth County	JSAS HEALTHCARE INC.	685 Neptune Boulevard Suite 101	Neptune	NJ	07753	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	2000316	NJ100156	✖	99	JSAS Healthcare, Inc. - 2000316	685 NEPTUNE BLVD	NEPTUNE	NJ	07754	\$730,080.00	\$730,080.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	1000140	NJ103431	✖	99	MARYVILLE, INC - 1000140	610 PEMBERTONTON BROWNS MILL ROAD	PEMBERTON	NJ	08068	\$40,603.00	\$40,603.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	2000680	NJ103109	✖	99	MARYVILLE, INC - 2000680	1903 Grant Avenue	Williamstown	NJ	08094	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	1000028	NJ106237	✖	99	Maryville, Inc. - 1000028	1903 Grant Avenue	Williamstown	NJ	08094	\$83,484.00	\$83,484.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	2000132	NJ100817	✖	99	Maryville, Inc. - 2000132	129 JOHNSON ROAD	TURNERSVILLE	NJ	08012	\$66,077.00	\$66,077.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	2000300	NJ107813	✖	99	Maryville, Inc. - 2000300	1173 EAST LANDIS AVENUE	VINELAND	NJ	08360	\$9,327.00	\$9,327.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	902924	NJ902924	✖	Mercer County	Mercer Council on Alcoholism and - Drug Addiction	408 Bellevue Avenue	Trenton	NJ	08618-4502	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	902924	NJ902924	✖	11	Mercer Council on Alcoholism and - Drug Addiction	408 Bellevue Avenue	Trenton	NJ	08618	\$571,763.00	\$215,663.00	\$0.00	\$356,100.00	\$0.00	\$0.00	\$0.00
	2000404	NJ101983	✖	99	Middletown Medical, LLC - 2000404	600 State Route 35	Red Bank	NJ	07701	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	2000423	NJ100651	✖	99	Morris County Aftercare Center - 2000423	273 East Main Street	Denville	NJ	07834	\$388,898.00	\$388,898.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	101818	NJ101818	✖	Morris County	Morris County Prevention is Key	25 West Main Street	Rockaway	NJ	07866	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	101818	NJ101818	✖	14	Morris County Prevention is Key	25 West Main Street	Rockaway	NJ	07866	\$580,666.00	\$172,666.00	\$0.00	\$408,000.00	\$0.00	\$0.00	\$0.00
	750299	NJ101301	✖	11	National Council on Alcoholism and - Drug Dependence	60 South Fullerton Avenue	ROBBINSVILLE	NJ	08691	\$299,180.00	\$0.00	\$0.00	\$299,180.00	\$0.00	\$0.00	\$0.00
	750299	NJ101301	✖	Mercer County	National Council on Alcoholism and - Drug Dependence	60 South Fullerton Avenue	ROBBINSVILLE	NJ	08691	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
					National Council on											

	103309	NJ103309	✗	09	Alcoholism and - Drug Dependence/Hudson County	309-311 Newark Avenue	EAST BRUNSWICK	NJ	08816	\$980,380.00	\$0.00	\$0.00	\$980,380.00	\$0.00	\$0.00	\$0.00	\$0.00
	302026	NJ302026	✓	Middlesex County	New Brunswick Counseling Center	320 Suydam Street	New Brunswick	NJ	08901	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	2000164	NJ101581	✗	99	New Brunswick Counseling Center - 2000164	320 Suydam Street	New Brunswick	NJ	08901	\$437,153.00	\$437,153.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	2000292	NJ100685	✗	99	New Brunswick Counseling Center d/b/a Burlington Comprehensive Counseling Center - 2000292	75 WASHINGTON ST	MOUNT HOLLY	NJ	08060	\$181,686.00	\$181,686.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	1000053	NJ103194	✗	99	New Hope Foundation, Inc. - 1000053	80 Conover Road	Marlboro	NJ	07746	\$82,411.00	\$82,411.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	1000058	NJ108183	✗	99	New Hope Foundation, Inc., Epiphany House, Inc. - 1000058	300 FOURTH AVENUE	ASBURY PARK	NJ	07712	\$98,026.00	\$98,026.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	2000110	NJ107003	✗	99	New Hope Foundation, Inc., Phillips House Outpatient Services - 2000110	190 CHELSEA AVE	LONG BRANCH	NJ	07740	\$143,803.00	\$143,803.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	2000319	NJ902445	✗	99	New Hope Foundation, Inc., The Open Door - 2000319	2-4 NEW AND KIRKPATRICK STS	NEW BRUNSWICK	NJ	08901	\$47,233.00	\$47,233.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	1000020	NJ107003	✗	99	New Hope Integrated Behavioral Health - 1000020	190 CHELSEA AVE	LONG BRANCH	NJ	07740	\$283,165.00	\$283,165.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	2000307	NJ106260	✗	99	New Hope Outpatient Services - 2000307	2 MONMOUTH AVE	FREEHOLD	NJ	07728	\$24,583.00	\$24,583.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	2000345	NJ100461	✗	99	New Horizon Treatment Services, Inc. - 2000345	132 PERRY STREET	TRENTON	NJ	08618	\$38,227.00	\$38,227.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	2000078	NJ103381	✗	99	New Horizon Treatment Services, Inc., Gryphon House - 2000078	144 PERRY STREET	TRENTON	NJ	08618	\$760.00	\$760.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	759802	NJ100858	✗	Ocean County	NEW JERSEY PREVENTION NETWORK	150 AIRPORT ROAD	LAKEWOOD	NJ	08701	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	759802	NJ100858	✗	15	NEW JERSEY PREVENTION NETWORK	150 AIRPORT ROAD	LAKEWOOD	NJ	08701	\$2,667,500.00	\$2,142,500.00	\$0.00	\$525,000.00	\$0.00	\$0.00	\$0.00	\$0.00
	2000281	NJ101635	✗	99	New Life Program - 2000281	331 White Horse Pike	Atco	NJ	08004	\$6,989.00	\$6,989.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	306092	NJ306092	✓	07	Newark Renaissance House Inc	P.O. Box 7057	Newark	NJ	07107-0057	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	101821	NJ101821	✗	07	North Jersey Community Research Initiative	393 Central Ave	Newark	NJ	07103	\$225,000.00	\$0.00	\$0.00	\$225,000.00	\$0.00	\$0.00	\$0.00	\$0.00
	2000320	NJ100487	✗	99	Northeast Life Skills Associates, Inc. - 2000320	121 Howe Ave	Passaic	NJ	07055	\$143,352.00	\$143,352.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	2000597	NJ101236	✗	99	Oaks Integrated Care - 2000597	770 Woodlane Rd.	Mount Holly	NJ	08060	\$21,989.00	\$21,989.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	2000657	NJ103416	✗	03	Oaks Integrated Care - 2000657	770 Woodlane Rd.	Mount Holly	NJ	08060	\$2,471.00	\$2,471.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	2000851	NJ102428	✗	04	Oaks Integrated Care, Inc. - 2000851	770 Woodlane Rd.	Mount Holly	NJ	08060	\$2,650.00	\$2,650.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	2000451	NJ101900	✗	99	Ocean Monmouth Care, LLC - 2000451	150 Brick Boulevard	Brick	NJ	08723	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	1000145	NJ102948	✗	99	Onward Behavioral Health - 1000145	600 South White Horse Pike	Hammononton	NJ	08037	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	100503	NJ100503	✗	Union County	Organization for Recovery Inc	P.O. Box 827	Plainfield	NJ	07060-1416	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	100503	NJ100503	✗	20	Organization for Recovery Inc	519 North Avenue	Plainfield	NJ	07060	\$25,908.00	\$25,908.00	\$25,908.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	2000304	NJ100503	✗	99	Organization for Recovery, Inc. - 2000304	519 North Ave	Plainfield	NJ	07060	\$465,540.00	\$465,540.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	100495	NJ100495	✓	Passaic County	Paterson Counseling Center Inc	319-321 Main Street	Paterson	NJ	07505	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	2000108	NJ100495	✗	99	Paterson Counseling Center, Inc. - 2000108	319-321 Main St	Paterson	NJ	07505	\$162,555.00	\$162,555.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	2000330	NJ102454	✗	99	Preferred Behavioral Health of N.J., Inc. - 2000330	848 W BAY AVE	BARNEGAT	NJ	08005	\$794.00	\$794.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00

	2000557	NJ102015	✖	99	Preferred Behavioral Health of New Jersey @ Toms River - 2000557	1191 LAKEWOOD ROAD	TOMS RIVER	NJ	08755	\$24,396.00	\$24,396.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
	2000152	NJ101295	✖	99	Preferred Behavioral Health of New Jersey, Inc. - 2000152	700 AIRPORT RD	LAKEWOOD	NJ	08701	\$50,586.00	\$50,586.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
	101295	NJ101295	✔	Ocean County	Preferred Behavioral Health of NJ	700 Airport Road P.O. Box 2036	Lakewood	NJ	08701 -1010	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
	101295	NJ101295	✖	15	Preferred Behavioral Health of NJ	700 Airport Road P.O. Box 2036	Lakewood	NJ	08701	\$211,710.00	\$60,210.00	\$60,210.00	\$151,500.00	\$0.00	\$0.00	\$0.00	\$0.00
	2000648	NJ102918	✖	99	Preferred Behavioral Health of NJ - 2000648	1405 HIGHWAY 35	OCEAN	NJ	07712	\$18,953.00	\$18,953.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	101308	NJ101308	✖	13	PREVENTION FIRST	1405 Highway 35	Ocean	NJ	07712	\$50,500.00	\$0.00	\$0.00	\$50,500.00	\$0.00	\$0.00	\$0.00	\$0.00
	101308	NJ101308	✖	Monmouth County	PREVENTION FIRST	1405 Highway 35	Ocean	NJ	07712	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	750802	NJ750802	✔	Union County	Prevention Links Inc	35 Walnut Avenue Suite 17	Clark	NJ	07066 -1442	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	750802	NJ750802	✖	20	Prevention Links Inc	35 Walnut Avenue Suite 17	Clark	NJ	07066	\$432,500.00	\$0.00	\$0.00	\$432,500.00	\$0.00	\$0.00	\$0.00	\$0.00
	999031	NJ101823	✖	03	PREVENTION PLUS OF BURLINGTON	1824 ROUTE 38 EAST	LUMBERTON	NJ	08048	\$448,000.00	\$0.00	\$0.00	\$448,000.00	\$0.00	\$0.00	\$0.00	\$0.00
	2000002	NJ100920	✖	99	Recovery Innovations, Inc. - 2000002	1 Corbett Way	Eatontown	NJ	07724	\$1,281.00	\$1,281.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	1000030	NJ750687	✖	99	Rescue Mission of Trenton - 1000030	96 CARROLL ST	TRENTON	NJ	08609	\$9,132.00	\$9,132.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	1000082	NJ750687	✖	99	Rescue Mission of Trenton - 1000082	96 CARROLL ST	TRENTON	NJ	08609	\$267,413.00	\$267,413.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	2000107	NJ101115	✖	99	Rescue Mission of Trenton - 2000107	72 EWING ST	TRENTON	NJ	08609	\$21,352.00	\$21,352.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	2000829	NJ103253	✖	99	Resource Center for the Chemically Dependent, Inc., d/b/a Sussex County Aftercare Center - 2000829	124 HAMPTON HOUSE ROAD	NEWTON	NJ	07860	\$178,159.00	\$178,159.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	1234	NJ104315	✖	12	RUTGERS THE STATE UNIV RBHS	100 JOYCE KILMER AVE	PISCATAWAY	NJ	08854	\$27,163.00	\$27,163.00	\$27,163.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	104315	NJ102934	✖	12	RUTGERS THE STATE UNIVERSITY OF NJ	33 Knightsbridge Road 2nd Fl East Wing	Piscataway	NJ	08854	\$143,454.00	\$0.00	\$0.00	\$143,454.00	\$0.00	\$0.00	\$0.00	\$0.00
	104315	NJ102934	✖	Middlesex County	RUTGERS THE STATE UNIVERSITY OF NJ	33 Knightsbridge Road 2nd Fl East Wing	Piscataway	NJ	08854	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	100747	NJ100747	✔	12	Rutgers/UBHC	671 Hoes Lane West	Piscataway	NJ	08855	\$1,584,081.00	\$1,584,081.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	100164	NJ301069	✖	15	Seashore Family Services of New Jersey	35 Beaverson Boulevard Suite 6-A	Brick	NJ	08723	\$131,480.00	\$131,480.00	\$131,480.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	100164	NJ301069	✖	Ocean County	Seashore Family Services of New Jersey	35 Beaverson Boulevard Suite 6-A	Brick	NJ	08723 -7859	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	2000302	NJ301309	✖	99	SODAT of NJ, Inc. - 2000302	124 NORTH BROAD STREET	WOODBURY	NJ	08096	\$22,130.00	\$22,130.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	2000331	NJ108068	✖	99	SODAT of NJ, Inc. - 2000331	75 MARKET STREET	SALEM	NJ	08079	\$1,547.00	\$1,547.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	2000198	NJ100882	✖	99	SODAT of NJ, Inc. Camden Office - 2000198	805-815 FEDERAL STREET	CAMDEN	NJ	08101	\$3,626.00	\$3,626.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	2000210	NJ108076	✖	99	SODAT of NJ, Inc. Mount Holly Office - 2000210	60 HIGH ST	MOUNT HOLLY	NJ	08060	\$512.00	\$512.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	2000040	NJ101237	✖	99	SODAT of NJ, Inc., Cumberland - 2000040	92 VINE STREET	BRIDGETON	NJ	08302	\$679.00	\$679.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	750612	NJ750612	✖	Somerset County	Somerset Council on - Alcoholism and Drug Dependency Inc	34 West Main Street Suite 307	Somerville	NJ	08876	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	750612	NJ750612	✖	18	Somerset Council on - Alcoholism and Drug Dependency Inc	34 West Main Street Suite 307	Somerville	NJ	08876	\$140,250.00	\$0.00	\$0.00	\$140,250.00	\$0.00	\$0.00	\$0.00	\$0.00
	100693	NJ100693	✔	18	Somerset Treatment Services	118 West End Avenue	Somerville	NJ	08876	\$21,590.00	\$21,590.00	\$21,590.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	100693	NJ100693	✔	Somerset County	Somerset Treatment Services	118 West End Avenue	Somerville	NJ	08876	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	2000200	NJ100693	✖	99	Somerset Treatment Services - 2000200	118 West End Avenue	Somerville	NJ	08876	\$209,468.00	\$209,468.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00

	2000355	NJ100677	✗	99	South Jersey Drug Treatment Center - 2000355	162 Sunny Slope Dr	Bridgeton	NJ	08302	\$43,342.00	\$43,342.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	109876	NJ109876	✗	04	Southern New Jersey Perinatal Cooperative	2500 McClellan Ave	Pennsauken	NJ	08109	\$182,245.00	\$182,245.00	\$182,245.00	\$0.00	\$0.00	\$0.00	\$0.00
	2000142	NJ306316	✗	99	Spectrum Health Care, Inc. - 2000142	74-80 Pacific Ave.	Jersey City	NJ	07304	\$904,651.00	\$904,651.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	306316	NJ306316	✗	09	Spectrum Healthcare Inc	74-80 Pacific Avenue	Jersey City	NJ	07304	\$120,902.00	\$120,902.00	\$120,902.00	\$0.00	\$0.00	\$0.00	\$0.00
	105072	NJ100095	✗	01	St. Barnabas Health Care Inst. for Prevention	1695 US HIGHWAY 9	TOMS RIVER	NJ	08754	\$6,687,290.00	\$5,682,410.00	\$0.00	\$1,004,880.00	\$0.00	\$0.00	\$0.00
	2000491	NJ101996	✗	99	STAND4RECOVERY PROGRAM - 2000491	316 HADDON AVE	COLLINGSWOOD	NJ	08108	\$10,104.00	\$10,104.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	999074	NJ102679	✗	Passaic County	STRAIGHT & NARROW INC	P.O. Box 2738	Paterson	NJ	07509	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	2000176	NJ306258	✗	99	Straight & Narrow, Inc. - 2000176	230 E RIDGEWOOD AVE	PARAMUS	NJ	07652	\$216,431.00	\$216,431.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	1000143	NJ102682	✗	99	Straight & Narrow, Inc. - Alpha House I - 1000143	394 STRAIGHT STREET	PATERSON	NJ	07501	\$886.00	\$886.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	2000308	NJ102679	✗	99	Straight and Narrow Outpatient Clinic - 2000308	508 Straight St	Paterson	NJ	07503	\$2,513.00	\$2,513.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	2000321	NJ100720	✗	99	Team Management 2000, Inc. - 2000321	84 MAIN STREET	HACKENSACK	NJ	07601	\$31,062.00	\$31,062.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	2000054	NJ101716	✗	99	Team Management 2000, Inc. CBO - 2000054	744 BROAD STREET	NEWARK	NJ	07102	\$7,629.00	\$7,629.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	2000689	NJ102850	✗	99	The Appropriate Place, Inc. - 2000689	660 S. 21ST STREET	IRVINGTON	NJ	07111	\$2,256.00	\$2,256.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	2000061	NJ100457	✗	99	The Bridge, Inc. - 2000061	860 Bloomfield Avenue	West Caldwell	NJ	07006	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	2000144	NJ370700	✗	99	The Bridge, Inc. - 2000144	14 Park Avenue	Caldwell	NJ	07006	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	101830	NJ101830	✗	02	The Center for Alcohol and - Drug Resource	241 Main Street	PARAMUS	NJ	07652	\$790,600.00	\$135,000.00	\$0.00	\$655,600.00	\$0.00	\$0.00	\$0.00
	107771	NJ107771	✗	18	THE CENTER FOR GREAT EXPECTATIONS	19 Dellwood Lane Suite B	Somerset	NJ	08873	\$187,000.00	\$187,000.00	\$187,000.00	\$0.00	\$0.00	\$0.00	\$0.00
	107771	NJ107771	✗	Somerset County	THE CENTER FOR GREAT EXPECTATIONS	19 Dellwood Lane Suite B	Somerset	NJ	08873	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	2000163	NJ101959	✗	99	The Center for Great Expectations - 2000163	303 GEORGE ST, 1ST FLOOR	NEW BRUNSWICK	NJ	08901	\$9,479.00	\$9,479.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	2000196	NJ306449	✗	99	The Lennard Clinic, Inc. - 2000196	461 Frelinghuysen Avenue	Newark	NJ	07114	\$424,539.00	\$424,539.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	2000417	NJ101215	✗	99	The Lennard Clinic, Inc. - 2000417	850 WOODRUFF LN	ELIZABETH	NJ	07201	\$215,380.00	\$215,380.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	102467	NJ102467	✗	03	THE NEW HOPE FOUNDATION INC	80 Conover Road	Marlboro	NJ	07746	\$761,488.00	\$761,488.00	\$761,488.00	\$0.00	\$0.00	\$0.00	\$0.00
	101309	NJ101309	✗	06	THE SOUTHWEST COUNCIL INC.	1405 North Delsea Drive	Vineland	NJ	08360	\$722,542.00	\$173,976.00	\$0.00	\$548,566.00	\$0.00	\$0.00	\$0.00
	2000249	NJ103520	✗	99	The Wise Program - 2000249	659 MARTIN LUTHER KING BLVD	NEWARK	NJ	07102	\$19,303.00	\$19,303.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	1000062	NJ101851	✗	99	Turning Point, Inc. - 1000062	680 BROADWAY	PATERSON	NJ	07514	\$283,886.00	\$283,886.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	2000642	NJ102456	✗	99	Turning Point, Inc. - 2000642	680 Broadway, Suite 104	Paterson	NJ	07514	\$2,984.00	\$2,984.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	2000702	NJ100641	✗	99	Turning Point, Inc. - 2000702	501 Prospect Street Unit 8	Lakewood	NJ	08701-5071	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	100939	NJ100939	✗	04	Urban Renewal Corp Sussex House	224 Sussex Avenue	CAMDEN	NJ	08102	\$21,590.00	\$21,590.00	\$21,590.00	\$0.00	\$0.00	\$0.00	\$0.00
	2000459	NJ000281	✗	99	Urban Treatment Associates, Inc. - 2000459	508 Atlantic Avenue	Camden	NJ	08104	\$107,357.00	\$107,357.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	2000526	NJ306142	✗	02	Vantage Health Systems, Inc.	2 Park Ave.	Dumont	NJ	07628	\$162.00	\$162.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	103147	NJ103147	✗	Middlesex County	VERITAS RECOVERY CENTER, LLC	540 Bordentown Avenue Suite 4500	South Amboy	NJ	08879	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	2000082	NJ108019	✗	99	Warren Medical Services - 2000082	590 Marshall Street	Phillipsburg	NJ	08865	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00

	2000322	NJ102452	✗	99	Wayne Counseling and Family Services - 2000322	1022 Hamburg Turnpike	Wayne	NJ	07470	\$7,308.00	\$7,308.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	371203	NJ102452	✗	Passaic County	WAYNE COUNSELING CTR INC	1022 Hamburg Turnpike	Wayne	NJ	07470	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	371203	NJ102452	✗	16	WAYNE COUNSELING CTR INC	1022 Hamburg Turnpike	Wayne	NJ	07470	\$150,975.00	\$0.00	\$0.00	\$150,975.00	\$0.00	\$0.00	\$0.00	\$0.00
	101836	NJ101836	✗	16	William Paterson University	300 Pompton Road	Wayne	NJ	07444	\$150,000.00	\$0.00	\$0.00	\$150,000.00	\$0.00	\$0.00	\$0.00	\$0.00
	101836	NJ101836	✓	Passaic County	William Paterson University	300 Pompton Road Overlook South	Wayne	NJ	07470	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	NJ306399	NJ306399	✓	99	YMCA of Greater Monmouth County	166 Main Street	Matawan	NJ	07747	\$4,919.00	\$4,919.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Total										\$41,445,145.00	\$32,490,020.00	\$4,878,446.00	\$8,955,125.00	\$0.00	\$0.00	\$0.00	\$0.00

* Indicates the imported record has an error.

Note: ¹42 CFR 8.12: Federal Opioid Treatment Standards (OTP) providers only
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Footnotes:

III: Expenditure Reports

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

This Maintenance of Effort table provides a description of non-federal state expenditures for authorized activities to prevent and treat substance use and provide recovery services flowing through the Single State Agency (SSA) during the state fiscal year immediately preceding the federal fiscal year for which the state is applying for funds. Dates given are for the FFY 2024 SUPTRS BG Report. For the FFY 2025 SUPTRS BG report, please increase each year by one. For detailed instructions, see those in BGAS.

Expenditure Period Start Date: 07/01/2022 Expenditure Period End Date: 06/30/2023

Total Single State Agency (SSA) Expenditures for Substance Abuse Prevention and Treatment		
Period (A)	Expenditures (B)	<u>B1(2021) + B2(2022)</u> 2 (C)
SFY 2021 (1)	\$152,686,955.00	
SFY 2022 (2)	\$125,360,635.00	\$139,023,795.00
SFY 2023 (3)	\$140,116,467.00	

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

SFY 2021	Yes	X	No
SFY 2022	Yes	X	No
SFY 2023	Yes	X	No

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

Yes	No	X
-----	----	---

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

If yes, SFY:

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

Yes	No
-----	----

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

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

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

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Footnotes:

The \$140,116,467 SFY 2023 Amount reported is the sum of \$113,038,753 reported in Table 2, Column E. State Funds and \$27,077,714 of the \$248,734,219 Medicaid funds included in Table 2 Column D

MAINTENANCE OF EFFORT (MOE) CALCULATIONS FOR SFY 2023 SUBSTANCE ABUSE PREVENTION AND TREATMENT (SAPT) BLOCK GRANT

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

Table 8a - Maintenance of Effort for State Expenditures for SAPT

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

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

REQUIREMENTS for STATEWIDE MOE: 45 CFR Part § 96.134

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

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

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

100-054-7700-158, Funds transferred from NJ Administrative Office of the Courts posted to this account
100-054-7700-161, Substance Abuse Treatment for DCP&P/Work First Mothers
100-054-7700-162, Community Based Substance Abuse Treatment and Prevention – State Share
100-054-7700-163, Medication Assisted Treatment Initiative
100-054-7700-165, Mutual Agreement Parolee Rehabilitation Project for Substance Abusers
100-054-7700-176, Alcohol Education Rehabilitation and Enforcement Fund (AEREF)
100-054-7700-178, Drug Enforcement and Demand Reduction Fund; Partnership for a Drug-Free NJ
100-046-4290-212, Recovery Coach Program
100-054-7700-231, Supportive Housing Subsidies
100-054-7700-232, Recovery Housing
100-054-7700-241, Opioid Reduction Options
100-054-7700-242, Jail MAT Reentry Initiative
100-054-7700-244, IME Addiction Call Center
100-054-7700-246, Media Campaign
100-054-7700-247, Substance Exposed Infants
760-054-7700-001, (4290-001) AEREF; funding for the Local Alcohol Authorities Expansion Program

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

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

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

Expenditures related to the Intoxicated Driver Resources Center Fund (100-054-7700-002), the Compulsive Gambling fund (100-054-7700-164), the Racing Commission Fees (100-054-7700-173) and Internet Gambling (100-054-7700-193) continue to be expressly excluded from New Jersey's SAPT Statewide MOE calculation as per past practice. Also excluded are Department of Treasury expenditures for rent, fringe benefits, and indirect costs.

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

Process to calculate New Jersey SAPT Statewide MOE

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

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

No sooner than one month following the close of New Jersey's State Fiscal Year, a report is created based on transactions downloaded from New Jersey's Comprehensive Financial System (NJDFS). An analysis to identify the allowability of all reported expenditures is conducted by the financial analyst responsible for the SAPT grant. Supporting backup documentation is compiled to support any needed adjustments that are identified. Adjustments may be required because any MOA reimbursement to DHS from another State agency will reduce the reimbursed DHS account by an amount equal to the reimbursement. The reimbursement distorts actual expenditures. The adjustment removes the distortion while correcting the total. Any required adjustment is reviewed by management who either approves, amends, or disapproves the adjustment which the analyst then includes or excludes from the report, whatever the case may be. The analyst notes any adjustment to the report. Reconciliation is performed to prove correctness of the report. After review and approval of the final report by management, the final figures are entered in the appropriate boxes of WEBbGAS Table 8a, Maintenance of Effort for State Expenditures.

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

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

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

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

Prior to FFY 2008, DAS reported only SAPT Block Grant expenditures expended from a single SAPT BG Award as the revenue source for meeting the PW/WDC MOE. In subsequent years, consistent with the implementing rule and emerging SAMHSA policy, DMHAS has utilized a mix of State and SAPT BG funds to

report a complete calculation of expenditures comprising the PW/WDC expenditure requirement. Consistent with the operative instructions for Table 8d, DMHAS continues to report State and BG expenditures on a State Fiscal Year (SFY) basis, i.e. SFY 2021.

Pregnant Women and Women with Dependent Children MOE Funding

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

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

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

The DMHAS combined SAPT Block Grant and State expenditures specifically includes funds classified and targeted to services for PW/WDC, based on object codes to properly classify those expenditures. For SFY 2022, it totals \$7,512,285 as documented in Row B on Table 8d in Web BGAS.

III: Expenditure Reports

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

This MOE table provides a report of state and SUBG funds expended on specialized SUD treatment services for pregnant women and women with dependent children for the state fiscal year immediately preceding the FFY for which the state is applying for funds.

Expenditure Period Start Date: 07/01/2022 Expenditure Period End Date: 06/30/2023

Base

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

Maintenance

Period	Total Women's Base (A)	Total Expenditures (B)	Expense Type
SFY 2021		\$ 8,171,204.00	
SFY 2022		\$ 7,512,285.00	
SFY 2023		\$ 8,093,363.00	☒ Actual ☐ Estimated
Enter the amount the State plans to expend in SFY 2024 for services for pregnant women and women with dependent children (amount entered must be not less than amount entered in Section III: Table 8b – Expenditures for Services to Pregnant Women and Women with Dependent Children, Base, Total Women’s Base (A) for Period of (SFY 1994)): \$ 8,000,000.00;			

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

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Footnotes:

IV: Population and Services Reports

Table 9 - Prevention Strategy Report

This table requires additional information (pursuant to Section 1929 of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-29) about the primary prevention activities conducted by the entities listed on SUPTRS BG Table 7.

Expenditure Period Start Date: 10/1/2020 Expenditure Period End Date: 9/30/2022

Column A (Risks)	Column B (Strategies)	Column C (Providers)
Pregnant women/teens	2. Education	
	1. Parenting and family management	5
	2. Ongoing classroom and/or small group sessions	5
Violent and delinquent behavior	2. Education	
	1. Parenting and family management	2
Mental health problems	1. Information Dissemination	
	1. Clearinghouse/information resources centers	21
	2. Resources directories	21
	4. Brochures	1
	8. Information lines/Hot lines	21
	5. Community-Based Process	
	3. Multi-agency coordination and collaboration/coalition	6
Economically disadvantaged	1. Information Dissemination	
	1. Clearinghouse/information resources centers	16
	5. Community-Based Process	
	2. Systematic planning	16
Already using substances	2. Education	
	1. Parenting and family management	12
	2. Ongoing classroom and/or small group sessions	14
	5. Mentors	8
	3. Alternatives	
	1. Drug free dances and parties	5
	3. Community drop-in centers	3
Children of People who Misuse Substances	2. Education	
	1. Parenting and family management	18
	2. Ongoing classroom and/or small group sessions	12
	3. Peer leader/helper programs	5

	4. Education programs for youth groups	6
	5. Mentors	24
	3. Alternatives	
	1. Drug free dances and parties	10
	2. Youth/adult leadership activities	4
	3. Community drop-in centers	3
	6. Environmental	
	1. Promoting the establishment or review of alcohol, tobacco, and drug use policies in schools	3
	2. Guidance and technical assistance on monitoring enforcement governing availability and distribution of alcohol, tobacco, and other drugs	7
	1. Information Dissemination	
People Who End High School Pre-Graduation	2. Resources directories	1
	2. Education	
	2. Ongoing classroom and/or small group sessions	1
	5. Mentors	1
People with Differing Physical Abilities	2. Education	
	5. Mentors	4
	4. Problem Identification and Referral	
	2. Student Assistance Programs	3
People Who Experience Abuse	1. Information Dissemination	
	1. Clearinghouse/information resources centers	3
	8. Information lines/Hot lines	3
	2. Education	
	2. Ongoing classroom and/or small group sessions	7
People With Housing Insecurity	2. Education	
	2. Ongoing classroom and/or small group sessions	2
	3. Alternatives	
	3. Community drop-in centers	3

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Footnotes:

IV: Population and Services Reports

Table 10a – Treatment Utilization Matrix

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

Expenditure Period Start Date: 7/1/2022 Expenditure Period End Date: 6/30/2023

Level of Care	SUPTRS BG Number of Admissions > Number of Persons Served		COVID-19 Number of Admissions > Number of Persons Served ¹		ARP Number of Admissions > Number of Persons Served ²		SUPTRS BG Service Costs			COVID-19 Costs ¹			ARP Costs ²		
	Number of Admissions (A)	Number of Persons Served (B)	Number of Admissions (C)	Number of Persons Served (D)	Number of Admissions (E)	Number of Persons Served (F)	Mean (G)	Median (H)	Standard Deviation (I)	Mean Cost (J)	Median Cost (K)	Standard Deviation (L)	Mean Cost (M)	Median Cost (N)	Standard Deviation (O)
DETOXIFICATION (24-HOUR CARE)															
1. Hospital Inpatient	11	11													
2. Free-Standing Residential	13,804	8,862													
REHABILITATION/RESIDENTIAL															
3. Hospital Inpatient	338	298			1	1									
4. Short-term (up to 30 days)	9,025	7,154			12	2									
5. Long-term (over 30 days)	5,386	4,379			235	25									
AMBULATORY (OUTPATIENT)															
6. Outpatient	24,007	20,240	58	37	1,416	393									
7. Intensive Outpatient	14,818	12,338	107	92	1,650	268									
8. Detoxification	226	190													
OUD MEDICATION ASSISTED TREATMENT															
9. MOUD Medication-Assisted Detoxification	3,191	2,586													
10. MOUD Medication-Assisted Treatment Outpatient	11,067	8,307	1	1	22	3									

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

¹The 24-month expenditure period for the COVID-19 Relief supplemental funding is March 15, 2021 – March 14, 2023, which is different from the expenditure period for the “standard” SUPTRS BG and MHBG. However, grantees are requested to annually report SUPTRS BG COVID-19 Supplemental Funding expenditures in accordance with requirements included in their current NoA Terms and Conditions.

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

³ In FY 2020 SAMHSA modified the “Level of Care” (LOC) and “Type of Treatment Service/Setting” to “Medication-Assisted Treatment” and “Medication-Assisted Treatment,” respectively. In prior SUPTRS BG Reports, the LOC was entitled “Opioid Replacement Therapy” and the Type of Treatment Service/Setting included “Opioid Replacement Therapy,” Row 9 and “ORT Outpatient,” Row 10. The changes inadvertently created a barrier for data analysis as one-to-one mapping of the data submitted in the FY 2020 Table 10 to the data submitted in prior Reports is not possible. In the current and future SUPTRS BG Reports, the LOC is “MOUD & Medication Assisted Treatment” and the Types of Treatment Service/Setting will include “MOUD Medication-Assisted Treatment Detoxification,” Row 9 and “MOUD & Medication Assisted Treatment Outpatient,” Row 10. MOUD & Medication-Assisted Treatment Withdrawal Management includes hospital detoxification, residential detoxification, or ambulatory detoxification services/settings AND Opioid Medication-Assisted Treatment. MOUD & Medication Assisted Treatment Outpatient includes outpatient services/settings AND Opioid Medication-Assisted Treatment.

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Footnotes:

Columns A and B include Covid-19 and ARP numbers.

Both expanded hours initiative (ARP funded) and special population initiative (COVID-19 Supplemental funded) started collecting data in February 2023, therefore, many admissions/unique served clients are not in table 10 reporting timeframe.

IV: Population and Services Reports

Table 10b – Number of Persons Served (Unduplicated Count) Who Received Recovery Supports

This table provides an aggregate profile of the unduplicated persons that received recovery support services funded through the SUPTRS BG by age and gender identity.

Expenditure Period Start Date:

Expenditure Period End Date:

	Age 0-5 ¹							Age 6-12						
	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non - Conforming	Other	Not Available	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non - Conforming	Other	Not Available
Peer-to-Peer Support Individual	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Peer-Led Support Group	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Peer-Led Training or Peer Certification Activity	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Recovery Housing	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Recovery Support Service Childcare Fee or Family Caregiver Fee	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Recovery Support Service Transportation	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Secondary School, High School, or Collegiate Recovery Program Service or Activity	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Recovery Social Support or Social Inclusion Activity	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other SAMHSA Approved Recovery Support Event or Activity	0	0	0	0	0	0	0	0	0	0	0	0	0	0

¹Age category 0-5 years is not applicable.

	Age 13-17							Age 18-20						
	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non - Conforming	Other	Not Available	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non - Conforming	Other	Not Available
Peer-to-Peer Support Individual	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Peer-Led Support Group	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Peer-Led Training or Peer Certification Activity	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Recovery Housing	0	0	0	0	0	0	0	4	5	0	0	0	0	0
Recovery Support Service Childcare Fee or Family Caregiver Fee	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Recovery Support Service Transportation	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Secondary School, High School, or Collegiate Recovery Program Service or Activity	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Recovery Social Support or Social Inclusion Activity	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other SAMHSA Approved Recovery Support Event or Activity	0	0	0	0	0	0	0	0	0	0	0	0	0	0

	Age 21-24							Age 25-44						
	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non - Conforming	Other	Not Available	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non - Conforming	Other	Not Available
Peer-to-Peer Support Individual	0	0	0	0	0	0	0	458	0	0	0	0	0	0
Peer-Led Support Group	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Peer-Led Training or Peer Certification Activity	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Recovery Housing	12	7	0	0	0	0	0	0	0	0	0	0	0	0
Recovery Support Service Childcare Fee or Family Caregiver Fee	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Recovery Support Service Transportation	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Secondary School, High School, or Collegiate Recovery Program Service or Activity	0	0	0	0	0	0	6,944	0	0	0	0	0	0	0
Recovery Social Support or Social Inclusion Activity	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other SAMHSA Approved Recovery Support Event or Activity	0	0	0	0	0	0	0	0	0	0	0	0	0	0

	Age 45-64							Age 65-74						
	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non - Conforming	Other	Not Available	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non - Conforming	Other	Not Available
Peer-to-Peer Support Individual	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Peer-Led Support Group	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Peer-Led Training or Peer Certification Activity	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Recovery Housing	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Recovery Support Service Childcare Fee or Family Caregiver Fee	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Recovery Support Service Transportation	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Secondary School, High School, or Collegiate Recovery Program Service or Activity	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Recovery Social Support or Social Inclusion Activity	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other SAMHSA Approved Recovery Support Event or Activity	0	0	0	0	0	0	0	0	0	0	0	0	0	0

	Age 75+							Age Not Available						
	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non - Conforming	Other	Not Available	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non - Conforming	Other	Not Available
Peer-to-Peer Support Individual	0	0	0	0	0	0	0	108	856	0	0	0	0	19,968
Peer-Led Support Group	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Peer-Led Training or Peer Certification Activity	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Recovery Housing	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Recovery Support Service Childcare Fee or Family Caregiver Fee	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Recovery Support Service Transportation	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Secondary School, High School, or Collegiate Recovery Program Service or Activity	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Recovery Social Support or Social Inclusion Activity	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other SAMHSA Approved Recovery Support Event or Activity	0	0	0	0	0	0	0	0	0	0	0	0	0	0

	Total						
	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non-Conforming	Other	Not Available
Peer-to-Peer Support Individual	566	856	0	0	0	0	19,968
Peer-Led Support Group	0	0	0	0	0	0	0
Peer-Led Training or Peer Certification Activity	0	0	0	0	0	0	0
Recovery Housing	16	12	0	0	0	0	0
Recovery Support Service Childcare Fee or Family Caregiver Fee	0	0	0	0	0	0	0
Recovery Support Service Transportation	0	0	0	0	0	0	0
Secondary School, High School, or Collegiate Recovery Program Service or Activity	0	0	0	0	0	0	6,944

Recovery Social Support or Social Inclusion Activity	0	0	0	0	0	0	0
Other SAMHSA Approved Recovery Support Event or Activity	0	0	0	0	0	0	0
Comments on Data (Age):							
Comments on Data (Gender):							
Comments on Data (Overall):	Peer-to-peer Support Individuals are represented by females only of the NJ Maternal Wraparound Program (M-WRAP) special initiative.						

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Footnotes:
SUPTRS Block Grant funds full-time outreach staff employed by Oxford House, Inc. to establish multiple homes per year. Current Oxford House occupancy is 1061 beds. Data on age and gender will be collected going forward.

New Jersey Recovery Support Efforts for Individuals with Substance Use Issues

New Jersey has been long invested in providing recovery support to individuals challenged by issues with substance use. Below is a description of initiatives that NJ has supported with either state, block grant or discretionary grant funding. The Table 10b on Recovery Supports funded by SUPTRS is only a fraction of all the work we have done in this arena.

Recovery support and recovery-oriented systems of care help people with mental and substance use disorders manage their conditions successfully. Peer support services include the coordination of personal, family, and community resources to achieve the best possible quality of life for every client entering the substance use early intervention, treatment or recovery system. The chronic nature of addiction requires recovery support to promote sustained periods of wellness to continuously reduce the need for additional acute care. Acute care substance use treatment without other recovery supports is often not sufficient in helping individuals to maintain long-term recovery. Recognizing that treatment for substance use disorders does not end upon discharge, a continuum of care recovery plan, including personal, family and community resources, is established. The plan ranges from low level contact such as quarterly telephone conversations to high level contact such as coaching, depending on support needed.

Peer Recovery Specialist Workforce

A key to successful recovery programs is the involvement of peers. Over the last several years, the DMHAS has made significant efforts to increase the SUD peer workforce. Recovery Specialists were hired for the Opioid Overdose Recovery Program (OORP), Support Team for Addiction Recovery (STAR), Telephone Recovery Support (TRS) and Intensive Recovery and Treatment Support (IRTS) programs, where they now play a vital role. They are employed in our two large Recovery Centers and all our smaller Community Peer Recovery Centers. They provide recovery support for our various SUD housing programs. While there is currently a gap in the provision of peer services in residential settings, DMHAS has issued an RFP and made awards to employ peers in residential settings. A current goal for DMHAS is to expand the SUD workforce and the wealth of experience peers can bring to the SUD continuum of care.

The DMHAS has also worked to develop two peer credentials, the Certified Peer Recovery Specialist (CPRS) and National Peer Recovery Support Specialist (NPRSS). It and has worked with Medicaid to reimburse OORP services in Emergency Rooms and SUD peer services in outpatient.

Additionally, DMHAS recognizes the importance of peer supervision and protection. The PAC Peer Recovery Support Services (PRSS) Committee developed *Guidelines for Best Practices: Peer Recovery Services* which were published June 2023 to help ensure that peer recovery support services are provided using best practices based in research and experiences in various settings. The PRSS Committee acknowledges that this report is the beginning of the development of necessary standards for peer recovery support services in New Jersey. The guidelines have been worked on for the past several years during the expansion of this evolving field. It is designed to bring practical processes, strategies and tools to peers, their supervisors, administrators, and others committed to initiating and sustaining best practices in the peer recovery support services field and the supporting work environments.

Peer-based recovery support is defined as a process of giving and receiving nonprofessional, nonclinical assistance to engage, educate, and support the client to make the necessary changes to live a self-directed life. In New Jersey, recovery support services are provided by certified peer recovery specialists with lived experience who have been successful in the recovery process in order to support others experiencing

similar situations. DMHAS views peers as an integral and equal partner in our system of care as recovery support services expand the capacity of formal and informal treatment and recovery pathways. Peers are an essential component of programs, including residential, outpatient, emergency department deployment, justice-involved programs, case management programs, and family and community recovery centers. Through shared understanding, respect, and mutual empowerment, certified peer recovery specialists strengthen an individual's motivation to change by initiating the recovery process to reduce the likelihood of a return to substance use.

Peer workers assist recoverees with accessing external and internal Recovery Capital, and family and/or social Recovery Capital. External Recovery Capital includes, but is not limited to, financial assets, health insurance, safe and recovery-conducive shelter, clothing, food, and access to transportation. Internal Recovery Capital includes, but is not limited to, values, knowledge, educational/vocational skills and credentials, self-awareness, self-esteem, self-efficacy, hopefulness/optimism, perception of one's past/present/future, sense of wholeness and healing. Family and/or social Recovery Capital includes, but is not limited to, intimate relationships, family and kinship relationships (defined here non-traditionally, i.e., family of choice), and social relationships that are supportive of recovery efforts. Recovery specialists encourage families (biological, nuclear or self-chosen) to become willing to participate in their loved one's treatment and recovery. The presence of others in recovery within the family and social network can help access sober outlets for sobriety-based fellowship/leisure and relational connections to conventional institutions (school, workplace, church, and other mainstream community organizations).

A review by the Peer Recovery Center of Excellence states that because of the knowledge gained through lived experience of addiction and recovery, and specialized training received, Peer Support Workers (PSWs) are uniquely positioned to provide four key types of social support often missing from the addiction and recovery field: emotional, informational, instrumental and affiliational. **Emotional** support is perhaps the most readily understood, as it is central to the peer role; peers offer empathy, encouragement, and care to the peers with whom they work. In providing **informational** support, PSWs share knowledge and information about the recovery process and often provide skills training related to achieving and maintaining a life in recovery. **Instrumental** support is a tangible form of support, providing concrete assistance to accomplish tasks, such as providing transportation. Through **affiliational** support, peer specialists help connect individuals to the greater recovery community, wrapping them in a supportive (Peer recovery support: evolving roles and settings: a literature review, March 2021.)

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), Peer Recovery Support Services (PRSS) workers have been successful in the recovery process by helping others that are experiencing similar situations. Through shared understanding, respect, and mutual empowerment, peer support workers help people become and stay engaged in the recovery process, thereby reducing the likelihood of relapse. PRSS services can effectively extend the reach of treatment beyond the clinical setting into the everyday environment of those seeking a successful, sustained recovery process.

Recovery support services encompass SAMHSA's guiding principles of recovery and include four major dimensions that support a life in recovery: health, home, purpose, and community. Peer workers assist individuals with developing a recovery plan that enables them to identify goals for achieving wellness. Peer workers also help the clients they work with to facilitate resilience and manage setbacks or other stressful events that may precipitate a return to substance use. New Jersey's recovery support services are designed to span all stages of recovery – from initiation/stabilization through recovery maintenance and the enhancement of quality of life in long-term recovery.

Peer Recovery Specialist Workforce

Bringing Recovery Supports to Scale – Technical Assistance Center Strategy

In recent years, New Jersey has greatly expanded, particularly for substance abuse treatment consumers, opportunities to provide peer-delivered services. Accordingly, the number of peers providing these services has also increased. Most of the positions held by peers, however, are part-time or casual in nature. There is a widely-acknowledged understanding, supported by scientific evidence, that peer-delivered services complement and enhance behavioral health care by creating the emotional, social and practical assistance necessary that enables the client/patient to manage their illness and stay healthy.

Peer-delivered services can have a transforming effect on larger systems of care and on our society by enhancing long-term recovery outcomes and elevating public and professional perceptions of hope for recovery. In addition, employment as a peer specialist brings financial benefits not only for the individual, but collectively to society as far too many people with behavioral health disorders are discouraged from working when employment can be a form of financial stability, source of identity, and a positive contributor to recovery.

In May 2017, New Jersey was one of 10 states selected to participate in the Bringing Recovery Supports to Scale – Technical Assistance Center Strategy (BRSS TACS) policy academy. With guidance from BRSS TACS DMHAS developed a plan by which it is expanding the role of peers in behavioral health service delivery, and developing career guidelines for peers who want to use their experiential knowledge to support the recovery goals of individuals experiencing mental illness or those who suffer from a substance use disorder.

Peer Recovery Support Specialists

Basic on guidance from SAMHSA and numerous research studies, the DMHAS SUD Peer Recovery Specialist provides non-clinical assistance and recovery supports services and works with individuals to assist with issues that often occur concurrently with a substance use disorder, such as homelessness, incarceration, legal issues, employment, education, transportation, need for social services, health care, child welfare involvement, child care, health insurance, documentation, etc. The Recovery Specialist provides services according to a recovery based philosophy of care and supports the individuals' continuing stability, recovery and wellness as they move through the recovery continuum and support recovery planning by linking individuals to resources and appropriate culturally-specific services in the community, identifying factors that impact wellness and recovery, providing assistance in the managing of crisis situations, and modeling strategies on how to manage addiction successfully.

Basic requirements for a DMHAS SUD Recovery Specialist are at minimum a high school diploma or equivalency; associate's degree or above preferred. Duties include providing recovery support and peer coaching to program participants. The Recovery Specialist is required to attend a three (3) day DMHAS mandated training that delineates peer role functions, competencies, responsibilities and includes an orientation to DMHAS' multiple treatment and recovery initiatives. If not already credentialed, it is expected that the Recovery Specialist will work towards attaining a Certified Peer Recovery Specialist (CPRS) or National Certified Peer Recovery Support Specialists (NCPRSS) credential by attending free training offered by NJPN. The Recovery Specialist must have two (2) years of experience in the guiding principles of recovery that assist individuals to improve their health and wellness, live a self-directed life, and reach their full potential. The Recovery Specialists are expected to work with individuals to support

and strengthen their capacity to engage in their personal recovery. The competencies and role of the Recovery Specialist shall include, but are not limited to the following:

- In collaboration with the individual, develop a recovery plan which should include culturally competent and relevant services that identifies goals with measurable objectives, assesses strengths, can be used to work towards those goals, identifies barriers that can inhibit goal attainment, and monitors the progress made attaining those goals;
- Educate the individuals on how to navigate treatment, social service and recovery support systems;
- Provide recovery support services based on the individual's preference and his/her assessed needs;
- Support the individuals as they move through the stages of change to encourage them in their recovery;
- Assist the individuals with accessing recovery support services in the community;
- Work collaboratively with the case manager to ensure the individual engages in services and transitions to the next level of care when indicated;
- Be a positive role model by sharing experiential knowledge, hope, and skills;
- Maintain relationships with the individual in order to assist him/her in the treatment engagement and retention process;
- Reinforce, guide, and reassure the individual that recovery is possible, and is built on multiple strengths, coping abilities, and the resources of each individual;
- Assist the individual with gaining skills and resources needed to initiate and maintain recovery and maintain compliance with MAT if it is part of their treatment;
- Assist in establishing and sustaining a social and physical environment supportive of recovery;
- Enhance identification and participation in the recovery community;
- Advocate for appropriate and effective community treatment and recovery;
- Empower individuals to make self-determined and self-directed choices about their recovery pathway;
- Provide support with face-to-face sessions and/or telephone support based on the individual's personal choice; and
- Help individuals maintain healthy community, family and social functioning.

Other examples of peer services include: recovery mentoring/coaching, recovery connecting, recovery consultation, peer support groups, and telephone recovery support.

Under the supervision of a licensed clinical professional, Certified Peer Recovery Specialists (CPRS) or National Certified Peer Recovery Support Specialists (NCPRSS) provide non-clinical assistance and support throughout all stages of the SUD recovery and rehabilitation process. Peer recovery support services are intended to provide individually-based direction, support, and encouragement for individuals in need of substance use disorder treatment.

Peer-based recovery support is defined as a process of giving and receiving nonprofessional, nonclinical assistance to engage, educate, and support the client to make the necessary changes to live a self-directed life. In New Jersey, recovery support services are provided by certified peer recovery specialists with lived experience who have been successful in the recovery process in order to support others experiencing similar situations. DMHAS views peers as an integral and equal partner in our system of care as recovery support services expand the capacity of formal and informal treatment and recovery pathways. Peers are an essential component of programs, including residential, therapeutic community, outpatient, emergency department deployment, justice-involved programs, family, and community recovery centers.

Through shared understanding, respect, and mutual empowerment, certified peer recovery specialists strengthen an individual's motivation to change by initiating the recovery process to reduce the likelihood of a return to substance use.

Recovery support services encompass SAMHSA's guiding principles of recovery and include four major dimensions that support a life in recovery: health, home, purpose, and community. Peer workers assist individuals with developing a recovery plan that enables them to identify goals for achieving wellness. Peer workers also help the clients they work with to facilitate resilience and manage setbacks or other stressful events that may precipitate a return to substance use. New Jersey's recovery support services are designed to span all stages of recovery – from initiation/stabilization through recovery maintenance and the enhancement of quality of life in long-term recovery.

The Division supports the role of peers through several individual and family-based initiatives. These programs assist individuals with Opioid Use Disorders or those who are at risk of an opioid overdose through supportive services, case management, education, resources, and advocacy for families and individuals.

- The Opioid Overdose Recovery Program (OORP), which operates in all 21 counties, provides support services to individuals reversed from opioid overdose treated at hospital emergency departments. Peers employed within the OORP program are instrumental in engaging recoverees by sharing stories of hope and recovery, meeting individuals where they are, and emphasizing that recovery occurs via many pathways.
- The Support Team for Addiction Recovery (STAR) initiative, which operates in all 21 counties, and is comprised of 12 teams, each consisting of a program supervisor, two case managers, and two peer recovery specialists. STAR focuses on promoting self-determination and helps recoverees connect to housing, employment, health, and social services, etc. The STAR team maintains contact with individuals to support their recovery and lead a productive life.
- The Maternal Wraparound Program (M-WRAP) combines intensive case management, wraparound services, and recovery supports for pregnant/postpartum women who have a substance use disorder during pregnancy and up to one year after birth. The M-WRAP model is intended to promote maternal health, improve birth outcomes, and reduce the risks and adverse consequences of prenatal substance exposure.
- Family Support Centers offered direct family support, education, resources, and advocacy in a safe and non-stigmatizing environment. Each regional center is staffed with Family Support Coordinators with lived experiences who are specially trained in the Community Reinforcement and Family Training (CRAFT) Model. This model teaches families self-protection and non-confrontational skills to help empower their loved one to seek treatment. It also helps each family member develop and work on their own Individualized Wellness Recovery Plan.
- Community Peer Recovery Centers (CPRCs) are places where individuals can access peer support, information about substance use disorder treatment, recovery support services, and information about other community resources in a supportive substance free environment. All CPRC services and activities are led and driven by peers who have experienced addiction and recovery, either directly or indirectly as a family member or friend. The overall goal of the CPRC is to provide a safe

place for recovering individuals to gather in support of one another and experience recovery-oriented living in a community setting.

- Intensive Recovery and Treatment Support (IRTS) program with the NJ Department of Corrections provides post-release services to a cohort of eligible offenders (n=200) with Opioid Use Disorder that receive MAT prior to release from prison, and to another cohort of non-MAT eligible offenders (n=400) both pre- and post-release into the community. IRTS links eligible offenders to recovery services necessary to support wellness and successful community re-integration. It helps offenders address issues such as: health/wellness, treatment adherence, employment, housing, and opportunities and skills to enhance the individual's ability to participate in meaningful life activities. There are five IRTS teams providing services for up to six months prior to release and up to 12 months post release.
- Telephone Recovery Support (TRS) program serves individuals discharged from substance use disorder treatment with an opioid use disorder, as well as those who are trying to maintain recovery from an opioid use disorder. Weekly phone calls are made by trained staff and volunteers who provide support, encouragement and information concerning recovery resources. TRS is a peer-to-peer check-in type service where the staff and volunteers provide local recovery supports, including information about local resources such as self-help meetings, food pantries, recovery houses and detox, if needed. TRS incorporates text messaging and other types of social media to appeal to the younger population who rely on cell phones and social media to communicate.

In addition to the role of peer workers, NJ OORP and STAR programs employ patient navigators and case managers, respectively. By utilizing multiple methods to gather information from program staff across programs and roles, the Camden Coalition has assisted DMHAS in identifying core competencies and role functions for OORP patient navigators and STAR case managers. One of the goals of this project is to demonstrate and delineate the unique similarities and differences patient navigators and case managers have in ensuring sustained recovery. A second goal of the project is to provide program specific training, coaching, skill labs, refresher courses and regional resources mapping. Correspondingly, DMHAS is planning to formulate a professional credential for OORP patient navigators and STAR case managers and collaborate with Division of Medical Assistance and Health Services (DMAHS) to obtain Medicaid reimbursement for these services.

Peer Training

DMHAS supports the advancement of peers by offering training and professional development activities that increase and enhance the peer workforce. All peers working in DMHAS initiatives attend a 3-day Ethics training. The curriculum includes self-reflection, self-disclosure, racial and culturally responsive practices, MOUD, motivational interviewing, outreach, and engagement techniques. In addition, peers attend the 5-day Connecticut Community for Addiction Recovery (CCAR) which leads to peer certification. DMHAS supports two pathways to peer certification. The International Reciprocity and Credentialing Consortium (IC&RC) NJ affiliate, the Addiction Professionals Certification Board, issues the Certified Peer Recovery Specialist (CPRS) and NAADAC/NCC AP, the Association for Addiction Professionals, issues the

National Certified Peer Recovery Support Specialist (NCPRS). To ensure DMHAS recovery programs have adequate staffing levels and that peers have equal opportunities to employment, DMHAS provides scholarships for training, certification, and testing fees. To date more than 1550 peers have been trained through the Division's Addiction Training and Workforce Development initiative; 553 or 36% of the peers trained have completed all training necessary to obtain certification which is substantial growth from the 200 last reported.

In addition to the basic core training, our training partner the New Jersey Prevention Network, has developed other training modules for peers. One currently being implemented is Basic Harm Reduction which utilizes the LeMire curriculum. NJPN is planning to develop a more advanced curriculum. NJPN is also working on a series of trainings that will lead to certificate in specialized areas, such as, working in emergency rooms, criminal justice settings, treatment agencies, etc.

Peer Recovery Support Summit

The DMHAS In conjunction with the New Jersey Prevention Network conducted its 7th Annual Peer Summit. The Summit, which was held in-person for the first time in three years as result of the pandemic, on September 27, 2023 and was entitled, The Rising Tide of Peer Support: Strategies to Save Lives. This event included 2 keynote speakers, 10 interactive workshops and recovery-oriented activity events brought together for everyone working in the peer recovery support services field. Workshops offered valuable insights, inspiration, connection and strategies for advancing recovery services with topics focusing on diversity and equity best practices. There was a total of 305 participants at the Summit.

Recovery Data Platform

To assist recovery-oriented agencies and programs with tracking recoveree progress, a DMHAS peer recovery data collection system was implemented in 2020. The Recovery Data Platform (RDP) collects real-time data that helps track and organize participants' program interactions and progress. Programs can track individuals' growth and follow trends that assist in meeting recoverees' needs. The RDP allows recoverees to see the progress they are making in real time which facilitates motivation to sustain recovery. Significant data collection includes assessment of recovery capital, a relationship scale, and an engagement scale that measures cravings. Output data includes recovery coaching and telephone recovery support logs, referrals, education, employment, and resource information.

The Recovery Data Platform (RDP) is a cloud-based software solution developed in part by Faces & Voices of Recovery and Recovery Trek. The platform aids Peer Service Providers with the tools and assessments needed to effectively implement peer recovery coaching programs. Through the use of robust reporting and scheduling tools, RDP provides an organization with outcomes data and service management tools. It is designed to capture peer services offered by organizations to individuals impacted by substance use disorders (SUDs). Recovery Data Platform (RDP) is one of the largest collections of data for participants in SUD peer services for the state of NJ. RDP is being used by several initiatives to centralize information which allows a robust real-time analysis of recovery support services.

The data used to conduct outcome analyses is gathered in RDP using scientifically validated tools. The three outcome measures predominately used by the RDP pilot program are: Assessment of Recovery

Capital, Cravings Rating Scale, and Outcome Rating Scale. These scores are based off of participant answers to questionnaires that are administered at regularly scheduled intervals. The outcome analysis focuses on establishing a baseline at the initiation of services and then re-evaluating.

Currently 13 programs are participating in the RDP Pilot. Participating organizations entered data on peer recovery support services provided to over 12,000 participants which exceeded the earmarked 10,000 and is anticipating exceeding 15,000 during 2023. RDP now has one of the largest collections of Community Peer Recovery Center data for the state of NJ.

The RDP is currently in a pilot phase and there are plans to eventually expand this to all SUD peer-based programs. It was budgeted for \$101,800 in NCE STR in 4/2019. Funds are also provided from Supplemental and ARPA for another \$50,000 each.

Peer Roster

DMHAS also has a Peer and Recovery Roster system to capture recovery program demographic data. Staff working in DMHAS recovery programs are required to enter information into the Roster via an online Qualtrics survey link. Program staff input information on their position, agency, supervisor, educational level, certification, credentialing, and training record. DMHAS staff are able to use Roster data to accurately identify the number of peers working in DMHAS programs, follow trends, and assess program and workforce needs. Information has been collected on 401 Peer Recovery Specialists. With the information collected from the peer roster, NJPN has developed dashboard reports for each funded DMHAS initiative to represent summary data points to track certification progress, training completed and current employment information. DMHAS staff are able to use Roster data to accurately identify the number of peers working in DMHAS programs, follow trends, and assess program and workforce needs.

Peer Medicaid Reimbursement

To ensure sustainability of recovery program services, DMHAS has been working closely with DMAHS to develop reimbursement for recovery and case management services. Since July 2019, DMAHS provides reimbursement for peers working in independent clinics providing outpatient substance use treatment services since. The New Jersey Medicaid 1115 Substance Use Disorder (SUD) Waiver included peer recovery support specialist (PRSS) services to be added to the State Plan. The purpose of a PRSS is to support NJ FamilyCare (NJFC) Medicaid beneficiaries throughout their continuum of care, improve transitions between levels of care, implement strategies to address opioid misuse related to an opioid use disorder, and reduce opioid related deaths. DMAHS also provides reimbursement for case management services for its supportive housing program.

DMHAS has worked with DMAHS to develop a bundled reimbursement rate for the Opioid Overdose Recovery Program (OORP). The New Jersey 1115 Substance Use Disorder (SUD) Demonstration included implementation of an Opioid Overdose Recovery Program (OORP). The Division of Mental Health and Addiction Services (DMHAS) initiated the program based on a recovery model to link individuals recovered from an opioid overdose and transported to an Emergency Department (ED) with appropriate addiction treatment and recovery support services. The Division of Medical Assistance and Health Services (DMAHS) began coverage of OORP services provided by DMHAS-contracted OORP providers effective January 2022.

Recovery Resource Directory

As an outcome of the SSA's State Opioid Response initiative, a need was identified to provide supportive training, coaching and resources for patient navigators and peer specialists employed in DMHAS recovery-based initiatives. In response to a repeated request by peers to have an informational directory which would allow users to quickly and conveniently identify resources when accessing services, the SSA funded a Recovery Resource Directory (RRD). The RRD is intended to assist peer workers to promote wellness and recovery for individuals managing a mental illness, substance use disorder, or co-occurring disorder. The web-based directory will quickly furnish peers and staff working in the Division's recovery-based initiatives with essential information and resources to facilitate and sustain individuals' recovery. Resources (e.g., organizations, support services, mutual aid meetings, housing, job placement, etc.) will be grouped by geographic location throughout New Jersey's 21 counties.

Advocacy

Citizen's Advisory Council

The Citizen's Advisory Council (CAC) is composed of consumer and citizen members representing the voices of New Jersey residents at risk for, struggling with, or otherwise affected by the chronic disease of addiction. The Council provides input and guidance to DMHAS in furthering its mission, linking the Division with consumers and advocating for the needs and interests of individuals, families, and communities. The CAC believes in:

- the rights of all citizens to access and receive quality prevention, treatment, recovery and support services without stigma;
- quality, holistic, comprehensive, affordable, client centered treatment services within a continuum of care that recognizes the need for life-long management;
- encouraging informed consumer choice, and that our collective voices are integral to DMHAS in fulfilling its mission.

Coalition for Addiction Recovery Support

The New Jersey Coalition for Addiction Recovery Support (NJ-CARS) is a statewide organization that provides an inclusive platform to celebrate the hope of recovery, promote the value of individuals with lived experience, and to incorporate and strengthen recovery support services across the continuum of care for substance use disorders throughout New Jersey.

NJ-CARS Advisory committee is a diverse group of experienced recovery support practitioners and providers from New Jersey comprised of 75% peers at minimum. CARS offers the opportunity for members to be part of a statewide voice for recovery. For organizations, it offers the opportunity to contribute to the development and expansion of recovery support services in New Jersey and an opportunity to coordinate the training and cultivation of the per workforce. The organization is currently funded through SAMHSA's Building Communities of Recovery (BCOR) grant.

Grassroots Recovery Organizations and Centers

The Recovery Movement is well established in New Jersey. In terms of social media, there are numerous NJ Recovery Support pages on Facebook, Instagram and Twitter – ranging from parent-to-parent support

groups sprung from the loss of their own children, to groups advocating for more treatment and recovery options for those suffering from a substance use disorder. At the community level, New Jersey has seen tremendous efforts in advocacy and recovery support. The New Jersey affiliate of the National Center for Advocacy and Recovery for Behavioral Health (NCAAR-BH – formerly NCADD-New Jersey) developed a “Recovery Advocates” program with graduates being divided into regional teams across the state. These Advocacy Leaders are trained on how to provide testimony to the New Jersey Assembly as well to develop regional events to educate the community about recovery and reduce stigma regarding addiction.

There are eight grassroots recovery organizations in NJ: Addictions Victorious (Gloucester County), A Change for Nick (Passaic County), CARES- Center for Addiction Recovery, Education and Success (Morris County), CARES (Warren County), City of Angels (Mercer County), CFC Loud and Clear (Monmouth County), Help Not Handcuffs (Monmouth County), Hope Sheds Light Foundation (Ocean County) and Recovery Advocates of America (Mercer County). Some of these organizations operate their own peer designed and run Recovery Centers independent of DMHAS funding: City of Angels, CARES- The Center for Addiction Recovery, Education and Success in Morris and Warren Counties, CFC Loud and Clear, Recovery Advocates of America and A Change for Nick. All of these centers train their peer recovery staff and volunteers using the Connecticut Community for Addiction Recovery (CCAR) model. These organizations are community-based and help individuals access treatment, provide support throughout their treatment experience and provide aftercare/relapse prevention supports and services after discharge. These are peer-designed, non-12 step affiliated groups, although 12 step meetings are often held on site.

Other Recovery Organizations

There are other recovery organizations that provide education, support and advocacy for those with SUD and their families and loved ones. Three grassroots coalitions provide family support: The Silent Epidemic (Gloucester County), Parent to Parent (Burlington County) and Stop the Heroin (Atlantic County). Seven organizations provide advocacy and training: National Council on Alcoholism and Drug Dependence NJ (Mercer County), Mental Health Association of NJ (Union County), Ammon Foundation (Union County), Mainstream Recovery (Monmouth County, New Jersey Prevention Network (Monmouth County), King's Crusade (Burlington County) and New Jersey Recovery Advocates (Bergen County). Five organizations provide recovery residences: Hansen Foundation (Atlantic County), Surfside Structured Sober Living (Atlantic County), Antonia Maria Foundation (Middlesex County), God Winks (Bergen County), and Milestone House (Bergen County).

Self Help

Self-Help Groups

Support for involvement of recovering persons in self-help groups such as Alcoholics Anonymous and Narcotics Anonymous is also routinely provided as part of recovery planning, beginning in treatment and continuing upon discharge. Recently, providers have included evidence-based approaches like SMART Recovery. Additionally, several providers in New Jersey have developed All-Recovery groups, which are open to anyone who is living with an addictive disorder: The meetings are attended by persons in recovery, and those seeking recovery, as well as their friends and loved ones.

Recovery Programs

The Division supports the role of peers through several individual and family-based initiatives. These programs, such as the Opioid Overdose Recovery Program, Maternal Wraparound Program, Support Teams for Addiction Recovery, Family Support Centers, Recovery Centers, Community Peer Recovery Centers, and prison-based Intensive Recovery Treatment Support, are described as follows.

Opioid Overdose Recovery Program

A Request for Proposals (RFP) was issued in June 2015 to develop an Opioid Overdose Recovery Program (OORP) to respond to individuals reversed from opioid overdoses and treated at hospital emergency departments as a result of the reversal. Programs in Atlantic, Camden, Essex, Monmouth and Ocean Counties were funded. Since then, additional OORP RFPs were issued using funds appropriated by the Governor, STR and SOR.

The Opioid Overdose Recovery Program utilizes recovery specialists and patient navigators to engage individuals reversed from an opioid overdose to provide non-clinical assistance, recovery supports and appropriate referrals for assessment and substance use disorder treatment. As of March 31, 2023, 25,072 individuals have been served by the OORP. While overdose and relapse prevention are key goals, the program is also intended to help individuals move into recovery.

The Opioid Overdose Recovery Program (OORP) provides support services to individuals reversed from opioid overdoses treated at hospital emergency departments. Peers working in OORP programs meet with individuals at bedside where they share their stories of hope and recovery. These peers continue to follow the patient for eight weeks after discharge and are instrumental in engaging individuals in the emergency department and beyond and letting them know that they are not alone and that recovery is possible by whatever pathway they choose.

Since its implementation on January 1, 2016, NJ's OORPs have cumulatively served 26,593 individuals who were reversed from an opioid overdose and were taken to a participating hospital emergency department. Eleven percent of individuals cumulatively served (3,032 of 26,593) were initially referred to withdrawal management and ten percent (2,641) of individuals cumulatively served were initially referred to substance use disorder treatment. An additional 11,421 (43%) individuals sought recovery support services. Common recovery supports included referrals to self-help, transportation supports, mental health and medical services and housing supports including sober living. OORPs operate in 56 of 75 (75%) hospital emergency departments throughout New Jersey. Fourteen OORPs are operating in all (100%) of the hospital emergency departments in their respective counties. Each of NJ's 21 counties has an OORP.

In 2018, the scope of core OORP activities was expanded by 16 of the 21 OORPs. The OORP expansion sites increased core services to include new sets of activities, including services beyond the emergency department in other areas within the hospital as well as services outside the hospital within the community for persons with an opioid or substance use disorder. OORP expansion within hospitals serves emergency department patients who suffered an opioid overdose but who were **not** administered naloxone as well as hospital in-patients with an identified primary or secondary OUD or SUD who are being treated for any condition in other hospital units. As with core OORP, OORP expansion provides eight weeks of patient follow-up. OORP expansion within the community includes funding additional peers to

perform community outreach for persons with an OUD and/or SUD at shelters and neighborhood fairs. Through expansion, partnerships with prosecutors, sheriffs and other law enforcement personnel, diversion programs, healthcare providers, treatment providers and community programs were established. Since its introduction, OORP expansion services have been provided to over 43,000 persons.

OORP is currently funded through a variety of sources: SUPTRS, State and SOR. The basic core OORP program is funded at \$255,750; across 21 programs this amounts to \$5,370,750. The expansion OORP for the 16 programs is \$3,432,891

Support Team for Addiction Recovery

Support Teams for Addiction Recovery (STAR) provide case management and recovery support services for individuals with opioid use disorder (OUD). The STAR initiative is comprised of teams, with each team consisting of a program supervisor, two case managers and two recovery specialists. The team maintains a caseload of 40 individuals. STAR case managers work with individuals to assist with issues that often occur concurrently with an OUD, such as homelessness, incarceration, legal issues, employment, education, transportation, need for social services, health care, child welfare involvement, child care, health insurance, documentation, etc. The STAR recovery specialists provide non-clinical assistance and recovery support services. The overall goal of STAR is to help individuals with an OUD achieve and maintain recovery, help reduce the risk of recurring episodes of opioid related problems, and prevent future overdose. The STR grant funded the initial STAR program in 10 counties. SOR and SOR supplemental grant funds enabled DMHAS to provide STAR services in all NJ's 21 counties from county correctional facilities.

In 2019, the ten STARs serving the counties with the greatest need (determined by number of overdoses, naloxone administrations, and rates of incarceration for opioid-related offences) received funds to develop an additional team to serve individuals with Opioid Use Disorder who are released from county or municipal jails. STAR programs used the funds to cover costs of hiring an additional case manager and recovery specialist for the new team. Services provided are similar to those offered the original STAR teams, but with modifications to provide more effective services to this special population

STAR tracks client outcomes through two surveys: the GPRA and the STAR survey. Results cited below come from the STAR survey administered at intake vs the STAR survey administered 6 months post intake. All results are based on proportion of individuals who answered to these questions and completed their surveys between January 1st 2021 to December 31st, 2022.

The STAR program reported a decline in drug usage among its clients at the 6- month follow up vs intake. For the primary substance of choice, either a stimulant or an opioid, the proportion of clients who reported that they had no relapse in the last 3 months increased 26.5% at the 6-month follow-up compared to the intake survey. For overall abstinence from all substances (including alcohol and tobacco), STAR reported an increase of 5.4% in the proportion of clients who reported no overdose in the past 3 months. Finally, the proportion of individuals who attended self-help programs in the last month increased 15.5% at the 6-month post intake vs the intake. In summation, the STAR program was associated with a significant increase in those did not use their primary substance, a smaller increase in the proportion of individuals who were abstinent from all substances, and was associated with improved participation in program to maintain abstinence.

Reduced drug usage is not the only improvement found in STAR clients. STAR also reported notable improvements in stability of client's living situation, which helps in maintaining abstinence from drugs. While housing is not a service directly funded from the SOR contract, our providers successfully formed links with Non-Governmental Organizations (NGOs) and government that provide housing. Our follow ups reported an increase of 5.5% of clients who have stable housing. To further illustrate this, in the most recent quarter (3rd quarter of federal fiscal year 2023) our providers were able to place and allow 45 STAR clients to move into stable housing. We were also very successful in increasing the proportion of individuals who reported being either employed, volunteering, and/or enrolled in educational/vocational programs by 71.9%. Our programs also worked help clients apply for health insurance such as Medicaid and our 6-month follow-up survey reported a 5% increase in the proportion of individuals who had health insurance. Finally, in the overall measure of financial stability; the proportion of individuals who agreed with the statement that they had enough money to meet their needs increased 11.4%.

Clients also reported improvements in Quality of Life and satisfaction with their health at 6 months into the STAR program. On the measurement of Quality of Life, the client's average reported quality of life had jumped 12.5% between the intake vs 6 months. On satisfaction with health, STAR saw a 11.3% increase in the average.

The 21 STARs are funded by SOR at \$380,000 each for a total of \$7,980,000. In addition, 10 STARs were each awarded \$175,000 to serve persons released from incarceration for an additional \$1,750,000.

Maternal Wraparound Program

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

Block Grant funding supports seven M-WRAP regions statewide. Target counties were selected based on a high incidence of Neonatal Abstinence Syndrome (NAS) from 2014 data provided by the Division of Medical Assistance and Health Services and the number of unduplicated pregnant women seeking substance use disorder treatment in those counties during 2015 according to data from the New Jersey Substance Abuse Monitoring System.

The overall goal with the M-WRAP is to alleviate barriers to services for women who are pregnant and dependent on opioids through comprehensive care coordination implemented within the five major timeframes when intervention in the life of the substance exposed infants (SEI) can reduce potential harm of prenatal substance exposure: pre-pregnancy, prenatal, birth, neonatal and early childhood. Care coordination also addresses screening, early intervention, assessment, treatment and recovery supports.

To ensure that the needs of the mother, infant and family receive coordination, access to and engagement in services, providers are required to develop Plans of Safe Care. 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. The M-WRAP model is intended to promote maternal health, improve birth outcomes for women, their infants and families, and reduce the risks and adverse consequences of prenatal substance exposure.

The onset of the COVID-19 pandemic resulted in many significant safety precautions at the national and state level. The stay-at-home orders, such as closures of businesses, schools, restrictions in gatherings has had an impact on the social determinants of health (food, security, employment, income, access to medical care, etc.). Pregnant and parenting women with a history of substance use disorder (SUD) 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 July, 2021, the M-WRAP statewide initiative eligibility criteria was expanded to include pregnant women with substance use disorder, not exclusive to opioid dependency.

In late Fall, 2022 ReachNJ, the central call-in line for New Jersey residents seeking help with a SUD, dedicated their public service announcement campaign to reach pregnant women. MWRAP provided training to ReachNJ to offer MWRAP as a resource and to provide warm hand-offs. MWRAP services provides the support needed to help pregnant and parenting women maintain a healthy recovery, resulting in less overdoses, and improved birth outcomes and maternal child health. In an effort to serve more pregnant women with SUD, MWRAP expanded the number of unduplicated pregnant women in SFY23 from 50 per region to 60. This expansion will provide MWRAP to approximately 420 unduplicated pregnant women.

The basic M-WRAP serving pregnant women with an OUD is funded for \$1,181,415 across seven regions serving all 21 counties of NJ. The expansion of M-WRAP to include all substances not limited to opioids was funded with an additional \$1,050,000 in SUPTRS Block Grant COVID-19 Supplemental funds and \$1,604,890 in SUPTRS Block Grant ARPA funds.

Collegiate Recovery

Six Higher Education institutions receive state or federal funds for Collegiate Recovery Programs. Rutgers University at New Brunswick and Newark, The College of New Jersey, Ocean County Community College, Rowan University and Stockton University are funded under the State Opioid Response (SOR 3.0) SAMHSA discretionary grant. Collegiate Recovery Programs provide housing and support services to students in recovery, including: screening and intervention services; self-help, mentoring, peer and academic support; crisis management and relapse prevention; community education; and alcohol-free/alternative programming and community service opportunities.

SUPTRS Block Grant COVID-19 Supplemental funds were used to enhance Collegiate Recovery Programs at three public Higher Education institutions. Rutgers University at New Brunswick and Newark and Rowan University are funded to provide services that include: recovery support, dedicated recovery housing, crisis and relapse prevention, and environmental management on campus.

Process and outcome data for the CY 2022 cycle of College Recovery Programs are reported as:

- 272 students receiving individual and/or group recovery support services
- 32 students reside in recovery housing
- 5,000 + students participated in campus-wide or large-scale substance-free activities/events

- 83% reported [past 30-day] abstinence from substance use
- 67% reported being employed
- 100% of students reported satisfactory academic standing
- 100% of students reported no criminal justice involvement
- 100% of students reported stable housing (on or off campus)
- 100% of students reported satisfaction with the services they receive through the collegiate recovery program

Family Support Centers

Three regional Family Support Centers (FSC) continue to be funded through SOR Funding to provide peer-to-peer family support services to families in each region whose loved ones suffer from an opioid use and/or stimulant use disorder. FSCs were the first formal family support service in the New Jersey's Substance Use Disorder continuum of care that offered direct family support, education, resources and advocacy in a safe and non-stigmatizing environment. Each regional center is staffed with Family Support Coordinators with lived experiences who are specially trained in the Community Reinforcement and Family Training (CRAFT) Model which teaches families self-protection along with non-confrontational skills to help empower their loved one to seek treatment. The CRAFT Model which was developed and researched by Robert J. Meyers, PhD. CRAFT is a non-confrontational intervention and skills-based program designed to impact families in multiple areas of their lives, including self-care, pleasurable activities, problem solving, and goal setting. CRAFT addresses their loved one's resistance to change, in addition to teaching families behavioral and motivational strategies for interacting with their loved one.

CRAFT training is provided by DMHAS to all FSC Coordinators. The three major goals of CRAFT that the Family Support Center Coordinators work with families on are:

- Reduce a loved one's harmful substance use
- Influence a loved one to seek substance use treatment and recovery
- Improve the functioning of family members by making positive life changes

Through brief CRAFT model supportive sessions, the FSC Coordinator assist family members with examining their interactions with the substance-using person, improving their communication strategies, and reducing emotional stress. support to parents, build hope and provide a sense of optimism, teach positive communication skills, be able to engage in role-plays with parents to rehearse positive communication skills, conduct supportive or psycho-education groups, develop wellness plans, share stories of hope and recovery, connect family members to each other, and advocate for inclusion of family members' health and safety.

The FCS Coordinator helps each family member develop and work on their own Individualized Wellness Recovery Plan. The overall goal of the FSC Coordinator is to provide compassionate support to empower family members to have a better quality of life, improve their psychological health, reduce levels of stress, feel less isolated, and gain skills needed to cope with their loved one's use. Families who receive FSC services also receive Naloxone Training and Kits to assist their loved ones at risk of opioid overdose.

In 2021, each regional FSC expanded due to the increased numbers of referrals coming from OORPs, STARs, ReachNJ, Connect4Recovery Call Center, Division of Children and Families, and Families, Drug

Court, Probation, and Treatment Providers to assist family members of loved ones with an *OOD/stimulant use disorder, and some families without*. Each FSC Region now provides family support services for at least 150 families in their region.

In addition to providing its families with Naloxone trainings, kits, and medication assisted resources and treatment, Regional FSCs also provide ongoing peer individual support, education, and coaching to families on an ongoing basis. The FSC's individual services and support to families constitute the most utilized form of service that the program offers.

As a result of the COVID-19 pandemic, several adaptations to FSCs continue to be made to accommodate the individualized needs of the families and staff members. The hybrid work model has become the new standard for each FSC. Since the objective of all peer work is to “meet people where they are,” the FSCs respected the participants’ wishes and continued with hybrid and virtual alternatives for individual and group sessions as well.

FSCs continued to run weekly virtual CRAFT-based Family Support Groups for enrolled FSC clients. Groups such as Helping Through Understanding; Understanding Substance Use; Strategies for Improving Communication; Strengthening Healthy Alternatives; Offering Information and Making Requests; Conversations Suggesting Treatment continue to be a success as evident by the fact that they are well attended and that families continue to provide positive feedback.

FSCs also offer families, various partners, and the community, educational workshops designated as “The Support Series” that also consist of CRAFT Strategies (topics include: Engagement Strategies, the Dichotomy of Control, Communication Skills, Boundary Setting, Enabling vs. Helping, Behavioral Reinforcement, Self-Care, The Stages of Change, Motivational Interviewing, Acceptance and Commitment Techniques, Unilateral Approach to Change, etc.). Monthly Self-Care events are also made available to help FSC family members; events include Floral Design Workshop, Crafting Hope, Self-Care Soiree, Pizza and Painting, Outdoor Paint Party, Spring Flower Arranging, Weekly Yoga for Recovery, Overbooked Book Club, and Tending Our Inner Self Book Club. The FSC also engages in community outreach events, meeting in-person with partners and providers, and meeting in-person with families at the agency and within the community. The FSC also continues to engage families remotely telephonically or virtually through the Telehealth platform.

In FY22, the Regional Family Support Centers provided support to 300 families who had a family member with a verified opioid and/or stimulant use disorder. FSCs also provided family support to 165 additional family members who could not verify the substance their loved one was using.

Outcome data for opioid/stimulant use families is collected through the FSC survey. The FSC enrollment survey is self-administered by family members within two weeks of their first contact with the program and a follow-up survey is completed approximately six months later. Data are from family members who received services from program inception through June 30, 2022.

Most (89.9%) family members were female and 59.9% were parents of their loved one with OUD. The highest percentage (58.9%) of loved ones of family members were aged 14-34 and the majority (73.5%) were male (n=296). Additional characteristics of family members and their loved ones are described

below. Please note that not all families who were served completed an intake survey. Therefore, the characteristics shown below do not reflect the full population of families served by the program. The majority of family members and their loved ones were White, non-Hispanic and comprising 89.5% for family members (n=286), and 79.0% for loved ones (n=286).

Updated outcome data are not available, so the most up-to-date data are included below. Family members' areas of concern regarding their loved ones are also collected. The greatest percentage of family members expressed concern regarding their loved one's mental health (94.4%), followed by interpersonal and family relationships (84.3%), and medical health (81.0%). The area of concern most frequently cited as the main concern was mental health, accounting for 55.6% (n=268).

The Significant Other Survey (SOS) assesses the impact of loved one's substance use on family members across the eight domains shown below. Items asked how often family members experienced a total of 54 difficulties as a result of a loved one's abuse of alcohol or drugs. On a scale ranging from 1 (never) to 5 (almost always), mean values were highest on the emotional (M = 3.60) and relationship (M = 3.52) domains. Impacts on the legal (M = 2.00) and physical violence (M = 2.00) domains were lowest.

In addition, the Central FSC Region used the FSC Recovery Data Platform (RDP) Pilot to collect data. This pilot dramatically improved the monthly reporting process, supported the hybrid work model, eliminated paper files and offered opportunities to track outcomes for the Central Region FSC. The owner of the platform, Faces and Voices of Recovery, agreed with the recommendation to identify one specific CRAFT strategies for each family interaction. This is a recent upgrade and a small sample so more data needs to be collected. Practicing self-care was identified as the most commonly used strategy and this was addressed by the introduction of the self-care events. This is an example of the output that will help the FSC in planning future programming:

Self-Care Strategy	Number of Interactions
Self-care	385
Problem Solving	108
Positive communication strategies	64
Getting a loved one to accept help	43
Understanding a loved one's triggers to use substances	38
Understanding readiness for change	24
Setting health boundaries	14

Telephone Recovery Support

The Telephone Recovery Support (TRS) program is intended for individuals discharged from substance use disorder treatment with an opioid use disorder, as well as those who are trying to maintain recovery from an opioid use disorder. In the Telephone Recovery Support (TRS) program, peers provide weekly telephone recovery support calls provide support, encouragement and information concerning recovery resources to people seeking and maintaining recovery from opioid addiction. TRS is a peer-to-peer check-in type service where the staff and volunteers will help provide local recovery supports, including information about local resources such as self-help meetings, food pantries, recovery houses and detox, if needed. Also included in TRS is the incorporation of text messaging and other types of social media in

order to appeal to the younger population who rely on cell phones and social media to communicate. Through May 2021, 1,026 individuals have been served by TRS.

As of end of June 2023 (the program began in July 2018) 1,370 clients have been served. 19,373 phone calls have been made by the staff of the Telephone Recovery Service over this time period. Average time for these outgoing phone calls is 6 minutes 28 seconds. During this time period 8,483 phone calls have been received by the staff at any time of day or night, 24/7. The average length of incoming calls is 9 minutes 15 seconds.

The TRS program is funded at \$416,762 with grant funds.

Intensive Recovery Treatment Support

The Intensive Recovery Treatment Support (IRTS) program is a collaboration with the NJ Department of Corrections (DOC) to provide peer services that expands pre- and post- release recovery support services to individuals within DOC with an opioid use disorder and facilitates continuity of care and treatment that includes comprehensive medical, substance use treatment and social services. Since 2017, DMHAS has worked with the Department of Corrections to provide Intensive Recovery Treatment Supports (IRTS) post-release services to a cohort of eligible offenders (n=200) with Opioid Use Disorder that receive MAT prior to release from prison, and to another cohort of non-MAT eligible offenders (n=400) both pre- and post-release into the community. Eligible Offenders being released from DOC custody who are receiving FDA approved medication assisted treatment for an OUD and who will continue to receive medication assisted treatment after their release from prison, and those Eligible Offenders, with an OUD, being released from custody who choose not to receive medication assisted treatment while incarcerated are participants in the PIRTS program. This program was developed through Memoranda of Agreement (MOA) with Rutgers University Behavioral Health Care and DOC. A key feature of this program is that the provider begins working with offenders six months prior to release. To date, 4,658 persons released from incarceration have received PIRTS services.

In October 2020, NJ Governor Phil Murphy signed legislation for the reduction of sentences and early release of certain NJ state prison inmates incarcerated for non-violent offenses. The law was effective in early November 2020. Through January 2021, almost 3,000 inmates were released. Approximately 800 of these individuals had an OUD diagnosis and 364 enrolled in the IRTS program. Two additional IRTS teams were developed to serve them.

IRTS links eligible offenders to recovery services necessary to support wellness and successful community re-integration. It helps offenders address issues such as: health/wellness, treatment adherence, employment, housing, and opportunities and skills to enhance the individual's ability to participate in meaningful life activities. There are five IRTS teams providing services for up to six months prior to release and up to 12 months post release.

In a subsample of IRTS (N = 334), the percentage who reported being housed increased from 74% in the first month after release to 84.7% in the fifth month, while the percentage who reported employment increased from 27% to 73%. The self-reported percentage using MOUD decreased modestly over this period but remained relatively high at 63.4% after five months. Self-reported alcohol and drug use increased over this time but remained below 30%. Among participants, on a monthly basis, 0.8% and 2.4%

of active participants in the community experienced overdose or return to prison, respectively. Of 1,364 participants in the program, 4.4% were known to experience an overdose at any time while in the program.

The following table provides a description of IRTS participants as of 12/31/2021.

Characteristic	%
Sex	
Female	6.7
Male	93.3
Race/Ethnicity	
Black, non-Hispanic	28.5
White, non-Hispanic	51.6
Other, non-Hispanic	1.6
Hispanic of any race	18.3
Age	
18-24	5.1
25-34	35.9
35-44	32.4
45-54	20.6
55+	6.0
MOUD Use while incarcerated and after release	
Participants who used MOUD both prior to and after release	64.1
Before only	10.3
After only	10.3
Neither period	15.4

Below is information about program outcomes (as of 12/31/2021). Of particular note are the low rate of overdoses among participants (.8%) and those who are on medication for OUD (65.4%).

Outcome	%
On medications for OUD	65.4%
In psychosocial SUD treatment	46.4%
In mental health treatment	31.4%
Housed	80.5%
Employed	45.8%
Alcohol use	14.4%
Illicit drug use	22.1%
Relapse	16.1%
Overdose	0.8%
Return to prison	2.4%

The program is funded with the SUPTRS for \$5,691,658 and \$3,342,720 in State funds.

Recovery Centers

New Jersey has two large-scale and 21 community peer recovery centers for individuals in recovery from substance use disorders. Recovery centers are places that those in recovery can find help, fellowship, and a safe haven. Peer workers provide mentoring, coaching, care coordination, social and recreation activities, life skills, vocational training, support groups, wellness classes, workshops and assistance in housing, childcare, language and employment.

The SSA opened New Jersey's first Recovery Center at Eva's Village in Paterson in September 2009, and its programs have grown exponentially in the last six years. This peer-driven and peer-operated center, which is open 365 days per year, provides the following services in the large metropolitan area and surrounding communities: referral to treatment, peer support services, housing assistance, employment assistance, and language assistance, and self-help advocacy, childcare assistance, and recreational activities, wellness classes of interest to the community and advocacy activities in support of recovery. Client choice to participate in program activities is paramount. Additionally, the Recovery Center's participants and staff continue to take leadership roles in community-oriented recovery activities such as hosting a Recovery Month walk and picnic celebration in the large catchment area of Passaic County as well as organizing transportation for many (bus loads) of their program participants to attend the largest Recovery celebration in the tri-state area in Philadelphia.

The SSA issued an RFP and subsequently awarded a contract to the Center for Family Services in Camden County in April 2012 to provide New Jersey's second Recovery Center. It opened in December 2012 at a suburban location in Camden County. Staff working seven days a week provide outreach to individuals in recovery as well as to provider treatment programs throughout the state. Like Eva's village before them, Living Proof Recovery Center has a peer advisory board and a full monthly calendar with weekly self-help meetings, anger management, resume-building and financial workshops. There are also sober social activities such as line dancing, wrap sessions and recovery movies on the weekends. Both recovery centers also provide Telephone Recovery Support (TRS) which has been is an evidence-based and data driven method of successful recovery support (White, 209). Both centers have a strong core of volunteers who are helping with day-to-day operations and recruitment. At present, staff and volunteers at both centers have used CRSP and updated CDA certification for staff and volunteers.

For SFY 2022, the two NJ State funded Regional Recovery Centers (Eva's Village and Living Proof Recovery Center of Voorhees) provided peer support services to 2,394 individuals. Funding for each center is \$350,000 for a total of \$700,000.

Community Peer Recovery Centers (CPRC)

From 2008 to 2019 there were only two state funded centers, one in the northern region of the state, Eva's Village in Paterson, and one location in the southern region of the state, Living Proof in Voorhees. Recovery support is an essential part of the continuum of care since substance use dependence (SUD) is a chronic biologically based disease of the brain and as such requires a system of care designed to treat a chronic condition rather than an acute illness. With other chronic conditions, e.g., diabetes, hypertension, heart disease, that are characterized by periods of wellness and acute episodes of care, the care system and intervention are designed to manage the illness in order to promote sustained periods of wellness and eliminate or minimize the need for acute care. Similarly, the SUD treatment system had to adapt to support the process of sustained recovery. The New Jersey Recovery Centers have been effective with many individuals seeking recovery.

During CY 2022, there were 84,437 discharges from substance abuse treatment in New Jersey. Of these, 24,555 or 29%, quit or dropped out of treatment. While ALL clients can benefit from recovery support services, those clients who did not complete treatment may find recovery support beneficial and a gateway back into treatment and/or sustained recovery. It is clear that there are significant numbers of people who could benefit from ongoing recovery programs. While these figures are drawn from those who enter the formal treatment system, there is a group of people of unknown size who have never accessed formal treatment who could also benefit from recovery services.

This is an opportunity for those for whom access to treatment is not possible or delayed due to insufficient capacity within the system. The DMHAS Recovery Centers offer training, social, educational and recreational opportunities. There are classes focused on wellness, nutrition and illness management, including classes on self-care, stress management, financial management, literacy education, job, and parenting skills. Housing assistance (e.g., finding apartments and roommates) is provided, and telephone support is available to Recovery Center participants. It is expected that this peer-delivered service will result in improved social functioning, reduced substance abuse and an improved quality of life, including more social connectedness.

DMHAS' plan was to expand the continuum of care to include an array of services that support individuals in their recovery from addiction. Recognizing the need to support individuals in their pathway to recovery, a Recovery Center is a place where individuals who have completed or left treatment, or who have never entered formal treatment, can find a nurturing and empowering environment in which they can learn new skills and develop a social network. A Recovery Center will help prevent relapse and provide support for sustained recovery within the community. Services will be provided by peers who will also serve as positive role models.

DMHAS has expanded Recovery Centers through the SOR funding. Funding was issued in 2019 through a Request for Proposals (RFP) to develop three Community Peer Recovery Centers (CPRC) where individuals can access peer support, information about substance use disorder treatment, recovery support services, and information about other community resources in a supportive substance free environment. DMHAS initially awarded three providers in the amount of \$100,000 each for start-up small-scale Recovery Centers to provide peer-to-peer recovery support services to prevent recurrent of substance use and promote sustained recovery. DMHAS issued another RFP in 2020 with SOR funding to expand the CPRCs. DMHAS awarded seven additional providers for peer-to-peer recovery support services that are responsive to community needs. All activities and services through the CPRCs are led and driven by "peers", individuals who have experienced addiction and recovery, either directly or indirectly as a family member or friend. The overall goal of the CPRC is to provide a safe place for recovering individuals to gather in support of one another and experience recovery-oriented living in a community setting. The CPRC is a place where those in recovery can have the opportunity to give back to their community thereby fostering senses of empowerment and independence. In March 2020, CPRCs have followed CDC and NJ DHS Guidelines due to the COVID Epidemic in providing Virtual Community Support Services (via phone and secure online services), and limited safe distancing in person recovery support services. All the CPRCs have now reopened their centers to in person as well as hybrid and virtual services. CPRCs found that one of the keys to building a recovery community is embracing the many pathways to recovery, as well as ensuring meeting individuals where they are at. CPRCs have been able to share information regarding Recovery, Treatment, and Harm Reduction at their centers, including distributing Naloxone Training and Kits.

DMHAS issued additional RFPs in SFY 2022-23 using SOR funds to expand to the 11 remaining New Jersey counties.

All activities and services through the CPRCs are led and driven by “peers”, individuals who have experienced addiction and recovery, either directly or indirectly as a family member or friend. CPRC programming focuses on different aspects of the four dimensions to support a healthy life (health, home, purpose, and community). The overall goal of the CPRC is to provide a safe place for recovering individuals to gather in support of one another and experience recovery-oriented living in a community setting. The CPRC is also a place where those in recovery can have the opportunity to give back to their community thereby fostering senses of empowerment and independence. With limited funding, CPRCs were able to respond to the challenges of the COVID Epidemic, by finding creative ways to keep individuals engaged with their centers via Virtual, Hybrid, as well as traditional In-Person Services. They are further challenged now by the continued and expanding need for community peer recovery support services to individuals exposed to all aspects of substance use; including keeping up with current SUD trends of use, treatment, medication assisted recovery, harm reduction; as well as the needs to assist individuals with transportation, and recovery support housing.

In FY 22, 19 SOR-funded CPRCs provided peer support services to 8,226 unduplicated individuals. The programs reported that 1,769 individuals received Recovery or Peer Coaching, 338 individuals received Recovery Housing and 398 individuals received Employment Support. The CPRC’s are funded at \$100,000 each for a total of \$1,900,000.

A small sampling of demographics of the participants who have visited a Community Peer Recovery Center through September 29, 2022 indicated there were 407 intake surveys reviewed. The largest percentage (58.7%) of participants were White, non-Hispanic, 26.5% were Black, non-Hispanic, 16.8% were Hispanic/Latino, and 13.0% identified as other. The largest age group was 25-44, representing 50.6% of participants. There were more male (62.0%) than female (38.0%) participants. Of CPRC participants that completed the survey (n=400), 26.7% (n=107) utilized MAT. Forty-five percent (n=41) were utilizing Methadone, 44.0% (n=40) buprenorphine, and 11.0% (n=10) Vivitrol.

According to a recent survey of CPRC, there is a list of additional services that CPRCs have been offering in addition to Recovery Coaching, Recovery Housing and Employment Support which include:

- Harm reduction
- Naloxone distribution
- Outreach
- Recovery support
- Treatment/care support/system navigation
- Case Management/Individual Services coordination
- Self-Help & Recovery Support Groups
- Community Resources
- Transportation
- Wellness activities
- Life Skills
- Special Interest (Parenting, Family, DV, angel, LG
- Spiritual and Faith-Based Support

- Cultural Historical & Gender Issues
- Family Support and Education
- Substance Abuse Education
- Relapse Prevention
- Child Care
- Parent Education and Child Development
- Spiritual and Faith-Based Support
- Basic Needs- Food, Clothing, Shelter

Peers in Residential Treatment

Over the last several years, the DMHAS has made significant efforts to increase the SUD peer workforce. Recovery Specialists were hired for the Opioid Overdose Recovery Program (OORP), Support Team for Addiction Recovery (STAR) and Telephone Recovery Support (TRS) programs, where they now play a vital role. The DMHAS has worked to develop two peer credentials, the Certified Peer Recovery Specialist (CPRS) and National Peer Recovery Support Specialist (NPRSS) and has worked with Medicaid to reimburse OORP services in Emergency Rooms and SUD peer services in outpatient settings. However, there is currently a gap in the provision of peer services in residential settings. These services are not eligible for reimbursement by Medicaid. The goal of this RFP is to continue to expand the SUD workforce and the wealth of experience peers can bring to treatment settings.

A Request for Proposals (RFP) was issued by DMHAS for substance use disorder (SUD) residential treatment agencies contracted by DMHAS to hire Peer Recovery Specialists to provide non-clinical assistance and recovery supports services. This RFP was funded by SUPTRS Block Grant COVID-19 Supplement and the American Rescue Plan Act of 2021 from the Substance Abuse and Mental Health Services Administration (SAMHSA). DMHAS awarded funding to support 26 peers as a result of this RFP for a total amount of \$1,425,000. The DMHAS is re-issuing the RFP to hire an additional 19 peers to work in residential services. Total annualized funding will be \$3,375,000 with the additional peers for a total of 45 peers.

Recovery High Schools

In the fall of 2014, New Jersey opened its first Recovery High School - the Raymond Lesniak ESH Recovery High School, which is located on the campus of Kean University in Union County. It is open to students throughout NJ. A Recovery High School is exclusively for young people that struggle with substance use disorders. Every member of the staff, faculty and administration in each school is required to attend numerous trainings regarding addiction and recovery. The school provides social, academic and counseling. The initial class enrolled approximately 20 students. The number of students enrolled is increasing annually. In 2018, two additional recovery high schools opened in New Jersey – one in Monmouth County, and the other in Cape May County. Planning is underway for another recovery high school in Ocean County. In 2023, the Ocean County Recovery High School Taskforce has been moving forward with their efforts by seeking to introduce peer recovery support services to adolescents trying to sustain long-term recovery. They have converted a separate section of its Ocean County Recovery Center into a youth-friendly environment that currently hosts academic support sessions, one-on-one meetings, and group sessions with a recovery specialist. By launching these services, the Ocean County Recovery High School Taskforce is taking the next step towards opening its recovery high school and will have the recovery services in place that will be directly integrated into the academic day once the school is open.

Transportation

Transportation Reimbursement and Invoicing Program (TRIP)

One of the determinants frequently reported across all healthcare domains, including behavioral health, is transportation (Locatelli et al., 2017; Syed et al., 2013). According to Bellamy et al. (2016), unreliable access to transportation was the most frequently documented and reported non-medical barrier to clients seeking substance abuse and mental health outpatient services. Transportation barriers manifest themselves in several ways: a lack of independent car ownership, high cost of public transportation, travel distance, travel time, parking fees, a lack of public transportation, distance from agency to a bus stop, and cost of ride-sharing services (Locatelli et al., 2017). Without adequate and affordable transportation options, clients are unable to begin vital treatment nor consistently attend and complete treatment, resulting in suboptimal outcomes. NJ's 2018 Household Survey of Drug Use and Health indicated that of the clients surveyed who indicated they wanted treatment, transportation was a barrier for 39% of the participants.

Transportation is a key recovery support. A reliable means of transportation is needed so clients can get to prevention, recovery and treatment support programs. As a result of this gap, DMHAS has developed a new program called the Transportation Reimbursement and Invoicing Program (TRIP). This will enable transportation to treatment for individuals who do not have Medicaid, as well as enable transportation to and from non-healthcare facilities such as Community Peer Recovery Centers or prevention programs. TRIP is intended and designed to eliminate transportation barriers and facilitate access to substance use disorder Treatment, Prevention and Recovery Support Services (RSS).

Critical partners are the County and Alcohol Drug Directors (CADADs), our various recovery support programs such as the Opioid Overdose Recovery Program (OORP), Support Team for Addiction Recovery (STAR), Community Peer Recovery Centers (CPRC), Intensive Recovery and Treatment Support (IRTS), Maternal Wrap Around Program (MWRAP), prevention and SUD treatment providers.

Currently, SUPTRS Block Grant COVID-19 Supplemental funds are being utilized. Funding of \$1,000,000 was set aside for this project.

Housing

Group Homes for Persons in Recovery (Oxford House)

Funding is provided to Oxford Houses to provide administrative and programmatic oversight of the statewide network of peer-led group recovery homes in New Jersey. The Oxford House model offers recovery-oriented living as a choice in a person's continuum of care. Recovery is an individualized process for individuals with substance use disorders. As of March 2023, New Jersey has approximately 146 Oxford Houses (107 male houses, 31 women houses, and 8 women with children houses); total beds are 1,164 with 858 male and 306 female beds. The Revolving Loan Fund is administered by Oxford House annually to establish new homes, with additional funding from the Administrative Office of the Courts and DMHAS treatment contracts. This funding supports Oxford House, Inc. outreach staff to establish homes exclusive for the Drug Court population and women with children.

Federal funding for the State Opioid Response (SOR) allowed for expansion of the Oxford House contract for three full-time Outreach staff employed by Oxford House, Inc. to establish 10 new homes per year.

DMHAS expanded the Oxford House contract in State Fiscal Year 2022 with SA Block Grant Funds for two additional full-time Outreach staff employed by Oxford House, Inc., and to support separate start-up funds to cover additional costs associated with the development and opening of houses for specialized populations. The special populations include the following: women with children and men with children, individuals re-entering from incarceration and individuals with a history of opioid use who are at high risk for an overdose death.

In response to the opioid overdose epidemic, and its effects related to Oxford House, DMHAS requires Oxford House outreach staff to conduct annual trainings (overdose specific) for the 14 Oxford House Chapters throughout the state. Trainings are provided at the Oxford House annual state workshop. Each home is required to maintain Naloxone kits on site. Oxford House has seen an increase in members applying for membership with opioid use disorder (OUD). This increase supports the need for Naloxone training and information on access to Medical Assisted Recovery (MAR) options. The New Jersey outreach team continues to educate members on MAR and the importance of being an active member of their recovery community. Oxford House shall make every effort to accept individuals prescribed Medication Assisted Treatment (MAT) as well as other legitimately prescribed medications. Women and children Oxford Houses are responsible for providing lockboxes to each woman for medication storage, and residents in Oxford Houses are responsible for their individual medication lockboxes.

The DMHAS Program Manager and Oxford House, Inc. communicate on a regular basis and updates are provided regarding the current housing market or other challenges facing individuals seeking sober living in the midst of a pandemic. Oxford House, Inc. is part of the continued efforts to provide evidence-based recovery housing amidst a global pandemic. COVID-19 in New Jersey presented significant challenges for rental properties that Oxford House utilizes. The housing market is still causing barriers to finding affordable houses to be used as new Oxford Houses. In addition, the average cost to rent homes the size needed to be used as Oxford Houses has dramatically increased in 2022. These challenges have caused the team to struggle to find houses in some regions of the state where the rental amounts are much higher. The Oxford House outreach team continues to be vigilant in exploring all possible ways of identifying new locations. The team is focused on maintaining the current network of Oxford Houses while simultaneously finding new and replacement Oxford Houses.

Oxford House utilized online platforms for workshops during the pandemic to provide the following: expand overdose reversal and prevention trainings to houses with statewide partners; help residents to schedule COVID-19 vaccines; virtual platforms to assist residents with recovery meetings; accessing unemployment benefits; helping residents regain and maintain financial stability through the pandemic; establish virtual/teleworking; helping residents with Oxford House operations; provide updates on CDC, New Jersey and Oxford House, Inc. guidelines. Oxford House maintained ongoing communication with treatment providers and other state systems regarding vacancies.

Oxford House reports that in SFY23 they began to see progress with the slowing spread of COVID19 infections, and the implications that came with it. Outreach staff, alums, and Oxford House members could visit each other in houses and hold face-to-face chapter and state meetings. These meetings have been a long-standing and stabilizing part of the Oxford House Model.

Supportive Housing

The SSA has two supportive housing programs modeled on Housing First and incorporated into its Medication Assisted Treatment Initiative (MATI). These two contracts combined provide for a total of 63 housing units, 31 units in Camden and 32 units in Atlantic City. Services are provided to individuals with substance abuse disorders who are homeless or at risk of becoming homeless, and are intravenous drug users. Women with children are given top priority. It includes rental subsidies and support services and is funded at \$903,104.

The SSA developed a Women's Intensive Supportive Housing (WISH) Program funded at \$386,029. This program 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. The RFP was for the development of a WISH team to provide case management and supportive housing services for 10 women and their children. A contract 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.

DMHAS awarded contracts in 2019 to provide individualized case management and supportive services to up to 200 individuals with an OUD, on average, up to 8 hours per month, billable in 15 units, based on individual needs. These services will assist individuals in seeking and connecting with behavioral health and or physical healthcare needs. DMHAS provides 175 rental subsidies, up to the fair market rate (FMR) as defined by the Department of Community Affairs (DCA) for lease-based housing. One-time funding will be available to consumers for security deposits, utility start-up costs and furnishings. Contracts were awarded four agencies to serve individuals in five counties: Atlantic, Burlington, Camden, Mercer and Monmouth. Since the awarding of the OUD contracts, the number of referrals has reached approximately 250 referrals with a total of 114 subsidies currently occupied, and an additional 24 in housing search phase. The turnover of the OUD vouchers is approximately 10%, with consumers surrendering the subsidies. The onset of the COVID-19 Pandemic has resulted in the full payment of rent for some of the OUD consumers since they lost employment.

Sober Housing

Contracts were awarded in 2019 for three pilot recovery-based housing residences (a minimum of five individuals in each residence), one in each region (North, Central and South), for individuals with an OUD who are homeless or at risk of homelessness. Individuals are in, or recently discharged, from treatment and are seeking a drug free, sober and supportive living environment, with access and linkage to sober community resources. Individualized case management and recovery-based housing services is provided for 15 individuals (a minimum of five individuals in each region) who have been identified as needing a safe, healthy, peer-lead, recovery-oriented environment. The housing provided must be licensed as a Class F, Cooperative Sober Living Residence (NJAC § 5:27). Accordingly, individuals are responsible for providing their own food and taking care of their own laundry. Treatment and counseling may not be provided in the residence; however, non-clinical recovery support services may be provided at the site and the agency may require, at its discretion, drug or alcohol testing of residents. (NJAC § 5:27-2.1). Although increased funded sober housing slots are needed, the pilots are thriving and continue to benefit those individuals seeking a stable sober environment.

Case Management

Recovery Support Care Management (RSCM)

RSCM was established and effective on March 7, 2023 and is a behavioral health service intended to support consumers who have a SUD with complex physical and/or psychosocial needs. RSCM provides direct and comprehensive assistance to consumers to ensure access to the necessary treatment, rehabilitative and recovery services with the intent of reducing psychiatric and addiction symptoms, connect consumers with services, improve transitions between levels of care, implement strategies to address their unique needs, reduce opioid related deaths and sustain recovery in the community while supporting the consumers' continued stability and recovery throughout the continuum of care. This service is available as an enhancement in all levels of care. This service may be provided face-to-face or via a telehealth platform. Since Medicaid offers Care Management in outpatient, RSCM is excluded from reimbursement for consumers admitted into Ambulatory LOCs in Recovery Care Efficiency (RCE). RSCM is being funded with SUPTRS COVID-19 Supplemental and will continue with ARPA funding. As of October, 2023, there were 1,405 unduplicated clients who received this service; \$346,000 was billed for this service by non-profit providers.

Recovery Management Check-Up (RMC)

The intent of the RFP is to offer an RMC service for discharged clients to support their independent living and success with recovery. The new proposed program will provide more methods of outreaching to clients. This will include virtual face-to-face visits, text messaging and chat features, and also the opportunity for actual in person contacts. This check-up service will help provide local recovery supports, including information about local resources such as self-help meetings, food pantries, and sober houses, if needed. The successful bidder will provide services to clients in each of the counties specified in the region the bidder will serve. Total annualized funding for this RFP is \$1,500,000. Three regional awards, (North, Central and South), each \$500,000, were made in March 2023 to two agencies (one agency will cover two regions) to provide this service.

RMC aims to identify and alleviate client problems before they derail recovery. Monthly contact forms the core of the proposed RMC. During these contacts, staff will assess clients using a brief tool to assess the individual's progress, current needs and check on recovery status. Problems will be addressed using motivational interviewing techniques or connecting clients to appropriate community resources or treatment if needed. The conceptual framework of RMC is to treat addiction as a chronic disease, with long-term management to minimize the number of acute episodes of substance abuse and with prompt treatment when episodes occur to prevent them from becoming more severe and consequential (Rush, B.R. et al. The interaction of co-occurring mental disorders and recovery management checkups on substance abuse treatment participation and recovery. *Evaluation Review* 32(1): 7-38, 2008).

"The RMC intervention offers a recovery-oriented approach," according to Dr. Thomas Hilton of NIDA's Division of Epidemiology, Services and Prevention Research. "It not only monitors substance abuse after treatment but also assesses the characteristics, or recovery capital, that facilitate a healthy, productive, drug-free lifestyle in the long term. Knowing each patient's recovery capital is critical because recovery occurs outside the direct care system and rests heavily on the shoulders of the individual. It makes good clinical sense to build up the patient's capacity for recovery if it is low, and the RMC offers a concrete intervention that provides support."

RMC providers ensure that the services provided ensure diversity, inclusion, equity, and cultural and linguistic competence to the target population. The successful bidder will continually assess and utilize

demographic data of participants' catchment area in its development and delivery of follow-up, and program outcomes to ensure it is relevant to the population served. Additionally, the successful bidder will analyze data to implement strategies to increase program participation.

The RMC will provide follow-up meetings/calls with discharged substance use disorder (SUD) clients to support and identify need for further interventions when needed. Should the individual need additional interventions and/or treatment, and if the consumer is agreeable, a referral to an appropriate community resource or admission to a treatment program would occur. The purpose of the check-up is to offer support and identify areas which may need additional intervention or community support.

This funding will enhance recovery support services for clients after discharge from the NJ substance use disorder treatment system. The RMC will provide face-to-face meetings either in-person or virtual with discharged consumers. The RMC is to identify and alleviate client problems before they derail recovery and to facilitate rapid readmission to treatment when recovery falters.

This program will have the potential to change and immeasurably improve countless lives affected by substance use throughout the State. By engaging clients monthly post discharge from SUD treatment, either by face-face meetings, telephone, or other social media communications avenues (e.g., text messaging, chat, etc.), the hope is to enable those in recovery to remain in recovery. Individuals will be offered encouragement and information about resources aimed at recovery. The scope of work includes:

- RMC Program will provide face-to-face meetings, which can be virtual or in-person with discharged clients who would benefit from more direct contact.
- Staff will assess the individual by administering a brief interview tool (to be provided by DMHAS).
- Should problems be identified, staff will provide intervention using motivational interviewing techniques.
- Should the individual need additional interventions and/or treatment, and is agreeable, referral to appropriate community resources, including admission to a treatment program, would occur.
- A minimum of 200 unduplicated clients are to be served monthly.
- Follow-up will continue for nine (9) months with monthly check-ups. If a client needs more support, additional check-ups can be added.
- Hours should be flexible to meet client needs.
- A variety of approaches will be utilized, such as virtual face-face meetings, chat, text, in-person meetings, etc.
- The successful bidder will provide services to clients in each of the counties specified in the region the bidder will serve.

RMC contractees are rapidly building up their program infrastructure and service capabilities. This involves recruiting and setting up partnership meetings, amongst others. Prevention is Key, the awardee for the northern region RMC program has conducted outreach, meetings and presentations to staff and participants in 103 substance use disorder facilities in the following counties: Bergen - 21 facilities, Essex - 37 facilities, Hudson - 21 facilities, Passaic – 4 facilities, and Morris - 20 facilities. Prevention Links, which won the RMC program awards for the central and southern regions is continuing to meet with local partners and prospective referring organizations. So far, the contractee has met with the following treatment agencies; New Hope, John Brooks Recovery Center, Eva's Village and have pending meetings with several others like Maryville, Integrity House, Straight & Narrow and Turning Point. The contractee is currently updating their website so referring treatment agencies can request recovery management

check-up services for their clients, and be able to link them up to the Recovery Data Platform (RDP) external electronic referral form. The website update will include, creating an improved resource directory for region specific recovery supports.

County Innovation

Recovery Support services were developed in all 21 NJ counties, utilizing State Opioid Response (SOR) funding. A description of these programs follows.

Atlantic \$126,059- 2 programs

Innovative Recovery Support Services: \$66,059

AIM provides support, encouragement, and empathy to a vulnerable population associated with those living with substance use disorder. Furthermore, AIM proposes to provide 200 individuals within the community with transportation, linkage to treatment facilities, assistance with sober living, and provide individuals with basic needs such as toiletries, food, and clothing. The level of service and cost proposed by AIM are within reason and a contract is warranted. AIM proposes to provide Recovery Support Services to 1000 individuals: \$50/client with follow-up \$50; Recovery House funding at \$175/week for 3 weeks; Assistance with 12-Step-Facilitation at \$50 x 3 events; Necessity support at \$50 x 2; Transportation costs up to \$750 (contingent on actual costs); Outreach \$200/event; Blessing Bags \$200/event, and Admin costs including insurance, etc.

John Brooks Recovery Center: \$60,000

The agency will assume to re-open/continue operating a Recovery Center that would provide innovative services to the recovering community, with an emphasis being placed on providing services to victims of the opioid epidemic and family members of victims of opioid overdose deaths. This would include John Brooks Recovery Center (JBRC) which submitted a proposal for \$60,000 to provide a wide array of recovery support services to all people in recovery with a substance use disorder. JBRC operates two Recovery Community Centers with the ability to service approximately 550 unduplicated individuals. Cost for individual peer to peer services, navigation, coaching, follow-up, education/prevention, and service connections (housing, employment, tobacco dependence) is \$16.00/15 minute unit of service. Cost for group peer to peer services, workshops, support groups, education, prevention, and health/wellness is \$4.00/each individual/group. The Recovery Center is located close to public transportation and will utilize both professional and volunteer staff to function daily.

Burlington \$134,615

Resource Recovery Center

The one-time award for the Resource Center is to provide an environment where individuals can access peer support, information about substance use disorder treatment, recovery support services, and information about other community resources in a supportive substance free environment.

The Resource Center will include an array of services that support individuals in their recovery from substance use and misuse. In summary, this funding will:

- Strengthen the linkage between treatment and recovery;

- Increase support for sustained recovery within the community;
- Offer resources to individuals seeking information on substance use disorder and behavioral treatment. Resources will include accessing treatment information through NJ Connect, private insurance, DMHAS Interim Managing Entity (IME) Addictions Access Center, Family Support Centers, Support Team for Addiction Recovery (STAR), Medication Assisted Treatment (MAT) options,
- Help prevent recurrence of substance use;
- Inform individuals about Naloxone training and where one can obtain a kit;
- Provide recovery resources;
- Provide a trauma informed community where individuals can achieve a full and satisfying life free of trauma and its consequences; and
- Provide a center for community-based leadership to grow and develop.

The coordinator is to be a person in Recovery and trained as a Certified Peer Recovery Specialist. An Oversight Team will be developed to guide the programming and running of the resource room. This team will include County A/D Director, Peers in Recovery, Providers, Burlington County Prosecutors Office (BCPO), etc. The coordinator will be responsible for the daily operations and oversight of the Resource Room (i.e., startup activities, growth, stabilization, and continued innovation). He/she will report to the A/D Director. The BCPO is providing a Certified Peer Recovery Specialist (CPRS)/Recovery Coach training run by City of Angels. It will be free to Burlington County residents and occur sometime in March. The BCPO, through its Operation Helping Hands Program, has offered to provide CPRS for July and August. The County will use funds to pay the CPRS the other months for the first year. A CPRS pool will be created to staff the recovery center with the coordinator. The County plans to have at least two people working the recovery room when it is open, so no one is there alone in case of emergency.

Camden \$190,039

Program: Joseph's House

Location: 555 Atlantic Ave, Camden, NJ 08104 which is an 88-bed shelter in Camden City. The shelter is co-ed

Program: Volunteers of America – Delaware Valley, Anna Sample Complex

Location: 408-416 Line Street, Camden, NJ 08103. 93-bed Transitional Housing program serves single women and families.

Since April 2020, Camden County was funded by the National Association of County & City Health Officials (NACCHO) to provide a Peer Recovery / Harm Reduction Specialists (CPRS/HRS) who are required to work 'in-person' at two homeless shelters under the direction or co-direction of the shelter and or substance use licensed treatment facility. For 2023/2024, Maryville, Inc., a SUD treatment provider who will supply the CPRS and coordinate the data.

The shelter administrative team/s will determine and provide the required hours based upon the number of overdoses in the area. Also considered is when the shelter guests are available. That means working during the day, evening and on weekends. The hired licensed entity selected to provide the CPRS service must enter into a Memorandum of Understanding (MOU) with the homeless shelter(s) post award, subject to the approval and acceptance by the County, to determine the hours of operation. They must

have mutual agreement of all operational terms, including provision of replacement staff in the event the assigned CPRS/HRS is unavailable.

Therefore, the CPRS/HRS is required to be co-supervised by the SUD treatment agency and shelter administrator. The CPRS/HRS cannot perform any activities on behalf of the SUD treatment agency, shelter or county not defined or approved by the shelter or county. The CPRS/HRS offers an opportunity to share the experience of lived experience, however, referrals will be made in accordance with the most evidenced based practices. The CPRS/HRS must be fully knowledgeable about 'harm reduction', Camden County's Syringe Access Program (SAP), and evidenced based SUD treatment. Individuals with 'opiate use disorders' (OUD) must be referred to the most evidenced based treatment. The shelters may bill \$1,004.00 per month for the provision of a desk and supervision. The CPRS provider may bill \$35,000.00 per CPRS plus up to 25% for fringe (\$8,750.00). The cost of CPRS cell phones, a lease of a vehicle, incidental travel costs for the patients, cell phones and tablets for the CPRS will be covered. CPRS must come from an agency that has direct capacity to an inpatient admission center. The County will cover the cost of an afterhours line with an inpatient treatment agency to allow for greater access to treatment for its residents. CPRS are provided instruction about Harm Reduction services. When shelter guests are not ready for treatment, they are encouraged to take advantage of harm reduction services. The County will directly with its harm reduction center to assist in the education about that topic. The County will also work with its shelters to increase their understanding of the value of harm reduction.

Program: Regan Center

Location: 508 Lakeland Road Gloucester Township, NJ 08012 (856) 549-0590

The Regan Center is a 23-bed facility comprised of a 15-bed emergency shelter program and 8-bed medical respite program for homeless adult men.

There are 2 CPRS full time. To complement this program, the County funded 1 CPRS with lawsuit remediation funds – to provide CPRS services for the other 3 shelters in the county. Burlington and Gloucester Counties refer all homeless individuals to Camden County's shelters.

Cape May \$35,751

This program will use funding to establish a recovery center in the county which will serve as the hub of many recovery programs that currently operate out of churches and other general areas. It will be peer driven and peer delivered and serve people currently in recovery and are dedicated to maintaining a sustainable path in recovery. Recovery specialists will be present to develop a recovery plan for those in attendance and assist with Medicaid applications. Support groups for special populations such as pregnant and new mothers, families (CRAFT) and Recovery Court alumni will be scheduled, education regarding treatment and MAT will be available, fellowship groups including 12 step and all recovery will be welcomed. Agencies will bring support programs on a routine basis such as work readiness, nutrition, job search, entitlements, etc. The Center will operate from 10 to 6 daily and allow for special or closed meetings after hours. It is expected that 300 people will participate and 100 will develop a recovery plan and will be linked to resources, including MAT. Thirty percent of those who develop a recovery plan will remain in recovery three months.

Gloucester \$111,151

This program is a collaboration between Gloucester County and Center for Family Services, operating on the campus of Rowan College of South Jersey. The program will provide the following:

- Expand Substance Abuse Family Recovery Support Program. Opening additional satellite locations in Gloucester County to provide better access to residents. Areas of particular interest would include the eastern part of Gloucester County (Monroe Twp., Franklin Twp., Clayton) and the southwest riverside communities (Paulsboro, Greenwich, Logan).
- Provide transportation to and from withdrawal management and treatment services. A subcontracted agency would provide transportation on an as-needed basis for Gloucester County residents.
- Additional Supports for sober living residents. Currently, Gloucester County funds a limited number of residents entering into sober living by paying their move-in fee and first 2 weeks rent. Funding is also made available in cases of hardship. Additional support is needed to provide daily living essentials, such as toiletries and food.
- Enhance Collaborations with community service organizations. Gloucester County will look to expand partnerships to increase access to, and education on, Medication Assisted Treatment, Narcan, SBIRT Intervention, Peer Recovery Support, Family Support, Sober Living, and other programs/services, at various locations throughout county.

Hudson \$203,963

The Hudson County Innovation Program will provide the following services.

- Supporting Treatment for Addiction, Recovery and Success (STARS) Program - Mobile outreach van to offer Info, Naloxone training and support services.
- STARS support materials
- Youth recovery support group (Ages 13 - 17)
- Young adults' recovery support group (Ages 18 - 24)
- 6 Recovery events
- Youth sober activities
- Outreach/ education to prescribers

Hunterdon \$35,708

The Hope One Vehicle in Hunterdon County will educate those addicted to heroin and other opioids about the dangers of ongoing use, as well as give resources to get help. It will provide transportation at the end of each shift to MAT services as well as to the County's screener for services to assist those who express interest in getting services. The County will also provide funds for taxi service back, or provide linkages to the local Link service. Transportation has long been a barrier that has prevented many from being able to consider getting to treatment. Hope One will work with the Social Services Department to assist consumers to be able to sign up for benefits, assisting them in being able to gain access for needed services, as well as housing and food needs. MOU's will be set up with mental health agencies, as well as the local health department, so that consumers can have referrals for services. Rapid testing HIV will be offered, as well as education on safe injection, abscesses, and Hepatitis C. Peer Specialists will be invited on Hope One as another way to reach out to consumers who may be using substances and as a means to educate and assist those who want to get treatment understand their options.

Mercer \$140,490

The overall goal of the implementation of a medication assisted treatment (MAT) Coordinator is to improve the availability and accessibility of an array of appropriate MAT, for people who have substance use disorders (SUD), especially those with opioid use disorder (OUD). The concept of a county MAT coordinator will help with promoting treatment services, consistent with DMHAS' message regarding this evidence-based practice. This position will help individuals and their families navigate the array of treatment providers in order to connect to MAT, especially for those individuals who are not yet eligible for other programmatic support. The MAT coordinator would have the full support of the Mercer County Department of Human Services to educate all areas of Human Services, such as aging providers, disability providers, criminal justice, youth, mental health, and the housing and homelessness system. For example, the MAT coordinator could provide education to the Coordinated Entry and Assessment System (CEASe-Homelessness system) with direct linkages to MAT. This position can support a housing first concept and provide one consistent message that MAT can help individuals. This coordinator will also accompany the CEASe system outreach team on their mobile van to help promote treatment services in order to help the unsheltered homeless population of people.

Middlesex \$264,916

The innovative MORE (Middlesex Outreach for Recovery) project will meet people wherever they are – whether in homes, parks, trailer parks, soup kitchens, food pantries, abandoned buildings and houses of worship. MORE is envisioned as a space where engagement and relationship building begin. MORE will offer water, non-perishable snacks, blankets, Fentanyl testing strips and other supplies, resource information and linkages, to establish trust and to empower people to begin addressing the complex issues at the heart of their personal challenges. Outreach will allow MORE to educate individuals and the larger community about available services, including evidence-based MAT. MORE will provide health and wellness promotion, preventative education and clinical services to underserved populations throughout Middlesex County. With a holistic, person-centered approach, MORE will:

- Reduce Opioid use
- Connect individuals diagnosed with opioid use disorders to medication-assisted treatment
- Support individuals on a path to recovery

Meeting people in the MORE will provide a greater amount of privacy, safety and resources than is possible through outreach activities conducted by staff on the streets, which is essential to determine eligibility for diagnostic and medical services.

Monmouth \$226,366

Monmouth County is utilizing the innovative grant award to fund a mobile recovery unit (not a vehicle per se, but a group of partnering agencies). The unit will go to targeted communities on a regular schedule throughout the period of the contract. The mobile recovery unit will outreach to the identified community and educate the community on substance use disorder (SUD), particularly opioid use disorder (OUD), and provide information on the resources available. Certified peer recovery specialists from partnering agencies will work to engage with individuals struggling with addiction and build a relationship in the identified communities. Simultaneously, they will have treatment agencies partner to offer a free half hour consultation with a licensed clinician via phone. This option will be open to an individual

contemplating treatment OR to the family member of a loved one with SUD. They can remain anonymous if they wish. If it is a person with SUD, the clinician will use the opportunity to engage, educate and discuss what their options may be for treatment and what treatment looks like with a particular focus on Medication Assisted Treatment (MAT) options. If the person decides at the end of the consultation, they'd like to seek treatment, they will be referred into the Monmouth County Care Management Collaborative and be assigned to an agency that will link them to treatment and continue to provide ongoing care management and support. If they do not want to seek treatment at that time, they can opt-in for a follow up "check-in" phone call from the clinician. Additionally, if the peer recovery specialist engages with someone in the community who does not want the consultation but does express interest in treatment, the recovery specialist can refer them directly to the Care Management Collaborative to be assigned.

The goal of the mobile recovery unit is to reach communities through boots on the ground efforts providing education and information/access to available resources utilizing certified peer recovery specialists to engage individuals at high risk of overdose who may not otherwise be seeking treatment and linking them to life saving medication assisted treatment and other treatment options. Additionally, the mobile recovery unit will work to engage families to provide information, support, and resources that will assist them in managing the impact of their loved one's addiction. It is expected that through these local, targeted efforts, Monmouth County will increase the number of residents with OUD on MAT and/or linked to a treatment program.

Morris \$151,505

Morris County has implemented a Successful Transition and Re-Entry (STAR) program model for Pre-Trial Division. The Addictions case manager provides up to 1 year of community engagement and linkage to services and recovery specialist available 24 hours for those involved in Pre-Trial services.

Ocean \$229,936

The Ocean County Innovation programming will provide the following services.

- Post-Narcan Case Management - social worker conduct post-Narcan interviews with police depts.,
- Recovery events
- Enhance recovery support programs w/ services aimed at emotional self-management,
- First month rent for those in need of Oxford House or Sober Living placement,
- Planning grant for Recovery High School,
- Transportation study of those provided w/ transportation and telephone case management vs control group of those who did not
- Training for 24 elementary school teachers on "Footprints for Life (EBP) for 2nd and 3rd graders

Passaic \$167,627

The Passaic County Mobile Recovery Unit Program is a mobile access unit (to be named at a later date) that will be used to engage individuals in the community. The provider will host the mobile access van in upper and lower Passaic County in areas determined to be locations of concern and need as it relates to opioid use and opioid addiction. Services provided will include: immediate information and resources, training on opioid overdose prevention and harm reduction, harm reduction kits, and support services to those in need of substance use support and treatment. In an effort to engage individuals in a friendly and

supportive manner, the mobile access unit will provide food, beverages, harm reduction kits as well as information.

The primary goal of the program is to ensure those in need of services and support for substance use receives the appropriate resources and assistance directly linked to services as needed. The program also aims to reduce rates of substance use, lessen crimes related to substance use, prevent opioid overdoses and overdose deaths, develop a rapport with those affected by addiction, and educate individuals on harm reduction methods. Initially, the van will be deployed in the community for two days per week for up to 4 hours each deployment.

Salem \$24,795

The program will support individuals in recovery by offering opportunities for exploring new activities on a regular basis both in and outside of Salem County. Very often, those new to recovery are focused on trying to regain life's balance and do not have the financial stability to pay for activities that will allow for them to discover new hobbies. Also, there are few opportunities for recovery supportive environments and those leading a substance abuse free lifestyle are seeking others on the same path. With limited sources of entertainment in Salem County, this is a gap that needs to be filled to support the recovery community. These opportunities would include a sober, substance abuse free environment and growing the individual's network of acquaintances. This will encourage healthy relationships with others in recovery from opioid use disorder. A certified recovery coach will be on site and have the tools to meet each person where they are in their recovery. This recovery coach can also connect event attendees to community resources and help them with wellness planning. Fellowship activities will be held on a monthly basis throughout Salem County. These monthly events will be 3 hours in length and take place at various times of day, depending on the activity. Some of these events may include: cooking classes, practicing yoga or tai chi, bowling, art classes, hiking, or attending a play or live music event. These monthly activities will be open to anyone in the recovery community that is looking for free activities and ways to meet others on their journey to long term recovery.

Somerset \$94,967

The innovation program will support the recovery of Somerset County pregnant/parenting women with an opioid use disorder (OUD). It will provide Somerset County pregnant/parenting women with an OUD linkage to recovery support services identified by DMHAS and SAMSHA as the following: employment assistance; peer to peer services; rental/housing assistance or sober living housing; transportation; child care assistance; education/training assistance; family counseling and education; medical or dental services; and groups such as relapse prevention, coping/life skills, parenting skills, AA or NA, sponsorship and faith-based groups.

Also, the program will provide evidenced-based family programs such as parent-child interaction therapy, multisystem therapy, multi-dimensional family therapy, or functional family therapy that increase the parent-child bond, strengthen families and keep families resilient, assist families integrate school involvement in child's social, emotional and academic success and reduce substance use and help families recover as a whole family.

Union \$170,574

Trinitas Regional Medical Center will provide wraparound services to connect Union County residents living with, or who have a history of, an opioid use disorder (OUD), addiction to stimulants, or co-occurring disorders to resources that support recovery. Family members of individuals affected by OUD and/or addiction to stimulants are also eligible to receive wraparound services.

Warren \$36,675

Warren provides a community program to provide Narcan trainings to community professionals and lay people. The program also provides education on addiction and treatment and recovery in schools, such as educational sessions for parents and loved ones.

IV: Population and Services Reports

Tables 11a, 11b and 11c - Unduplicated Count of Persons Served for Alcohol and Other Drug Use

This table provides an aggregate profile of the unduplicated number of admissions and persons for services funded through the SUPTRS BG. This table should not include persons served using COVID-19 Relief Supplemental Funding.

Expenditure Period Start Date: Expenditure Period End Date:

SUPTRS BG Table 11a - Unduplicated Count of Persons Served For Alcohol and Other Drug Use

This table provides an aggregate profile of the unduplicated number of admissions and persons for services funded through SUPTRS BG. This table should not include persons served using COVID-19 Relief Supplemental Funding.

	Total								American Indian or Alaska Native						
	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non- Conforming	Other	Not Available	Total	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non- Conforming	Other	Not Available
0-5 years ¹	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
6-12 years	1	4	0	0	0	0	0	5	0	0	0	0	0	0	0
13-17 years	244	453	0	0	0	0	0	697	3	2	0	0	0	0	0
18-20 years	214	442	0	0	0	0	0	656	3	5	0	0	0	0	0
21-24 years	555	1,169	0	0	0	0	0	1,724	4	23	0	0	0	0	0
25-44 years	10,996	18,898	0	0	0	0	0	29,894	55	198	0	0	0	0	0
45-64 years	6,837	13,518	0	0	0	0	0	20,355	29	141	0	0	0	0	0
65-74 years	792	1,774	0	0	0	0	0	2,566	6	18	0	0	0	0	0
75+ years	73	154	0	0	0	0	0	227	0	3	0	0	0	0	0
Not Available	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	19,712	36,412	0	0	0	0	0	56,124	100	390	0	0	0	0	0
Pregnant Women	835								6						
Number of Persons Served who were admitted in a Period Prior to the 12-month reporting Period	28824														
Number of Persons Served outside of the levels of care described on SUPTRS BG Table 10	149														

Are the values reported in this table generated from a client-based system with unique identifiers?

☒ Yes ☐ No

Comments on Data (Race)	
Comments on Data (Gender)	
Comments on Data (Overall)	The totals for Males and Females include Males and Females by race and Males and Females who are Hispanic or Latino.

¹Age category 0-5 years is not applicable.

SUPTRS BG Table 11a - Unduplicated Count of Persons Served For Alcohol and Other Drug Use (continued)

	Asian							Black or African American						
	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non- Conforming	Other	Not Available	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non- Conforming	Other	Not Available
0-5 years ¹	0	0	0	0	0	0	0	0	0	0	0	0	0	0

6-12 years	0	0	0	0	0	0	0	1	1	0	0	0	0	0
13-17 years	3	7	0	0	0	0	0	55	103	0	0	0	0	0
18-20 years	2	8	0	0	0	0	0	75	139	0	0	0	0	0
21-24 years	7	24	0	0	0	0	0	168	475	0	0	0	0	0
25-44 years	67	206	0	0	0	0	0	2,186	5,086	0	0	0	0	0
45-64 years	26	76	0	0	0	0	0	2,501	5,062	0	0	0	0	0
65-74 years	4	4	0	0	0	0	0	386	779	0	0	0	0	0
75+ years	0	0	0	0	0	0	0	17	50	0	0	0	0	0
Not Available	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	109	325	0	0	0	0	0	5,389	11,695	0	0	0	0	0
Pregnant Women	4							157						

¹Age category 0-5 years is not applicable.

SUPTRS BG Table 11a - Unduplicated Count of Persons Served For Alcohol and Other Drug Use (continued)

	Native Hawaiian or Other Pacific Islander							White						
	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non- Conforming	Other	Not Available	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non- Conforming	Other	Not Available
0-5 years ¹	0	0	0	0	0	0	0	0	0	0	0	0	0	0
6-12 years	0	0	0	0	0	0	0	0	3	0	0	0	0	0
13-17 years	1	4	0	0	0	0	0	178	325	0	0	0	0	0
18-20 years	3	5	0	0	0	0	0	127	274	0	0	0	0	0
21-24 years	6	8	0	0	0	0	0	358	628	0	0	0	0	0
25-44 years	94	211	0	0	0	0	0	8,436	13,020	0	0	0	0	0
45-64 years	53	133	0	0	0	0	0	4,187	8,020	0	0	0	0	0
65-74 years	4	18	0	0	0	0	0	386	950	0	0	0	0	0
75+ years	0	2	0	0	0	0	0	56	98	0	0	0	0	0
Not Available	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	161	381	0	0	0	0	0	13,728	23,318	0	0	0	0	0
Pregnant Women	6							648						

¹Age category 0-5 years is not applicable.

SUPTRS BG Table 11a - Unduplicated Count of Persons Served For Alcohol and Other Drug Use (continued)

	Some Other Race							More than One Race Reported						
	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non- Conforming	Other	Not Available	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non- Conforming	Other	Not Available
0-5 years ¹	0	0	0	0	0	0	0	0	0	0	0	0	0	0
6-12 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
13-17 years	0	0	0	0	0	0	0	4	12	0	0	0	0	0
18-20 years	0	0	0	0	0	0	0	4	11	0	0	0	0	0
21-24 years	0	0	0	0	0	0	0	12	11	0	0	0	0	0
25-44 years	0	0	0	0	0	0	0	158	175	0	0	0	0	0
45-64 years	0	0	0	0	0	0	0	40	84	0	0	0	0	0
65-74 years	0	0	0	0	0	0	0	6	5	0	0	0	0	0

75+ years	0	0	0	0	0	0	0	0	1	0	0	0	0	0
Not Available	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	0	0	0	0	0	0	0	224	299	0	0	0	0	0
Pregnant Women	0							12						

¹Age category 0-5 years is not applicable.

SUPTRS BG Table 11a - Unduplicated Count of Persons Served For Alcohol and Other Drug Use (continued)

	Race Not Available							Not Hispanic or Latino						
	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non- Conforming	Other	Not Available	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non- Conforming	Other	Not Available
0-5 years ¹	0	0	0	0	0	0	0	0	0	0	0	0	0	0
6-12 years	0	0	0	0	0	0	0	1	2	0	0	0	0	0
13-17 years	0	0	0	0	0	0	0	88	178	0	0	0	0	0
18-20 years	0	0	0	0	0	0	0	130	256	0	0	0	0	0
21-24 years	0	0	0	0	0	0	0	412	770	0	0	0	0	0
25-44 years	0	2	0	0	0	0	0	9,301	14,642	0	0	0	0	0
45-64 years	1	2	0	0	0	0	0	6,004	10,675	0	0	0	0	0
65-74 years	0	0	0	0	0	0	0	829	1,530	0	0	0	0	0
75+ years	0	0	0	0	0	0	0	71	128	0	0	0	0	0
Not Available	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	1	4	0	0	0	0	0	16,836	28,181	0	0	0	0	0
Pregnant Women	2							698						

¹Age category 0-5 years is not applicable.

SUPTRS BG Table 11a - Unduplicated Count of Persons Served For Alcohol and Other Drug Use (continued)

	Hispanic or Latino							Hispanic or Latino Origin Not Available						
	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non- Conforming	Other	Not Available	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non- Conforming	Other	Not Available
0-5 years ¹	0	0	0	0	0	0	0	0	0	0	0	0	0	0
6-12 years	0	2	0	0	0	0	0	0	0	0	0	0	0	0
13-17 years	155	273	0	0	0	0	0	0	0	0	0	0	0	0
18-20 years	82	182	0	0	0	0	0	0	0	0	0	0	0	0
21-24 years	148	388	0	0	0	0	0	0	0	0	0	0	0	0
25-44 years	1,629	4,050	0	0	0	0	0	0	0	0	0	0	0	0
45-64 years	799	2,620	0	0	0	0	0	0	0	0	0	0	0	0
65-74 years	65	237	0	0	0	0	0	0	0	0	0	0	0	0
75+ years	1	26	0	0	0	0	0	0	0	0	0	0	0	0
Not Available	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	2,879	7,778	0	0	0	0	0	0	0	0	0	0	0	0
Pregnant Women	135							0						

¹Age category 0-5 years is not applicable.

SUPTRS BG Table 11b - COVID-19 Number of Persons Served (Unduplicated Count) for Alcohol and Other Drug Use¹

This table provides an aggregate profile of the unduplicated number of admissions and persons for services funded under COVID-19 Relief Supplemental Funding.

Total	American Indian or Alaska Native
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	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non- Conforming	Other	Not Available	Total	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non- Conforming	Other	Not Available
0-5 years ²	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
6-12 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
13-17 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
18-20 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
21-24 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
25-44 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
45-64 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
65-74 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
75+ years	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Not Available	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Pregnant Women	0								0						

¹The 24-month expenditure period for the COVID-19 Relief supplemental funding is March 15, 2021 – March 14, 2023, which is different from the expenditure period for the "standard" SUPTRS BG and MHBG. However, grantees are requested to annually report SUPTRS BG COVID-19 Supplemental Funding expenditures in accordance with requirements included in their current NoA Terms and Conditions.

²Age category 0-5 years is not applicable.

Comments on Data (Race)	
Comments on Data (Gender)	
Comments on Data (Overall)	Table 11B: Due to lack of information to separate clients served by COVID-19 supplemental funds from other funding sources, we do not have data to complete Table 11B.

SUPTRS BG Table 11b - COVID-19 Number of Persons Served (Unduplicated Count) for Alcohol and Other Drug Use (continued)

	Asian							Black or African American						
	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non- Conforming	Other	Not Available	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non- Conforming	Other	Not Available
0-5 years ¹	0	0	0	0	0	0	0	0	0	0	0	0	0	0
6-12 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
13-17 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
18-20 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
21-24 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
25-44 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
45-64 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
65-74 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
75+ years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Not Available	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Pregnant Women	0							0						

¹Age category 0-5 years is not applicable.

SUPTRS BG Table 11b - COVID-19 Number of Persons Served (Unduplicated Count) for Alcohol and Other Drug Use (continued)

	Native Hawaiian or Other Pacific Islander							White						
	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non- Conforming	Other	Not Available	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non- Conforming	Other	Not Available
0-5 years ¹	0	0	0	0	0	0	0	0	0	0	0	0	0	0
6-12 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
13-17 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
18-20 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
21-24 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
25-44 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
45-64 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
65-74 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
75+ years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Not Available	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Pregnant Women	0							0						

¹Age category 0-5 years is not applicable.

SUPTRS BG Table 11b - COVID-19 Number of Persons Served (Unduplicated Count) for Alcohol and Other Drug Use (continued)

	Some Other Race							More than One Race Reported						
	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non- Conforming	Other	Not Available	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non- Conforming	Other	Not Available
0-5 years ¹	0	0	0	0	0	0	0	0	0	0	0	0	0	0
6-12 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
13-17 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
18-20 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
21-24 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
25-44 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
45-64 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
65-74 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
75+ years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Not Available	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Pregnant Women	0							0						

¹Age category 0-5 years is not applicable.

SUPTRS BG Table 11b - COVID-19 Number of Persons Served (Unduplicated Count) for Alcohol and Other Drug Use (continued)

	Race Not Available							Not Hispanic or Latino						
	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non- Conforming	Other	Not Available	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non- Conforming	Other	Not Available
0-5 years ¹	0	0	0	0	0	0	0	0	0	0	0	0	0	0
6-12 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
13-17 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0

18-20 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
21-24 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
25-44 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
45-64 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
65-74 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
75+ years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Not Available	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Pregnant Women	0							0						

¹Age category 0-5 years is not applicable.

SUPTRS BG Table 11b - COVID-19 Number of Persons Served (Unduplicated Count) for Alcohol and Other Drug Use (continued)

	Hispanic or Latino							Hispanic or Latino Origin Not Available						
	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non-Conforming	Other	Not Available	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non-Conforming	Other	Not Available
0-5 years ¹	0	0	0	0	0	0	0	0	0	0	0	0	0	0
6-12 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
13-17 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
18-20 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
21-24 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
25-44 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
45-64 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
65-74 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
75+ years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Not Available	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Pregnant Women	0							0						

¹Age category 0-5 years is not applicable.

SUPTRS BG Table 11c - Sexual Orientation Unduplicated Count of Persons Served for Alcohol and Other Drugs

Sexual Orientation									
A. Age	B. Straight or Heterosexual	C. Homosexual (Gay or Lesbian)	D. Bisexual	E. Queer	F. Pansexual	G. Questioning	H. Asexual	I. Other	J. Not Available
0-5 years ¹	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+ years	0	0	0	0	0	0	0	0	0
TOTAL	0	0	0	0	0	0	0	0	0

Footnotes:

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

Table 11C: DMHAS does not collect SUD treatment data regarding gender identity and sexual orientation.

IV: Population and Services Reports

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

Expenditure Period Start Date: 7/1/2022 Expenditure Period End Date: 6/30/2023

Early Intervention Services for Human Immunodeficiency Virus (HIV)		
1. Number of EIS/HIV projects among SUPTRS BG sub-recipients in the state	Statewide: _____	Rural: _____
2. Total number of individuals tested through SUPTRS BG sub-recipient EIS/HIV projects:		
3. Total number of HIV tests conducted with SUPTRS BG EIS/HIV funds:		
4. Total number of tests that were positive for HIV		
5. Total number of individuals who prior to the 12-month reporting period were unaware of their HIV infection		
6. Total number of HIV-infected individuals who were diagnosed and referred into treatment and care during the 12-month reporting period		
7. Total number of persons at risk for HIV/AIDS referred for PrEP services?		
Identify barriers, including State laws and regulations, that exist in carrying out HIV testing services:		

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Footnotes:
New Jersey is not a HIV designated state.

IV: Population and Services Reports

Table 13 - Charitable Choice – Required

Under Charitable Choice Provisions; Final Rule (42 CFR Part 54), states, local governments, and religious organizations, such as SAMHSA grant recipients, must: (1) ensure that religious organizations that are providers provide to all potential and actual program beneficiaries (services recipients) notice of their right to alternative services; (2) ensure that religious organizations that are providers refer program beneficiaries to alternative services; and (3) fund and/or provide alternative services. The term “alternative services” means services determined by the state to be accessible and comparable and provided within a reasonable period of time from another substance use disorder provider (“alternative provider”) to which the program beneficiary (services recipient) has no religious objection. The purpose of this table is to document how the state is complying with these provisions.

Expenditure Period Start Date: 7/1/2022 Expenditure Period End Date: 6/30/2023

Notice to Program Beneficiaries - Check all that apply:

- ☒ Used model notice provided in final regulation.
- ☐ Used notice developed by State (please attach a copy to the Report).
- ☒ State has disseminated notice to religious organizations that are providers.
- ☒ State requires these religious organizations to give notice to all potential beneficiaries.

Referrals to Alternative Services - Check all that apply:

- ☐ State has developed specific referral system for this requirement.
- ☐ State has incorporated this requirement into existing referral system(s).
- ☐ SAMHSA’s Behavioral Health Treatment Locator is used to help identify providers.
- ☐ Other networks and information systems are used to help identify providers.
- ☒ State maintains record of referrals made by religious organizations that are providers.

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

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

There were no additional trainings provided to local government and faith based and community organizations on these requirements for SFY 2023. In January 2020, all DMHAS addictions providers received correspondence indicating the Division’s intent to monitor the provisions of the Charitable Choice Act. The correspondence included the model notice and the Charitable Choice law. In addition to the questionnaire portion of the annual site visit monitoring form (the form is sent to the agency prior to the review period and requires the agency to identify if they are, or are not faith-based in their approach to substance abuse treatment), all providers are required to submit quarterly referral logs to the Program Management Officers of the Contract Monitoring Unit in the event the agency receives a referral or request for transfer. In addition, the Program Management Officers of the Contract Monitoring Unit are required to complete an annual site visit to all of the contracted agencies. During the annual site visit, the Program Management Officers ask direct questions to executive staff members present at the opening interview pertaining to Charitable Choice referrals. The responses are recorded and documented in the annual site visit report. There were 0 Charitable Choice referrals for SFY 2023.

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Footnotes:

V: Performance Data and Outcomes

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

Short-term Residential(SR)

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

	At Admission(T1)	At Discharge(T2)
Number of clients employed or student (full-time and part-time) [numerator]	990	464
Total number of clients with non-missing values on employment/student status [denominator]	7,143	7,143
Percent of clients employed or student (full-time and part-time)	13.9%	6.5%
Notes (for this level of care):		
Number of CY 2022 admissions submitted:		10,604
Number of CY 2022 discharges submitted:		10,473
Number of CY 2022 discharges linked to an admission:		8,654
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):		7,192
Number of CY 2022 linked discharges eligible for this calculation (non-missing values):		7,143

Source: SAMHSA/CBHSQ TEDS CY 2022 admissions file and CY 2022 linked discharge file
[Records received through 2/1/2024]

Long-term Residential(LR)

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

	At Admission(T1)	At Discharge(T2)
Number of clients employed or student (full-time and part-time) [numerator]	1,954	2,073
Total number of clients with non-missing values on employment/student status [denominator]	5,979	5,979
Percent of clients employed or student (full-time and part-time)	32.7%	34.7%
Notes (for this level of care):		
Number of CY 2022 admissions submitted:		7,908
Number of CY 2022 discharges submitted:		7,810
Number of CY 2022 discharges linked to an admission:		7,549
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):		6,069

Number of CY 2022 linked discharges eligible for this calculation (non-missing values):	5,979
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Source: SAMHSA/CBHSQ TEDS CY 2022 admissions file and CY 2022 linked discharge file
[Records received through 2/1/2024]

Outpatient (OP)

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

	At Admission(T1)	At Discharge(T2)
Number of clients employed or student (full-time and part-time) [numerator]	7,690	9,166
Total number of clients with non-missing values on employment/student status [denominator]	13,328	13,328
Percent of clients employed or student (full-time and part-time)	57.7%	68.8%
Notes (for this level of care):		
Number of CY 2022 admissions submitted:		27,153
Number of CY 2022 discharges submitted:		27,031
Number of CY 2022 discharges linked to an admission:		24,258
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):		13,665
Number of CY 2022 linked discharges eligible for this calculation (non-missing values):		13,328

Source: SAMHSA/CBHSQ TEDS CY 2022 admissions file and CY 2022 linked discharge file
[Records received through 2/1/2024]

Intensive Outpatient (IO)

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

	At Admission(T1)	At Discharge(T2)
Number of clients employed or student (full-time and part-time) [numerator]	4,455	5,827
Total number of clients with non-missing values on employment/student status [denominator]	12,101	12,101
Percent of clients employed or student (full-time and part-time)	36.8%	48.2%
Notes (for this level of care):		
Number of CY 2022 admissions submitted:		21,159
Number of CY 2022 discharges submitted:		21,216
Number of CY 2022 discharges linked to an admission:		17,712
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):		12,678

Number of CY 2022 linked discharges eligible for this calculation (non-missing values):	12,101
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Source: SAMHSA/CBHSQ TEDS CY 2022 admissions file and CY 2022 linked discharge file
[Records received through 2/1/2024]

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Footnotes:

V: Performance Data and Outcomes

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

Short-term Residential(SR)

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

	At Admission (T1)	At Discharge (T2)
Number of clients living in a stable situation [numerator]	5,522	6,674
Total number of clients with non-missing values on living arrangements [denominator]	7,149	7,149
Percent of clients in stable living situation	77.2%	93.4%
Notes (for this level of care):		
Number of CY 2022 admissions submitted:		10,604
Number of CY 2022 discharges submitted:		10,473
Number of CY 2022 discharges linked to an admission:		8,654
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):		7,192
Number of CY 2022 linked discharges eligible for this calculation (non-missing values):		7,149

Source: SAMHSA/CBHSQ TEDS CY 2022 admissions file and CY 2022 linked discharge file
[Records received through 2/1/2024]

Long-term Residential(LR)

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

	At Admission (T1)	At Discharge (T2)
Number of clients living in a stable situation [numerator]	5,427	5,335
Total number of clients with non-missing values on living arrangements [denominator]	5,991	5,991
Percent of clients in stable living situation	90.6%	89.1%
Notes (for this level of care):		
Number of CY 2022 admissions submitted:		7,908
Number of CY 2022 discharges submitted:		7,810
Number of CY 2022 discharges linked to an admission:		7,549
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):		6,069
Number of CY 2022 linked discharges eligible for this calculation (non-missing values):		5,991

Outpatient (OP)

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

	At Admission (T1)	At Discharge (T2)
Number of clients living in a stable situation [numerator]	12,959	12,959
Total number of clients with non-missing values on living arrangements [denominator]	13,372	13,372
Percent of clients in stable living situation	96.9%	96.9%
Notes (for this level of care):		
Number of CY 2022 admissions submitted:		27,153
Number of CY 2022 discharges submitted:		27,031
Number of CY 2022 discharges linked to an admission:		24,258
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):		13,665
Number of CY 2022 linked discharges eligible for this calculation (non-missing values):		13,372

Intensive Outpatient (IO)

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

	At Admission (T1)	At Discharge (T2)
Number of clients living in a stable situation [numerator]	11,381	11,411
Total number of clients with non-missing values on living arrangements [denominator]	12,125	12,125
Percent of clients in stable living situation	93.9%	94.1%
Notes (for this level of care):		
Number of CY 2022 admissions submitted:		21,159
Number of CY 2022 discharges submitted:		21,216
Number of CY 2022 discharges linked to an admission:		17,712
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):		12,678
Number of CY 2022 linked discharges eligible for this calculation (non-missing values):		12,125

Footnotes:

V: Performance Data and Outcomes

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

Short-term Residential(SR)

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

	At Admission(T1)	At Discharge(T2)
Number of Clients without arrests [numerator]	6,905	7,089
Total number of Admission and Discharge clients with non-missing values on arrests [denominator]	7,152	7,152
Percent of clients without arrests	96.5%	99.1%
Notes (for this level of care):		
Number of CY 2022 admissions submitted:		10,604
Number of CY 2022 discharges submitted:		10,473
Number of CY 2022 discharges linked to an admission:		8,654
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):		7,201
Number of CY 2022 linked discharges eligible for this calculation (non-missing values):		7,152

Source: SAMHSA/CBHSQ TEDS CY 2022 admissions file and CY 2022 linked discharge file
[Records received through 2/1/2024]

Long-term Residential(LR)

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

	At Admission(T1)	At Discharge(T2)
Number of Clients without arrests [numerator]	5,761	5,935
Total number of Admission and Discharge clients with non-missing values on arrests [denominator]	6,029	6,029
Percent of clients without arrests	95.6%	98.4%
Notes (for this level of care):		
Number of CY 2022 admissions submitted:		7,908
Number of CY 2022 discharges submitted:		7,810
Number of CY 2022 discharges linked to an admission:		7,549
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):		6,116

Number of CY 2022 linked discharges eligible for this calculation (non-missing values):	6,029
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Source: SAMHSA/CBHSQ TEDS CY 2022 admissions file and CY 2022 linked discharge file
[Records received through 2/1/2024]

Outpatient (OP)

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

	At Admission(T1)	At Discharge(T2)
Number of Clients without arrests [numerator]	13,296	13,282
Total number of Admission and Discharge clients with non-missing values on arrests [denominator]	13,587	13,587
Percent of clients without arrests	97.9%	97.8%
Notes (for this level of care):		
Number of CY 2022 admissions submitted:		27,153
Number of CY 2022 discharges submitted:		27,031
Number of CY 2022 discharges linked to an admission:		24,258
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):		13,934
Number of CY 2022 linked discharges eligible for this calculation (non-missing values):		13,587

Source: SAMHSA/CBHSQ TEDS CY 2022 admissions file and CY 2022 linked discharge file
[Records received through 2/1/2024]

Intensive Outpatient (IO)

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

	At Admission(T1)	At Discharge(T2)
Number of Clients without arrests [numerator]	11,958	12,027
Total number of Admission and Discharge clients with non-missing values on arrests [denominator]	12,387	12,387
Percent of clients without arrests	96.5%	97.1%
Notes (for this level of care):		
Number of CY 2022 admissions submitted:		21,159
Number of CY 2022 discharges submitted:		21,216
Number of CY 2022 discharges linked to an admission:		17,712
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):		12,975

Number of CY 2022 linked discharges eligible for this calculation (non-missing values):	12,387
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Source: SAMHSA/CBHSQ TEDS CY 2022 admissions file and CY 2022 linked discharge file
[Records received through 2/1/2024]

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Footnotes:

V: Performance Data and Outcomes

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

Short-term Residential(SR)

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

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

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol [numerator]	3,493	6,960
All clients with non-missing values on at least one substance/frequency of use [denominator]	6,964	6,964
Percent of clients abstinent from alcohol	50.2%	99.9%

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

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

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		3,468
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	3,471	
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T2 / #T1 x 100]		99.9%

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

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

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		3,492
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	3,493	
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T2 / #T1 x 100]		100.0%

Notes (for this level of care):

Number of CY 2022 admissions submitted:	10,604
Number of CY 2022 discharges submitted:	10,473
Number of CY 2022 discharges linked to an admission:	8,654
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	7,201
Number of CY 2022 linked discharges eligible for this calculation (non-missing values):	6,964

Long-term Residential(LR)

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

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

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol [numerator]	3,043	5,549
All clients with non-missing values on at least one substance/frequency of use [denominator]	5,590	5,590
Percent of clients abstinent from alcohol	54.4%	99.3%

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

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

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		2,523
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	2,547	
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T2 / #T1 x 100]		99.1%

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

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

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		3,026
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	3,043	
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T2 / #T1 x 100]		99.4%

Notes (for this level of care):

Number of CY 2022 admissions submitted:	7,908
Number of CY 2022 discharges submitted:	7,810
Number of CY 2022 discharges linked to an admission:	7,549
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	6,116
Number of CY 2022 linked discharges eligible for this calculation (non-missing values):	5,590

Outpatient (OP)

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

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

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol [numerator]	7,003	8,959
All clients with non-missing values on at least one substance/frequency of use [denominator]	10,003	10,003
Percent of clients abstinent from alcohol	70.0%	89.6%

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

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

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		2,412
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	3,000	
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T2 / #T1 x 100]		80.4%

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

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

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		6,547
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	7,003	
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T2 / #T1 x 100]		93.5%

Notes (for this level of care):

Number of CY 2022 admissions submitted:	27,153
Number of CY 2022 discharges submitted:	27,031
Number of CY 2022 discharges linked to an admission:	24,258
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	13,934
Number of CY 2022 linked discharges eligible for this calculation (non-missing values):	10,003

Source: SAMHSA/CBHSQ TEDS CY 2022 admissions file and CY 2022 linked discharge file
[Records received through 2/1/2024]

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

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

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol [numerator]	5,337	6,976
All clients with non-missing values on at least one substance/frequency of use [denominator]	8,167	8,167
Percent of clients abstinent from alcohol	65.3%	85.4%

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

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

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		2,039
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	2,830	
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T2 / #T1 x 100]		72.0%

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

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

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		4,937
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	5,337	
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T2 / #T1 x 100]		92.5%

Notes (for this level of care):

Number of CY 2022 admissions submitted:	21,159
Number of CY 2022 discharges submitted:	21,216
Number of CY 2022 discharges linked to an admission:	17,712
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	12,975
Number of CY 2022 linked discharges eligible for this calculation (non-missing values):	8,167

Source: SAMHSA/CBHSQ TEDS CY 2022 admissions file and CY 2022 linked discharge file
[Records received through 2/1/2024]

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Footnotes:

V: Performance Data and Outcomes

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

Short-term Residential(SR)

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

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

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs [numerator]	2,459	6,940
All clients with non-missing values on at least one substance/frequency of use [denominator]	6,964	6,964
Percent of clients abstinent from drugs	35.3%	99.7%

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

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

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator]		4,484
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	4,505	
Percent of clients abstinent from drugs at discharge among clients using Drug at admission [#T2 / #T1 x 100]		99.5%

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

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

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [numerator]		2,456
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	2,459	
Percent of clients abstinent from drugs at discharge among clients abstinent from Drug at admission [#T2 / #T1 x 100]		99.9%
Notes (for this level of care):		
Number of CY 2022 admissions submitted:		10,604
Number of CY 2022 discharges submitted:		10,473
Number of CY 2022 discharges linked to an admission:		8,654
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):		7,201
Number of CY 2022 linked discharges eligible for this calculation (non-missing values):		6,964

Long-term Residential(LR)

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

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

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs [numerator]	2,955	5,436
All clients with non-missing values on at least one substance/frequency of use [denominator]	5,590	5,590
Percent of clients abstinent from drugs	52.9%	97.2%

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

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

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator]		2,532
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	2,635	
Percent of clients abstinent from drugs at discharge among clients using Drug at admission [#T2 / #T1 x 100]		96.1%

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

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

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [numerator]		2,904
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	2,955	
Percent of clients abstinent from drugs at discharge among clients abstinent from Drug at admission [#T2 / #T1 x 100]		98.3%

Notes (for this level of care):

Number of CY 2022 admissions submitted:	7,908
Number of CY 2022 discharges submitted:	7,810
Number of CY 2022 discharges linked to an admission:	7,549
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	6,116
Number of CY 2022 linked discharges eligible for this calculation (non-missing values):	5,590

Outpatient (OP)

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

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

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs [numerator]	6,613	8,114
All clients with non-missing values on at least one substance/frequency of use [denominator]	10,003	10,003
Percent of clients abstinent from drugs	66.1%	81.1%

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

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

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator]		2,170
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	3,390	
Percent of clients abstinent from drugs at discharge among clients using Drug at admission [#T2 / #T1 x 100]		64.0%

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

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

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [numerator]		5,944
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	6,613	
Percent of clients abstinent from drugs at discharge among clients abstinent from Drug at admission [#T2 / #T1 x 100]		89.9%

Notes (for this level of care):

Number of CY 2022 admissions submitted:	27,153
Number of CY 2022 discharges submitted:	27,031
Number of CY 2022 discharges linked to an admission:	24,258
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	13,934
Number of CY 2022 linked discharges eligible for this calculation (non-missing values):	10,003

Source: SAMHSA/CBHSQ TEDS CY 2022 admissions file and CY 2022 linked discharge file
[Records received through 2/1/2024]

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

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

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs [numerator]	4,499	6,054
All clients with non-missing values on at least one substance/frequency of use [denominator]	8,167	8,167
Percent of clients abstinent from drugs	55.1%	74.1%

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

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

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator]		2,087
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	3,668	
Percent of clients abstinent from drugs at discharge among clients using Drug at admission [#T2 / #T1 x 100]		56.9%

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

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

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [numerator]		3,967
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	4,499	
Percent of clients abstinent from drugs at discharge among clients abstinent from Drug at admission [#T2 / #T1 x 100]		88.2%

Notes (for this level of care):

Number of CY 2022 admissions submitted:	21,159
Number of CY 2022 discharges submitted:	21,216
Number of CY 2022 discharges linked to an admission:	17,712
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	12,975
Number of CY 2022 linked discharges eligible for this calculation (non-missing values):	8,167

Source: SAMHSA/CBHSQ TEDS CY 2022 admissions file and CY 2022 linked discharge file
[Records received through 2/1/2024]

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Footnotes:

V: Performance Data and Outcomes

Table 19 – State Description of Social Support of Recovery Data Collection

Short-term Residential(SR)

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

	At Admission (T1)	At Discharge (T2)
Number of clients participating in self-help groups (AA NA meetings attended, etc.) [numerator]	1,300	5,405
Total number of Admission and Discharge clients with non-missing values on participation in self-help groups [denominator]	7,201	7,201
Percent of clients participating in self-help groups	18.1%	75.1%
Percent of clients with participation in self-help groups at discharge minus percent of clients with self-help attendance at admission Absolute Change [%T2-%T1]	57.0%	
Notes (for this level of care):		
Number of CY 2022 admissions submitted:	10,604	
Number of CY 2022 discharges submitted:	10,473	
Number of CY 2022 discharges linked to an admission:	8,654	
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	7,201	
Number of CY 2022 linked discharges eligible for this calculation (non-missing values):	7,201	

Source: SAMHSA/CBHSQ TEDS CY 2022 admissions file and CY 2022 linked discharge file
[Records received through 2/1/2024]

Long-term Residential(LR)

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

	At Admission (T1)	At Discharge (T2)
Number of clients participating in self-help groups (AA NA meetings attended, etc.) [numerator]	1,383	3,890
Total number of Admission and Discharge clients with non-missing values on participation in self-help groups [denominator]	6,113	6,113
Percent of clients participating in self-help groups	22.6%	63.6%
Percent of clients with participation in self-help groups at discharge minus percent of clients with self-help attendance at admission Absolute Change [%T2-%T1]	41.0%	
Notes (for this level of care):		
Number of CY 2022 admissions submitted:	7,908	
Number of CY 2022 discharges submitted:	7,810	

Number of CY 2022 discharges linked to an admission:	7,549
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	6,116
Number of CY 2022 linked discharges eligible for this calculation (non-missing values):	6,113

Source: SAMHSA/CBHSQ TEDS CY 2022 admissions file and CY 2022 linked discharge file
[Records received through 2/1/2024]

Outpatient (OP)

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

	At Admission (T1)	At Discharge (T2)
Number of clients participating in self-help groups (AA NA meetings attended, etc.) [numerator]	2,506	2,977
Total number of Admission and Discharge clients with non-missing values on participation in self-help groups [denominator]	13,903	13,903
Percent of clients participating in self-help groups	18.0%	21.4%
Percent of clients with participation in self-help groups at discharge minus percent of clients with self-help attendance at admission Absolute Change [%T2-%T1]	3.4%	
Notes (for this level of care):		
Number of CY 2022 admissions submitted:	27,153	
Number of CY 2022 discharges submitted:	27,031	
Number of CY 2022 discharges linked to an admission:	24,258	
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	13,934	
Number of CY 2022 linked discharges eligible for this calculation (non-missing values):	13,903	

Source: SAMHSA/CBHSQ TEDS CY 2022 admissions file and CY 2022 linked discharge file
[Records received through 2/1/2024]

Intensive Outpatient (IO)

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

	At Admission (T1)	At Discharge (T2)
Number of clients participating in self-help groups (AA NA meetings attended, etc.) [numerator]	2,942	3,353
Total number of Admission and Discharge clients with non-missing values on participation in self-help groups [denominator]	12,881	12,881
Percent of clients participating in self-help groups	22.8%	26.0%
Percent of clients with participation in self-help groups at discharge minus percent of clients with self-help attendance at admission Absolute Change [%T2-%T1]	3.2%	
Notes (for this level of care):		
Number of CY 2022 admissions submitted:	21,159	

Number of CY 2022 discharges submitted:	21,216
Number of CY 2022 discharges linked to an admission:	17,712
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	12,975
Number of CY 2022 linked discharges eligible for this calculation (non-missing values):	12,881

Source: SAMHSA/CBHSQ TEDS CY 2022 admissions file and CY 2022 linked discharge file
[Records received through 2/1/2024]

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Footnotes:

V: Performance Data and Outcomes

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

Level of Care	Average (Mean)	25 th Percentile	50 th Percentile (Median)	75 th Percentile
DETOXIFICATION (24-HOUR CARE)				
1. Hospital Inpatient	16	3	4	5
2. Free-Standing Residential	6	4	6	7
REHABILITATION/RESIDENTIAL				
3. Hospital Inpatient	156	6	8	110
4. Short-term (up to 30 days)	21	12	22	28
5. Long-term (over 30 days)	76	22	37	117
AMBULATORY (OUTPATIENT)				
6. Outpatient	123	47	88	148
7. Intensive Outpatient	93	29	60	111
8. Detoxification	44	9	25	43
OUD MEDICATION ASSISTED TREATMENT				
9. OUD Medication-Assisted Detoxification ¹	7	4	6	8
10. OUD Medication-Assisted Treatment Outpatient ²	197	44	108	269

Level of Care	2022 TEDS discharge record count	
	Discharges submitted	Discharges linked to an admission
DETOXIFICATION (24-HOUR CARE)		
1. Hospital Inpatient	49	37
2. Free-Standing Residential	16913	11652
REHABILITATION/RESIDENTIAL		
3. Hospital Inpatient	63	8
4. Short-term (up to 30 days)	10473	8654

5. Long-term (over 30 days)	7810	7549
AMBULATORY (OUTPATIENT)		
6. Outpatient	27031	13981
7. Intensive Outpatient	21216	17712
8. Detoxification	257	156
OUD MEDICATION ASSISTED TREATMENT		
9. OUD Medication-Assisted Detoxification ¹		3893
10. OUD Medication-Assisted Treatment Outpatient ²		10277

Source: SAMHSA/CBHSQ TEDS CY 2022 admissions file and CY 2022 linked discharge file
[Records received through 2/1/2024]

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

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

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Footnotes:

V: Performance Data and Outcomes

Table 21 – Substance Use Disorder Primary Prevention NOMs Domain: Reduced Morbidity – Abstinence from Drug Use/Alcohol Use Measure: 30-Day Use

A. Measure	B. Question/Response	C. Pre- populated Data	D. Approved Substitute Data
1. 30-day Alcohol Use	Source Survey Item: NSDUH Questionnaire. "Think specifically about the past 30 days, that is, from [DATEFILL] through today. During the past 30 days, on how many days did you drink one or more drinks of an alcoholic beverage?[Response option: Write in a number between 0 and 30.]" Outcome Reported: Percent who reported having used alcohol during the past 30 days.		
	Age 12 - 20 - CY 2020 - 2021		
	Age 21+ - CY 2020 - 2021		
2. 30-day Cigarette Use	Source Survey Item: NSDUH Questionnaire: "During the past 30 days, that is, since [DATEFILL], on how many days did you smoke part or all of a cigarette?[Response option: Write in a number between 0 and 30.]" Outcome Reported: Percent who reported having smoked a cigarette during the past 30 days.		
	Age 12 - 17 - CY 2020 - 2021		
	Age 18+ - CY 2020 - 2021		
3. 30-day Use of Other Tobacco Products	Survey Item: NSDUH Questionnaire: "During the past 30 days, that is, since [DATEFILL], on how many days did you use [other tobacco products] ^[1] ?[Response option: Write in a number between 0 and 30.]" Outcome Reported: Percent who reported having used a tobacco product other than cigarettes during the past 30 days, calculated by combining responses to questions about individual tobacco products (cigars, smokeless tobacco, pipe tobacco).		
	Age 12 - 17 - CY 2020 - 2021		
	Age 18+ - CY 2020 - 2021		
4. 30-day Use of Marijuana	Source Survey Item: NSDUH Questionnaire: "Think specifically about the past 30 days, from [DATEFILL] up to and including today. During the past 30 days, on how many days did you use marijuana or hashish?[Response option: Write in a number between 0 and 30.]" Outcome Reported: Percent who reported having used marijuana or hashish during the past 30 days.		
	Age 12 - 17 - CY 2020 - 2021		
	Age 18+ - CY 2020 - 2021		
5. 30-day Use of Illicit Drugs Other Than Marijuana	Source Survey Item: NSDUH Questionnaire: "Think specifically about the past 30 days, from [DATEFILL] up to and including today. During the past 30 days, on how many days did you use [any other illicit drug]? ^[2] " Outcome Reported: Percent who reported having used illicit drugs other than marijuana or hashish during the past 30 days, calculated by combining responses to questions about individual drugs (heroin, cocaine, hallucinogens, inhalants, methamphetamine, and misuse of prescription drugs).		
	Age 12 - 17 - CY 2020 - 2021		

[1]NSDUH asks separate questions for each tobacco product. The number provided combines responses to all questions about tobacco products other than cigarettes.

[2]NSDUH asks separate questions for each illicit drug. The number provided combines responses to all questions about illicit drugs other than marijuana or hashish.

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Footnotes:

V: Performance Data and Outcomes

Table 22 – Substance Use Disorder Primary Prevention NOMs Domain: Reduced Morbidity – Abstinence from Drug Use/Alcohol Use Measure: Perception of Risk/Harm of Use

A. Measure	B. Question/Response	C. Pre- populated Data	D. Approved Substitute Data
1. Perception of Risk From Alcohol	Source Survey Item: NSDUH Questionnaire: "How much do people risk harming themselves physically and in other ways when they have five or more drinks of an alcoholic beverage once or twice a week?[Response options: No risk, slight risk, moderate risk, great risk]" Outcome Reported: Percent reporting moderate or great risk.		
	Age 12 - 20 - CY 2020 - 2021		
	Age 21+ - CY 2020 - 2021		
2. Perception of Risk From Cigarettes	Source Survey Item: NSDUH Questionnaire: "How much do people risk harming themselves physically and in other ways when they smoke one or more packs of cigarettes per day?[Response options: No risk, slight risk, moderate risk, great risk]" Outcome Reported: Percent reporting moderate or great risk.		
	Age 12 - 17 - CY 2020 - 2021		
	Age 18+ - CY 2020 - 2021		
3. Perception of Risk From Marijuana	Source Survey Item: NSDUH Questionnaire: "How much do people risk harming themselves physically and in other ways when they smoke marijuana once or twice a week?[Response options: No risk, slight risk, moderate risk, great risk]" Outcome Reported: Percent reporting moderate or great risk.		
	Age 12 - 17 - CY 2020 - 2021		
	Age 18+ - CY 2020 - 2021		

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Table 23 – Substance Use Disorder Primary Prevention NOMs Domain: Reduced Morbidity – Abstinence from Drug Use/Alcohol Use Measure: Age of First Use

A. Measure	B. Question/Response	C. Pre- populated Data	D. Approved Substitute Data
1. Age at First Use of Alcohol	Source Survey Item: NSDUH Questionnaire: "Think about the first time you had a drink of an alcoholic beverage. How old were you the first time you had a drink of an alcoholic beverage? Please do not include any time when you only had a sip or two from a drink. [Response option: Write in age at first use.]" Outcome Reported: Average age at first use of alcohol.		
	Age 12 - 20 - CY 2020 - 2021		
	Age 21+ - CY 2020 - 2021		
2. Age at First Use of Cigarettes	Source Survey Item: NSDUH Questionnaire: "How old were you the first time you smoked part or all of a cigarette?[Response option: Write in age at first use.]" Outcome Reported: Average age at first use of cigarettes.		
	Age 12 - 17 - CY 2020 - 2021		
	Age 18+ - CY 2020 - 2021		
3. Age at First Use of Tobacco Products Other Than Cigarettes	Source Survey Item: NSDUH Questionnaire: "How old were you the first time you used [any other tobacco product] ^[1] ?[Response option: Write in age at first use.]" Outcome Reported: Average age at first use of tobacco products other than cigarettes.		
	Age 12 - 17 - CY 2020 - 2021		
	Age 18+ - CY 2020 - 2021		
4. Age at First Use of Marijuana or Hashish	Source Survey Item: NSDUH Questionnaire: "How old were you the first time you used marijuana or hashish?[Response option: Write in age at first use.]" Outcome Reported: Average age at first use of marijuana or hashish.		
	Age 12 - 17 - CY 2020 - 2021		
	Age 18+ - CY 2020 - 2021		
5. Age at First Use Heroin	Source Survey Item: NSDUH Questionnaire: "How old were you the first time you used heroin? [Response option: Write in age at first use.]" Outcome Reported: Average age at first use of heroin.		
	Age 12 - 17 - CY 2020 - 2021		
	Age 18+ - CY 2020 - 2021		
6. Age at First Misuse of Prescription Pain Relievers Among Past Year Initiates	Source Survey Item: NSDUH Questionnaire: "How old were you the first time you used [specific pain reliever] ^[2] in a way a doctor did not direct you to use it?"[Response option: Write in age at first use.]" Outcome Reported: Average age at first misuse of prescription pain relievers among those who first misused prescription pain relievers in the last 12 months.		

	Age 12 - 17 - CY 2020 - 2021		
	Age 18+ - CY 2020 - 2021		

[1]The question was asked about each tobacco product separately, and the youngest age at first use was taken as the measure.
[2]The question was asked about each drug in this category separately, and the youngest age at first use was taken as the measure.
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Table 24 – Substance Use Disorder Primary Prevention NOMs Domain: Reduced Morbidity – Abstinence from Drug Use/Alcohol Use Measure: Perception of Disapproval/Attitudes

A. Measure	B. Question/Response	C. Pre- populated Data	D. Approved Substitute Data
1. Disapproval of Cigarettes	Source Survey Item: NSDUH Questionnaire: "How do you feel about someone your age smoking one or more packs of cigarettes a day?[Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove]" Outcome Reported: Percent somewhat or strongly disapproving.		
	Age 12 - 17 - CY 2020 - 2021		
2. Perception of Peer Disapproval of Cigarettes	Source Survey Item: NSDUH Questionnaire: "How do you think your close friends would feel about you smoking one or more packs of cigarettes a day?[Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove]" Outcome Reported: Percent reporting that their friends would somewhat or strongly disapprove.		
	Age 12 - 17 - CY 2020 - 2021		
3. Disapproval of Using Marijuana Experimentally	Source Survey Item: NSDUH Questionnaire: "How do you feel about someone your age trying marijuana or hashish once or twice?[Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove]" Outcome Reported: Percent somewhat or strongly disapproving.		
	Age 12 - 17 - CY 2020 - 2021		
4. Disapproval of Using Marijuana Regularly	Source Survey Item: NSDUH Questionnaire: "How do you feel about someone your age using marijuana once a month or more?[Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove]" Outcome Reported: Percent somewhat or strongly disapproving.		
	Age 12 - 17 - CY 2020 - 2021		
5. Disapproval of Alcohol	Source Survey Item: NSDUH Questionnaire: "How do you feel about someone your age having one or two drinks of an alcoholic beverage nearly every day?[Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove]" Outcome Reported: Percent somewhat or strongly disapproving.		
	Age 12 - 20 - CY 2020 - 2021		

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Table 25 – Substance Use Disorder Prevention NOMs Domain: Reduced Morbidity – Abstinence from Drug Use/Alcohol Use
Measure: Perception of Workplace Policy

A. Measure	B. Question/Response	C. Pre- populated Data	D. Approved Substitute Data
Perception of Workplace Policy	Source Survey Item: NSDUH Questionnaire: "Would you be more or less likely to want to work for an employer that tests its employees for drug or alcohol use on a random basis? Would you say more likely, less likely, or would it make no difference to you?[Response options: More likely, less likely, would make no difference]" Outcome Reported: Percent reporting that they would be more likely to work for an employer conducting random drug and alcohol tests.		
	Age 15 - 17 - CY 2020 - 2021		
	Age 18+ - CY 2020 - 2021		

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

A. Measure	B. Question/Response	C. Pre- populated Data	D. Approved Substitute Data
Average Daily School Attendance Rate	Source: National Center for Education Statistics, Common Core of Data: <i>The National Public Education Finance Survey</i> available for download at http://nces.ed.gov/ccd/stfis.asp . Measure calculation: Average daily attendance (NCES defined) divided by total enrollment and multiplied by 100.		
	School Year 2020		

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

A. Measure	B. Question/Response	C. Pre- populated Data	D. Approved Substitute Data
Alcohol-Related Traffic Fatalities	Source: National Highway Traffic Safety Administration Fatality Analysis Reporting System Measure calculation: The number of alcohol-related traffic fatalities divided by the total number of traffic fatalities and multiplied by 100.		
	CY 2020	25.8	

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

A. Measure	B. Question/Response	C. Pre- populated Data	D. Approved Substitute Data
Alcohol- and Drug- Related Arrests	Source: Federal Bureau of Investigation Uniform Crime Reports Measure calculation: The number of alcohol- and drug-related arrests divided by the total number of arrests and multiplied by 100.		
	CY 2020	9.1	

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

A. Measure	B. Question/Response	C. Pre- populated Data	D. Approved Substitute Data
1. Family Communications Around Drug and Alcohol Use (Youth)	Source Survey Item: NSDUH Questionnaire: "Now think about the past 12 months, that is, from [DATEFILL] through today. During the past 12 months, have you talked with at least one of your parents about the dangers of tobacco, alcohol, or drug use? By parents, we mean either your biological parents, adoptive parents, stepparents, or adult guardians, whether or not they live with you." [Response options: Yes, No] Outcome Reported: Percent reporting having talked with a parent.		
	Age 12 - 17 - CY 2020 - 2021		
2. Family Communications Around Drug and Alcohol Use (Parents of children aged 12-17)	Source Survey Item: NSDUH Questionnaire: "During the past 12 months, how many times have you talked with your child about the dangers or problems associated with the use of tobacco, alcohol, or other drugs?" ^[1] [Response options: 0 times, 1 to 2 times, a few times, many times] Outcome Reported: Percent of parents reporting that they have talked to their child.		
	Age 18+ - CY 2020 - 2021		

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

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Table 30 – Substance Use Disorder Primary Prevention NOMs Domain: Retention Measure: Percentage of Youth Seeing, or Listening to a Prevention Message

A. Measure	B. Question/Response	C. Pre- populated Data	D. Approved Substitute Data
Exposure to Prevention Messages	Source Survey Item: NSDUH Questionnaire: "During the past 12 months, do you recall [hearing, reading, or watching an advertisement about the prevention of substance use] ^[1] ?" Outcome Reported: Percent reporting having been exposed to prevention message.		
	Age 12 - 17 - CY 2020 - 2021		

[1]This is a summary of four separate NSDUH questions each asking about a specific type of prevention message delivered within a specific context
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Reporting Period Start and End Dates for Information Reported on SUPTRS BG Tables 31, 32, 33, 34 and 35

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

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

Tables	A. Reporting Period Start Date	B. Reporting Period End Date
1. Table 31 – Substance Use Disorder Primary Prevention Individual-Based Programs and Strategies – Number of Persons Served by Age, Gender, Race, and Ethnicity	1/1/2021	12/31/2021
2. Table 32 – Substance Use Disorder Primary Prevention Population-Based Programs and Strategies – Number of Persons Served by Age, Gender, Race, and Ethnicity	1/1/2021	12/31/2021
3. Table 33 (Optional) – Substance Use Disorder Primary Prevention Number of Persons Served by Type of Intervention	1/1/2021	12/31/2021
4. Table 34 – Substance Use Disorder Primary Prevention Number of Evidence-Based Programs and Strategies by Type of Intervention	1/1/2021	12/31/2021
5. Table 35 – Total Substance Use Disorder Primary Prevention Number of Evidence Based Programs/Strategies and Total SUPTRS BG Dollars Spent on Substance Use Disorder Primary Prevention Evidence-Based Programs/Strategies	10/1/2020	9/30/2023

General Questions Regarding Prevention NOMS Reporting

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

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

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

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

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

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Table 31 – Substance Use Disorder Primary Prevention Individual-Based Programs and Strategies – Number of Persons Served by Age, Gender, Race, and Ethnicity

Category	Total
A. Age	196,000
0-5	15,092
6-12	78,400
13-17	29,400
18-20	21,560
21-24	8,624
25-44	23,520
45-64	7,275
65-74	3,060
75 and Over	5,882
Age Not Known	3,187
B. Gender	196,000
Male	104,500
Female	91,500
Trans man	0
Trans woman	0
Gender non-conforming	0
Other	0
C. Race	196,000
White	89,570
Black or African American	56,840
Native Hawaiian/Other Pacific Islander	1,875

Asian	9,825
American Indian/Alaska Native	650
More Than One Race (not OMB required)	11,760
Race Not Known or Other (not OMB required)	25,480
D. Ethnicity	196,000
Hispanic or Latino	62,990
Not Hispanic or Latino	115,640
Ethnicity Unknown	17,370

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

Category	Total
A. Age	612825
0-5	8900
6-12	51700
13-17	163000
18-20	52600
21-24	43000
25-44	112800
45-64	53850
65-74	61975
75 and Over	18000
Age Not Known	47000
B. Gender	612825
Male	263527
Female	245130
Trans man	0
Trans woman	0
Gender non-conforming	0
Other	104168
C. Race	612825
White	251259
Black or African American	113500
Native Hawaiian/Other Pacific Islander	7100

Asian	93200
American Indian/Alaska Native	1700
More Than One Race (not OMB required)	43066
Race Not Known or Other (not OMB required)	103000
D. Ethnicity	612825
Hispanic or Latino	140950
Not Hispanic or Latino	330926
Ethnicity Unknown	140949

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Table 33 (Optional) – Substance Use Disorder Primary Prevention Number of Persons Served by Type of Intervention

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

Intervention Type	A. Individual-Based Programs and Strategies	B. Population-Based Programs and Strategies
1. Universal Direct	142,000	N/A
2. Universal Indirect	N/A	\$612,825.00
3. Selective	31,000	N/A
4. Indicated	23,000	N/A
5. Total	196,000	\$612,825.00
Number of Persons Served ¹	196,000	612,825

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Table 34 – Substance Use Disorder Primary Prevention Number of Evidence-Based Programs and Strategies by Type of Intervention

Definition of Evidence-Based Programs and Strategies: The guidance document for the Strategic Prevention Framework State Incentive Grant, **Identifying and Selecting Evidence-based Interventions**, provides the following definition for evidence-based programs:

- Inclusion in a Federal List or Registry of evidence-based interventions
- Being reported (with positive effects) in a peer-reviewed journal
- Documentation of effectiveness based on the following guidelines:
 - Guideline 1:
The intervention is based on a theory of change that is documented in a clear logic or conceptual model; and
 - Guideline 2:
The intervention is similar in content and structure to interventions that appear in registries and/or the peer-reviewed literature; and
 - Guideline 3:
The intervention is supported by documentation that it has been effectively implemented in the past, and multiple times, in a manner attentive to Identifying and Selecting Evidence-Based Interventions scientific standards of evidence and with results that show a consistent pattern of credible and positive effects; and
 - Guideline 4:
The intervention is reviewed and deemed appropriate by a panel of informed prevention experts that includes: well-qualified prevention researchers who are experienced in evaluating prevention interventions similar to those under review; local prevention practitioners; and key community leaders as appropriate, e.g., officials from law enforcement and education sectors or elders within indigenous cultures.

1. Describe the process the State will use to implement the guidelines included in the above definition.

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

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

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

Table 34 - SUBSTANCE USE DISORDER PRIMARY PREVENTION Number of Evidence-Based Programs and Strategies by Type of Intervention

	A. Universal Direct	B. Universal Indirect	C. Universal Total	D. Selective	E. Indicated	F. Total
1. Number of Evidence-Based Programs and Strategies Funded	12	6	18	13	8	39
2. Total number of Programs and Strategies Funded	12	6	18	13	8	39
3. Percent of Evidence-Based Programs and Strategies	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

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Table 35 – Total Substance Use Disorder Primary Prevention Number of Evidence Based Programs/Strategies and Total SUPTRS BG Dollars Spent on Substance Use Disorder Primary Prevention Evidence-Based Programs/Strategies

	Total Number of Evidence-Based Programs/Strategies for IOM Category Below	Total Substance Use Block Grant Dollars Spent on evidence-based Programs/Strategies
Universal Direct	Total # 12	\$1,791,025.00
Universal Indirect	Total # 6	\$2,865,640.00
Selective	Total # 13	\$2,686,538.00
Indicated	Total # 8	\$1,611,923.00
Unspecified	Total # 0	
	Total EBPs: 39	Total Dollars Spent: \$8,955,126.00

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Prevention Attachments

Submission Uploads

FFY 2024 Prevention Attachment Category A:		
File	Version	Date Added

FFY 2024 Prevention Attachment Category B:		
File	Version	Date Added

FFY 2024 Prevention Attachment Category C:		
File	Version	Date Added

FFY 2024 Prevention Attachment Category D:		
File	Version	Date Added

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