

New Jersey

UNIFORM APPLICATION

FY 2026 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)

A: State Information

State Information

I. State Agency for the Block Grant

Agency Name State of New Jersey, Department of Human Services, Division of Mental Health and Addiction Services

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III. Expenditure Period

State Expenditure Period

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To 6/30/2025

Block Grant Expenditure Period

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Footnotes:

B: Annual Update

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

Priority #: 1

Priority Area: Pregnant Women/ Women with Dependent Children

Priority Type:

Population(s): PWWDC

Goal of the priority area:

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

Objective:

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

Strategies to attain the goal:

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

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

related deaths) were attributed to SUD occurring from day 43 postpartum to day 100. These deaths could have been prevented. Lack of continuity of care and/or proper care coordination was identified as the top contributing factor. Postpartum women with a history of SUD and co-occurring disorder are most vulnerable for relapse and should have access to resources that can help support her infant and families. Supporting maternal mental well-being strengthens not only mothers, parents and women but also their families and their communities. SAMHSA has prioritized addressing maternal mental health conditions and co-occurring SUD. The DMHAS Women's Services Coordinator submitted a successful application to the Center for Mental Health Services, Learning Collaborative: Maternal Mental Health and will be participating on this Learning Collaborative through August 2024. The goal is to build on existing policies including the MWRAP and IOT-SEI maternal child health pregnant and parenting persons initiatives to improve access to services and reduce barriers to care.

- The DMHAS Women's Services Coordinator represents DMHAS on the Maternal and Child Health Policy Innovation Program (MCH PIP) Alumni Policy Academy from August 2023 through April 2024 convened by National Academy for State Health Policy (NASHP) with support from the Health Resources and Services Administration, Maternal and Child Health Bureau (HRSA-MCH). NJ Medicaid, DOH, DHS and DCF are state partners on the MCH PIP with NJ Medicaid as the lead state agency. The overall goal is to improve maternal health outcomes by addressing SDOH-related barriers (e.g., transportation, child care, language/low literacy, discrimination) to accessing maternity care; effective referral processes for health-related social needs of pregnant and parenting persons. DMHAS maternal child health initiatives (IOT-SEI and MWRAP) provide intensive case management, recovery supports, and specialty services to assist pregnant and parenting persons with SUD and co-occurring to access care, address barriers and SDOH to help improve maternal health outcomes.
- Integrated Opioid Treatment and Substance Exposed Infants (IOT-SEI) Initiative. Five awards across the State, funded with the Governor's State Opioid funds. This Initiative provides an array of integrated services for opioid dependent pregnant women, their infants and family. Providers are required to ensure a full continuum of services and to establish mechanisms to develop a coordinated and cohesive approach for working together across systems that include, SUD treatment, medical community, maternal child health, and child welfare. Initiative focuses on alleviating barriers to services. Services range from: mother's medical/prenatal and obstetrical care, SUD treatment for OUD including MAT, new born/infant medical care, child welfare services as identified, intensive case management, recovery supports, assistance with housing, case management and other wraparound services. Providers must ensure that there is comprehensive care coordination from prenatal through the birth event, postpartum, and early childhood.
- Data Collection (MWRAP and IOT-SEI). DMHAS Researcher is collecting and analyzing data to understand the impact of each program on outcomes for the mother and her child, to evaluate program effectiveness, make recommendations for program improvement and sustainability. COVID-19 specific data was collected starting July 2020. The purpose of the data was to understand how individual participants were affected and what specific steps were taken to address COVID-19 related challenges. Data collected included the impact of social determinants of health on health outcomes in the time of COVID-19 such as housing, transportation and healthcare.
- Supportive Housing. DMHAS developed a Women's Intensive Supportive Housing (WISH) Program. WISH provides permanent supportive housing for pregnant and/or parenting women with a co-existing substance abuse disorder and mental illness who are homeless or at risk of homelessness and being discharged from a licensed long-term residential substance abuse treatment and/or halfway house facility. An RFP was developed and released in January 2015 for the development of a WISH team to provide case management and supportive housing services for 10 women and their children. The RFP was awarded in 2015 to a licensed treatment provider who specializes in women's gender specific treatment, offers a continuum of care, and has a longstanding history of providing supportive housing and has demonstrated success in managing permanent supportive housing programs. Since 2014, DMHAS has a Memorandum of Understanding (MOU) with NJ DCF, DCP&P to fund ten (10) supportive housing subsidies annually for the "Keeping Families Together" (KFT) program for parents involved with the child welfare system who are homeless or at imminent risk and in which one or more adults in the family is diagnosed with a co-occurring mental health illness and substance use disorder. DCP&P contracts with a provider for the KFT program in Essex County.
- Sober Living. New Jersey contracts with Oxford House Inc. which has dedicated women's homes and women with children homes. The contract has been expanded to develop additional homes for special populations including women with children. Women and Children Oxford Houses are required to provide lockboxes to each for medication storage. Residents in Oxford Houses is responsible for their individual medication lock boxes. Outreach staff conduct annual training (Overdose Specific) at each Chapter meeting at the annual state workshop. Currently, there are 14 Oxford House Chapters throughout the state. This is in response to the heroin overdose epidemic in the state of New Jersey and its effects related to Oxford House. Each home is required to maintain Naloxone kits on site. In 2022 Oxford House continued to see an increase in members applying for membership with OUD. This increase created a more significant need for naloxone training and information on access to Medical Assisted Recovery (MAR) options. The New Jersey Oxford House outreach team continues to educate members on MAR and the importance of being an active member of their recovery community.
- Systems Collaboration PPW. Twelve (12) of New Jersey's 21 counties continue to have monthly DCP&P Child Welfare Substance Use Disorder Consortia meetings which have moved to virtual meetings. Child welfare staff, DMHAS, Division of Family Development, Substance Use Disorder Provider Agencies, Work First New Jersey, Substance Abuse Initiative (WFNJ SAI) providers, and Boards of Social Services meet each month and plan on how to better serve families, leading to more effective policies and practices to meet the needs of infants, children and families. The Consortia also addresses ASFA timelines, Plans of Safe Care, and reunification for children in out of home placement. Through collaboration, multiple agencies working with the same family can improve communication to reduce the gaps in service delivery and improve coordination of services. The Consortia allow for cross systems collaboration with local treatment programs and other community partners who can provide the expertise needed to better serve families in the child welfare system.
- Advertising Campaign. New Jersey continues its statewide advertising campaign centered around opioid use and bringing public awareness to call ReachNJ, the 24/7 Addiction Hotline, for treatment. New messaging, beginning in August 2022, has added pregnant women, along with student athletes and older adults, as target groups. This is a statewide campaign that utilizes television and radio advertisements, bus wraps, billboards and social media to encourage New Jerseyans to access treatment. Recently the TV ad aired on NBC during the Macy's Thanksgiving Day Parade and later that evening during an NFL football game.

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

Edit Strategies to attain the objective here (if needed): Continuum of Care and Women's Services: Contracted providers are required to provide continuum of care services ranging from prevention, treatment and recovery supports. March 2024, the NJ DMHAS Office of Treatment and Recovery Supports hosted trainings to the treatment and maternal child health providers on Improving Clinical Recovery Services for Pregnant and Parenting People. The training was supported by SAMHSA's State Program Improvement Technical Assistance (TA) Project and provided by SAMHSA's State TA provider, JBS International. The two-part virtual sessions included "Family Centered Treatment and Trauma Informed Care including Stigma Education". Extension for Community Healthcare Outcomes (ECHO) and Maternal Child Health: DMHAS Office of Treatment and Recovery Supports has a Memorandum of Agreement (MOA) with Rutgers Robert Wood Johnson Medical School, Office of Community Health to provide ECHO technical assistance and training. The ECHO series

"Maternal Child Health Pregnant and Parenting Women with Opioid Use Disorder (MCH PPW-OUD) started January 2020 through December 31, 2021. The MCH PPW-OUD ECHO provides education and training to primary care practitioners, SUD treatment providers, behavioral health practitioners, and other stakeholders in clinic settings and at home, utilizing a web-based video collaboration between a multi-disciplinary team of specialists and primary care practitioners on best practices for the assessment, case management, intervention, treatment and recovery support services for PPW with an OUD. The ECHO goal is to increase the capacity and competency of behavioral health providers, community support organizations, medical community, and child welfare to support prevention, treatment, and recovery of pregnant and parenting persons with OUD and other substances. ECHO positions communities to reduce the NAS birth rates, improve use of medication assisted treatment, family formation and early infant development; improve access to physical and mental health care by educating more providers, midwives, doulas, and other health care professionals on best practices during prenatal and perinatal periods. The MOA was extended several times in order to continue technical assistance, including education and training. The most recent extension is from October 2023 through September 2025. This ECHO series held evening sessions in an effort to reach out to practitioners and prescribers, with sessions focused on the latest FDA approved techniques for Medication Assisted Treatment (MAT), integrated care, and wraparound services, stigma of mental health and substance use, screening protocols, improving access to substance use treatment, Plans of Safe Care, and coordinated care for pregnant persons with OUD and their newborns. The new series which started January 2024 through August 2024 includes 18 sessions with five (5) community workshops and another 18 sessions with five (5) community education workshops through August 2025. The community education workshops focus on educating the target audience on referral and linkages between providers, practitioners, and community services to support pregnant and parenting persons and their family. These series focus on maternal opioid intervention and care coordination. Didactic topics with the 18 sessions range from integrative approach to care for pregnant persons; bridging the gap from patient to plan; implementation that is meaningful and impactful; prenatal care with an opioid/substance use disorder; addressing stigma; perinatal depression; navigating the system to maximize successful family formation, the role of racism in maternal child health, etc. Maternal Wrap Around Program (MWRAP): MWRAP is a statewide initiative that provides intensive case management and recovery support services for pregnant women with SUD during pregnancy and up to one year after the birth event. Intensive case management focuses on developing a single, coordinated care plan for pregnant/postpartum women, their infants and families. Intensive Case Managers work as liaisons to all relevant entities involved with each woman. The Recovery Support Specialists provide non-clinical assistance and recovery supports while maintaining follow-up with the women and their infants. The overall goal of the MWRAP is to alleviate barriers to services through comprehensive care coordination that is implemented within the five major timeframes when intervention in the life of the substance exposed infants (SEI) can reduce potential harm of prenatal substance exposure: pre-pregnancy, prenatal, birth, neonatal and early childhood. MWRAP is intended to promote maternal health, improve birth outcomes, and reduce the risks and adverse consequences of prenatal substance exposure. Each MWRAP region is required to provide services to sixty (60) unduplicated women, a total of 420 unduplicated women. Maternal Mental Health and SUD: Nurture NJ focuses on improving collaboration and programming between Departments, agencies and stakeholders to achieve its goal to make NJ the safest place in the country to give birth and raise a baby. Nurture NJ wants to ensure that all women are healthy and have access to care before pregnancy and is a high quality equitable system of care with services from prenatal to postpartum provided in a supportive community environment. The New Jersey Division of Mental Health and Addiction Services (DMHAS) submitted a successful application. Areas of focus included: building the existing integrated behavioral healthcare collaborations to address mental health issues and SUD for pregnant and parenting persons; strengthen coordinated care; improve continuity of care and linkages; identify barriers to care; expand state capacity to address social determinants of health (SDOH) needs that impact perinatal and postpartum populations (e.g. housing, employment, legal, food security, etc.); address stigma and racial disparities, improve access to services; and build on the existing practices and current initiatives. New Jersey's application cited data from the New Jersey Maternal Mortality Report (2016-2018) where the New Jersey Maternal Mortality Review Committee (NJMMRC) identified a total of 125 pregnancy-associated deaths that have a temporal relationship to pregnancy (within 365 days). Of the 125 pregnancy-associated deaths, 44 (35%) were pregnancy-related, 74 (59%) were pregnancy-associated (not related deaths) were attributed to SUD occurring from day 43 postpartum to day 100. These deaths could have been prevented. Lack of continuity of care and/or proper care coordination was identified as the top contributing factor. Postpartum women with a history of SUD and co-occurring disorder are most vulnerable for relapse and should have access to resources that can help support her infant and families. Supporting maternal mental well-being strengthens not only mothers, parents and women but also their families and their communities. SAMHSA has prioritized addressing maternal mental health conditions and co-occurring SUD. The DMHAS Women's Services Coordinator submitted a successful application to the Center for Mental Health Services, Learning Collaborative: Maternal Mental Health and will be participating on this Learning Collaborative through August 2024. The goal is to build on existing policies including the MWRAP and IOT-SEI maternal child health pregnant and parenting women's initiatives to improve access to services and reduce barriers to care. The DMHAS LC goal was to improve collaboration and care coordination around mental health and SUD prenatally through postpartum, up to one year after the birth event. The New Jersey case challenge was important because the contributing factors in the majority of preventable, pregnancy associated, not related deaths included: limited access to services, barriers to care, lack of continuity of care and coordination, complications from SUD and mental health conditions, stigma, and racial disparities. Maternal Mental Health Learning Collaborative Report and Activities: January, 2024 SAMHSA's Center for Mental Health Services (CMHS) invited all states and territories to apply for the Maternal Mental Health LC, a competitive process where only eight (8) states/territories would be selected. The New Jersey Division of Mental Health and Addiction Services (DMHAS) submitted a successful application. Areas of focus included: building the existing integrated behavioral healthcare collaborations to address mental health issues and SUD for pregnant and parenting persons; strengthen coordinated care; improve continuity of care and linkages; identify barriers to care; expand state capacity to address social determinants of health (SDOH) needs that impact perinatal and postpartum populations (e.g. housing, employment, legal, food security, etc.); address stigma and racial disparities, improve access to services; and build on the existing practices and current initiatives March 2024, the New Jersey DMHAS LC team attended an in-person kickoff meeting at SAMHSA facilitated by SAMHSA's state technical assistance team. Subsequent meetings were held monthly through virtual sessions and conclude September 2024. The Maternal Mental Health LC states/territories were required to present a case challenge on how to improve their state maternal mental health services. Additional presentations were provided by subject matter experts and federal agencies. Topics included: Stigma and Engagement; Access & Integrated Care; Implementation of Evidence-Based Practices/Dissemination of Research; Perinatal Supports; Funding/Reimbursement. State/territory awardees through the multi-session meetings were able to share and learn culturally relevant best practices and evidence-based, evidence-informed, and promising approaches to promote and support maternal mental health and SUD. The DMHAS LC goal was to improve collaboration and care coordination around mental health and SUD prenatally through postpartum, up to one year after the birth event. The New Jersey case challenge was important because the contributing factors in the majority of preventable, pregnancy associated, not related deaths included: limited access to services, barriers to care, lack of continuity of care and coordination, complications from SUD and mental health conditions, stigma, and racial disparities. The DMHAS LC team used data from three sources for their case challenge: New Jersey Substance Abuse Monitoring System (NJSAMS); Maternal Wrap Around Program (MWRAP) and the

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Integrated Opioid Treatment and Substance Exposed Infants (IOT-SEI) Initiatives. MWRAP and IOT-SEI are special initiatives that focus on maternal child health. MWRAP combines intensive case management, wraparound services, and peer recovery supports for pregnant/postpartum persons with a SUD during pregnancy and up to one year after birth. IOT-SEI provides an array of integrated services that focuses on alleviating barriers to services ranging from: mother’s medical/prenatal and obstetrical care, SUD treatment for OUD including MAT, mental health services, new born/infant medical care, child welfare services as identified, intensive case management, recovery supports, assistance with housing, case management and other wraparound services. Both initiatives are intended to promote maternal health, improve birth outcomes, and reduce the risks and adverse consequences of prenatal substance exposure. The three (3) data sources capture pregnant persons and co-occurring disorders. The MWRAP and IOT-SEI state fiscal year data for 2023 respectively indicated for MWRAP – 70% or 139 pregnant individuals had co-occurring mental health conditions with a 100% referral rate for mental health treatment; IOT-SEI state fiscal year data for 2023 indicated 69% or 72 individuals presented with co-occurring mental health conditions with a 100% referral rate for mental health treatment. NJSAMS pregnant persons treatment admissions with co-occurring disorder indicated calendar year 2021 (n = 423) or (67%); calendar year 2022 (n = 413) or 66.4%; calendar year 2023 (n = 261) or 63%. As a result of the DMHAS LC several changes are currently underway to improve access to care, reduce barriers and expand state capacity for pregnant and parenting persons with SUD and mental health issues. New Jersey submitted a successful application for In-Depth Technical Assistance (IDTA): “Advancing Collaborative Practice and Policy: Promoting Healthy Development and Family Recovery for Infants, Children, Parents, and Caregivers Affected by Prenatal Substance Exposure”, through the National Center on Substance Abuse and Child Welfare (NCSACW). Goals established included: conduct a statewide landscape analysis of resources targeted at individuals and the families of individuals with SUD; establish a comprehensive and seamless system of care among state agencies, healthcare providers, and community level and non-profit organizations to address SUD during and after pregnancy; increase the percentage of prenatal Plans of Safe Care that community partners develop; and develop and update protocols and policies that aim to prevent neonatal abstinence syndrome (NAS), substance exposed infants (SEI) and SUD to implement care coordination through the New Jersey Plans of Safe Care model. The IDTA team is a diverse group that includes state representatives from Departments of Human Services (DMHAS and Medicaid), Children and Families, and Health, the Governor’s Office, representatives from the Maternal Child Health Consortia (MCHC), NCSACW, stakeholders, a Person with Lived Experience, New Jersey Quality Health Care Institute (NJQHCI), New Jersey Maternal and Infant Health Innovation Center, and other community partners who work with the perinatal population. Objectives from the Maternal Mental Health LC will be integrated into the IDTA action plan to increase collaborations among stakeholders, community, and perinatal workforce for pregnant and parenting persons with SUD and mental health issues. The overall IDTA goal is to improve collaboration, care coordination around SUD and mental health from pregnancy through postpartum, up to one year after the birth event and into early childhood. Currently, planning is underway between DMHAS and the New Jersey Department of Children and Families (DCF) to expand the current infrastructure to build the prenatal pathway for SUD and mental health concerns by including the statewide MWRAP initiative in the Connecting NJ (CNJ) system. Connecting NJ is a county level single point of entry (via telephone) for pregnant people county-based, that simplifies and streamlines the referral process for obstetrical and prenatal care providers, community agencies, and families. The goal is to increase referrals to support the intersection of SUD and mental health perinatally resulting in improved integration with community based behavioral health resources. Since MWRAP services are provided during pregnancy and up to one year after the birth event, MWRAP should provide the supports to help mom sustain a healthy recovery, reduce relapse rates, and overdoses, including death. DMHAS collaborated with NJ DCF Division of Child Protection and Permanency (DCPP) case practice lead, to develop a Prenatal Pathway with SUD concerns. If a pregnant person has a positive screen for illegal substances prenatally or has substance misuse and does not have any other children in their care, and a call comes into the DCF State Central Registry system, known as SCR, that registry will generate referrals to the county-based MWRAPS. DMHAS participated on the Maternal and Child Health Policy Innovation Program (MCH PIP) Alumni Policy Academy from August 2023 through April 2024 convened by the National Academy for State Health Policy (NASHP) with support from the Health Resources and Services Administration, Maternal and Child Health Bureau (HRSA-MCH). State partners include Department of Human Services with Medicaid as the lead agency, DMHAS and representatives from the Departments of Health and Children and Families. The overall goal is to improve maternal health outcomes by addressing SDOH related barriers to accessing maternity care. DMHAS MWRAP and IOT-SEI are initiatives that provide the intensive case management, recovery supports and specialty services to assist pregnant and parenting persons with SUD and co-occurring to access care, address barriers and SDOH. Recognizing that some contributing factors among pregnancy associated, but not related cases for mental health and SUD can be lack of provider knowledge, DMHAS has increased efforts to educate the perinatal workforce, medical community, and the behavioral health providers on services, resources and best practices that can have a positive impact on maternal health. DHS through DMHAS provided funding to the New Jersey Quality Health Care Institute to partner with a provider to conduct statewide trainings to MWRAP staff and the perinatal workforce on Mental Health First Aid (MHFA) to raise awareness around the impact of perinatal mental health. The perinatal workforce is uniquely positioned to identify mental health symptoms early and intervene when needed on MHFA. The trainings focused on maternity-specific scenarios to teach participants how to assist pregnant and parenting persons experiencing mental health symptoms in crisis and non-crisis situations and intervene when needed. DMHAS will continue to support maternal mental well-being for pregnant and parenting persons with SUD and their families through collaborations with state systems, community partnerships, and other stakeholders. Lessons learned from the technical assistance provided through the Maternal Mental Health LC and the DMHAS case challenge will help to guide DMHAS to strengthen the current system. DMHAS anticipates to build a foundation where there is a seamless and integrated approach across all systems to reduce disparities, be sensitive to individual’s experiences, culture and community and reduce maternal mortality related to mental health and SUD in the postpartum period.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Increase the number of individuals receiving recovery support services in the Maternal Wraparound Program (MWRAP).
Baseline Measurement:	SFY 2023: 381 individuals received recovery support services in the Maternal Wraparound Program consisting of 111 mothers, 45 babies/birth, 40 children under 1 year old and 185 children 1-17 years old.
First-year target/outcome measurement:	Increase the number of individuals receiving MWRAP recovery support services in SFY 2024 by 1%.

Second-year target/outcome measurement: Increase the number of individuals receiving MWRAP recovery support services by another 1% by the end of SFY 2025. The change in SFY 2025 will be measured by calculating the percentage difference from SFY 2023 to SFY 2025.

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

Data Source:

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

New Data Source(if needed):

Description of Data:

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

New Description of Data:(if needed)

Data issues/caveats that affect outcome measures:

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

New Data issues/caveats that affect outcome measures:

Providers interactive program discussion showed that some data issues/caveats that affect outcome measures, which are being effectively addressed, include the following: • Referrals across services providers at all levels of care was strengthened • Advocacy on stigma was strengthened • Mechanism improved to reduce staff turnover/attrition

Report of Progress Toward Goal Attainment

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

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

How first year target was achieved (optional):

SFY 2024: 384 individuals received recovery support services in the Maternal Wraparound Program consisting of 125 mothers, 97 babies/birth, 28 children under 1 year old and 134 children 1-17 years old. The MWRAP target for SFY 2024 of 1% increase of 381 (SFY 2024 total client served 384) was achieved through strengthening referral, increased advocacy against stigma, and strengthening mechanism to reduce staff turnover and attrition.

Priority #: 2

Priority Area: Persons Who Inject Drugs (PWID)

Priority Type:

Population(s): PWID

Goal of the priority area:

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

Objective:

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

Strategies to attain the goal:

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

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

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

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

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Increase the percentage of PWID admissions for whom MAT is planned.
Baseline Measurement:	SFY 2023: MAT planned for 60% of PWID admissions.
First-year target/outcome measurement:	Maintain a minimum of 60% of PWID treatment admissions for whom MAT is planned .
Second-year target/outcome measurement:	Increase the percentage of PWID treatment admissions for whom MAT is planned by 2% from SFY 2024 by the end of SFY 2025. The change in SFY 2025 will be measured by calculating the percentage difference from SFY 2023 to SFY 2025.
New Second-year target/outcome measurement(if needed):	
Data Source:	The percentage of PWID for whom MAT is planned in SFY 2023 through SFY 2025 will be tracked by the SSA's New Jersey Substance Abuse Monitoring System (NJSAMS).
New Data Source(if needed):	
Description of Data:	All agencies licensed to provide substance use disorder treatment in New Jersey must report on NJSAMS, the SSA's real-time web-based client administrative data system. The system collects basic client demographic, financial, level of care and clinical information for every client. All national outcome measures (NOMS) are incorporated into the system. Outcome measures are linked to the client at admission and discharge.
New Description of Data:(if needed)	
Data issues/caveats that affect outcome measures:	Outcome measures are collected at a client's admission and discharge per the approach used with TEDS and not at different periods of time during the course of treatment.
New Data issues/caveats that affect outcome measures:	There is a decreased trend of heroin use as primary drug in recent years. DMHAS will monitor the trend in relation to its impact on our

outcome measure.

Report of Progress Toward Goal Attainment

First Year Target:



Achieved



Not Achieved (*if not achieved, explain why*)

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

How first year target was achieved (optional):

SFY 2024: MAT planned for 60% of PWID admissions.

Priority #:

3

Priority Area:

Heroin/Opioid Users

Priority Type:

Population(s):

Other

Goal of the priority area:

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

Objective:

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

Strategies to attain the goal:

- Public Awareness Campaign. Continue to utilize a public awareness campaign focusing on reducing stigma/discrimination for individuals with an OUD, family members and the public about the benefits of utilizing medications to support recovery for an Opioid Use Disorder (MOUD).
- Building Capacity Initiative. Initiative focuses on addressing challenges faced by both licensed mental health and substance use disorder programs that require start-up funds to increase their capacity to offer MAT, specifically buprenorphine to their clients. Contracted MH and SUD programs are expected to build capacity to offer MAT in compliance with all federal and New Jersey state regulations.
- Vivitrol Enhancement. DMHAS will continue the Vivitrol Enhancement through its Fee-for-Service (FFS) Network. This enhancement allows providers to be reimbursed for the provision of Vivitrol as well as other ancillary services in FFS initiatives. Licensed SUD agencies can be enrolled in the enhancement if have proper approval of policies and procedures from the Department of Health, Certificate of Need & Licensing (CN&L).
- Buprenorphine Enhancement. DMHAS will continue the Buprenorphine Enhancement, similar to the one created for Vivitrol, that reimburses FFS Network providers for the provision of buprenorphine at their agencies. Licensed SUD agencies are able to participate in the enhancement with proper approval (MAT Waiver) issued by CN&L.
- Jail MAT and Case Management Initiative. DMHAS collaborates with the State's 21 county jails that established MAT programs or enhanced existing MAT services for inmates. In addition, DMHAS works with county correctional facilities and have established justice involved re-entry services for detainees where case managers at county jails conduct intake assessments and establish pre-release plans for needed services in the community, which include linking individuals to community MAT services.
- American Society of Addiction Medicine Booklets. DMHAS will continue to provide a statewide distribution of American Society of Addiction Medicine (ASAM) booklets entitled "Opioid Addiction Treatment: A Guide for Patients, Families and Friends" which provide facts about treatment, including MAT as a best practice, and provides NJ-specific resources to accessing treatment and recovery services. These guides are provided in English, Spanish and Braille and goal is to provide in additional languages that are prevalent in New Jersey. In addition, DMHAS worked with the NJ Division of Deaf and Hard of Hearing (DDHH) to create a video link in American Sign Language (ASL).
- Community Training. DMHAS will continue its Memorandum of Agreement (MOA) with Rutgers University, Robert Wood Johnson Medical School for a train-the-trainer program on Medications for Opioid Use Disorder (MOUD), the opioid epidemic (specific to New Jersey) and concepts of SUD (specific to OUD) for a minimum of 40 graduate students at Rutgers University. This project will continue to educate, support, and mentor graduate students to give free educational talks, through use of PowerPoint presentations, to community businesses and organizations in efforts to reduce stigma/discrimination around medication to support an individual's recovery.
- Low Threshold Buprenorphine Induction at Harm Reduction Centers. Continue low threshold buprenorphine induction programming at all statewide Harm Reduction Centers (HRCs) while also continuing to encourage collaboration and affiliation agreements between the HRCs and substance use disorder agencies to ensure referral to comprehensive treatment programs, when clinically indicated.
- Expanded Hour Opioid Treatment Program. Continuance of an expanded hour Opioid Treatment Program (OTP) initiative which provides increased (i.e. evening) hours that are not typically provided in efforts to assist individuals with easier access to services/care.
- Cultural Competency Training and Practice for Opioid Treatment Providers. DMHAS contracts with a provider whose goal is to help narrow the treatment gap experienced by Black/African Americans (AA) who are diagnosed with opioid and stimulant use disorders and who are statistically less likely to receive or access services. Another significant goal of this initiative is to increase the prescribing of Medication for Opioid Use Disorders (MOUD) among the Black/AA community.
- Long-Term Residential Incentive Payment. A new innovation is paying long term residential providers for providing MAT to clients. Effective June 1, 2020, the Long-term Residential (LTR) reimbursement rate was increased, as well as the ability to pay for Medication Assisted Treatment (MAT) and MAT related services. On August 20, 2021, the Department of Health (DOH) issued Guidance 7-2021 that reported Long Term Residential (LTR) facilities do not need to seek approval from DOH to prescribe medication, other than Methadone, for the treatment of substance use disorders. As a result, effective October 15, 2021, the base rate for Long Term Residential [H0019HF] includes the MAT add-on of \$5.00 per unit and increased to \$152.60 per day inclusive of Room and Board. Beginning July 1, 2020, additional incentive payments became available for the utilization of MAT and MAT capacity in LTR. The incentive rate creates the capacity to prescribe and administer MAT, which minimally includes Buprenorphine, but also may include Naltrexone and other FDA-approved products for Opioid Use Disorder (OUD) and for Alcohol Use Disorder (AUD). The rates and incentives are structured as follows: 1. The increased base LTR per diem rate for treatment plus Room and Board. 2. When an LTR provider site has least 40% of eligible clients receiving an approved medication for treatment of an OUD or an AUD, the provider's

rate will increase by \$10.00 per unit of service. This incentive threshold applies to medications arranged for using an external provider (e.g., Methadone from an OTP; Buprenorphine from OBAT) and provided by the LTR Provider. 3. The LTR provider can bill for medications inclusive of administration costs in addition to the new rates. To qualify for the incentive rate, Medicaid and DMHAS will determine a 40% MAT utilization rate through NJSAMS reporting at client discharge. This benchmark is measured as those individuals who are medication-eligible who receive qualifying medications as reported in the NJSAMS Discharge data. The measurement will include all discharges, including duplicated and unduplicated individuals. The medications that qualify are FDA-approved for the treatment for OUD and AUD and are inclusive of Buprenorphine, Sublocade, Methadone, Naltrexone (for OUD), and Naltrexone for Disulfiram, Acamprosate (for AUD); note that, at a minimum, Buprenorphine must be provided to receive the incentive. The benchmark will be measured by site based on the overall data, initially every three months starting July 1, 2020 for fiscal year 2021 and then every six months thereafter, which continues today. The applicable incentive rate applies to all billed LTR units for the prospective period when the provider site meets the 40% benchmark incentive criteria.

- **MOUD Survey.** Vital Strategies is working with the DMHAS and has developed a survey on the use of MOUD to be sent to all licensed SUD providers. The goal is to better understand the utilization of MOUD by providers, if there is reluctance to use MOUD and identify what barriers exist. This information can inform DMHAS as to actions needed to promote the use of MOUD by providers.
- **DMHAS finalized a Memorandum of Agreement (MOA)** with the Rutgers Northern and Rowan Southern Centers of Excellence (COE) to provide technical assistance and training to the statewide county jails that participate in the County Correctional Facilities MAT and Case Management program.
- **Homeless Shelter Initiative.** DMHAS continues to increase access to buprenorphine and other ancillary services for individuals with a substance use disorder through current programming available at homeless shelters. Contracted providers will continue to develop the capacity to provide low threshold medication as well as other support services for individuals who reside or drop in at the shelters, linking them to treatment and recovery services, when appropriate.
- **Mobile Medication Units.** Providing services in convenient locations, specifically through existing and new mobile medication programming, in order to reduce barriers and engage individuals in care as easily as possible.
- **DMHAS worked with the Department of Health, Certificate of Need & Licensing (CN&L)** to eliminate the need for a MAT Waiver that was previously required at residential SUD treatment agencies.

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

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Increase the percentage of heroin/other opiate admissions for whom MAT was planned.
Baseline Measurement:	SFY 2023: MAT planned for 57% of heroin/other opiate admissions.
First-year target/outcome measurement:	Increase the percentage of heroin/other opiate admissions for whom MAT is planned by 1%.
Second-year target/outcome measurement:	Increase the percentage of heroin/other opiate admissions for whom MAT is planned by another 1%. The change in SFY 2025 will be measured by calculating the percentage difference from SFY 2023 to SFY 2025.

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

Data Source:

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

New Data Source(if needed):

Description of Data:

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

New Description of Data:(if needed)

Data issues/caveats that affect outcome measures:

None

New Data issues/caveats that affect outcome measures:

There is a decreased trend of heroin use as primary drug in recent years. DMHAS will monitor the trend in relation to its impact on our outcome measure.

Report of Progress Toward Goal Attainment

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

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

How first year target was achieved (optional):

SFY 2024: MAT planned for 58.8% of heroin/other opiate admissions. This is an increase of 1.8% from the baseline measurement.

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

Goal of the priority area:
TB (Persons with or at risk of tuberculosis who are receiving SUD treatment services)

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

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

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

Annual Performance Indicators to measure goal success

Indicator #: 1

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

Baseline Measurement: According to SFY 2023 Annual Site Monitoring Reports of DMHAS' SUPTRS Block Grant contracted agencies, 94% of the agencies that were monitored (34 of 36 agencies) were in compliance with offering every client a tuberculosis evaluation.

First-year target/outcome measurement: An increase of 3% above the baseline measure.

Second-year target/outcome measurement: An additional increase of 2% above the first-year target measure.

New Second-year target/outcome measurement(if needed): An increase of 3% above the first-year target measure.

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/outcome was not achieved, and changes proposed to meet target/outcome:
According to SFY 2024 Annual Site Monitoring Reports of DMHAS' SUPTRS Block Grant contracted agencies, 94% of the agencies that were monitored (16 of 17 agencies) were in compliance with offering every client a tuberculosis evaluation. There was no percentage difference in baseline measure. One agency was found to be not in compliance with 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 2025.

How first year target was achieved (optional):

Priority #: 5
Priority Area: Tobacco
Priority Type:
Population(s): PP

Goal of the priority area:

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

Objective:

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

Strategies to attain the goal:

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

Edit Strategies to attain the objective here:

(if needed)

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Past month tobacco product use (any) among persons aged 12 to 17.
Baseline Measurement:	According to 2021 NSDUH data, 1.97 percent of the target population reported tobacco product use (any) during the month prior to participating in the survey.
First-year target/outcome measurement:	A reduction of .10% below the baseline measure.
Second-year target/outcome measurement:	An additional reduction of .05% below the first year measure.
New Second-year target/outcome measurement(if needed):	An additional reduction of .02% below the first year measure.
Data Source:	2021 National Survey on Drug Use and Health: Model-Based Prevalence Estimates (50 States and the District of Columbia), Tobacco Product Use in the Past Month, by Age Group and State: Percentages, Annual Averages Based on 2021 NSDUH data for New Jersey.
New Data Source(if needed):	2021-2022 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
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/outcome was not achieved, and changes proposed to meet target/outcome:

According to 2021-2022 NSDUH data, 1.92 percent of the target population reported tobacco product use (any) during the month prior to participating in the survey. This is a reduction of .05 percent from baseline measure. Reason why target was not achieved, and changes proposed to meet target: The rate for tobacco use among persons age 12-17 in NJ is already extremely low. Recent prevention efforts focus on e-cigarettes and vaping as these issues are (unfortunately) far more prevalent than tobacco use among this population. However, effective January 2025, our prevention coalitions will conduct statewide outreach and education to vendors who sell tobacco products – to remind them that the sale of tobacco products to persons under 21 is illegal. Previously, this approach has been very effective in reducing useage rates among this population.

How first year target was achieved (optional):

Priority #: 6

Priority Area: Alcohol

Priority Type:

Population(s): PP

Goal of the priority area:

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

Objective:

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

Strategies to attain the goal:

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

Edit Strategies to attain the objective here:

(if needed)

Annual Performance Indicators to measure goal success

Indicator #: 1

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

Baseline Measurement: According to 2021 NSDUH data, 17.98 percent of the target population reported binge drinking during the month prior to participating in the survey.

First-year target/outcome measurement: A reduction of .50% 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):

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

New Data Source(if needed):

Alcohol Use and Binge Alcohol Use in the Past Month among Individuals Aged 12 to 20, by Age Group and State: Percentages, Annual Averages Based on 2021-2022 NSDUH data for New Jersey

Description of Data:

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

New Description of Data:(if needed)

Data issues/caveats that affect outcome measures:

None

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

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

How first year target was achieved (optional):

According to 2021 NSDUH data, 12.63 percent of the target population reported binge drinking during the month prior to participating in the survey. According to 2021-2022 NSDUH data, 9.13 percent of the target population reported binge drinking during the month prior to participating in the survey. This is a reduction of 3.5 percent from baseline measure .

Priority #: 7

Priority Area: Marijuana

Priority Type:

Population(s): PP

Goal of the priority area:

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

Objective:

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

Strategies to attain the goal:

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

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

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Marijuana Use in the Past Year by persons aged 12-17.
Baseline Measurement:	According to 2021 NSDUH data, 8.13 percent of the target population reported marijuana use during the year prior to participating in the survey.
First-year target/outcome measurement:	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 the most recent rate (11.17 percent) of the target population reporting marijuana use during the year prior to participating in the NSDUH survey.

Data Source:

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

New Data Source(if needed):

Marijuana Use in the Past Year, by Age Group and State: Percentages, Annual Averages Based on 2021-2022 NSDUH data for New Jersey

Description of Data:

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

New Description of Data(if needed)

Data issues/caveats that affect outcome measures:

None.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

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

According to 2021 NSDUH data, 8.13 percent of the target population reported marijuana use during the year prior to participating in the survey. According to 2021-2022 NSDUH data, 11.17 percent of the target population reported marijuana use during the year prior to participating in the survey. This is an increase of 3.04% above baseline measure. The sale of recreational marijuana in New Jersey was legalized in 2021. We are still determining how best to address the issue of marijuana use among youth. The number of dispensaries in the state increases monthly. As such, marijuana is more readily available. Our prevention coalitions focus on municipal-level ordinances, which, after being adopted locally, can be enacted at the state level. Such as: • Require marijuana packaging to be labeled with THC content and clear warnings, and be child-resistant and not appealing to youth; • Require age verification at points of entry and sale; • Prohibit marijuana advertisements that appeal to minors, are in locations where minors can be expected to be, and appear in media likely to be seen/heard by minors; • Prohibit marijuana products that appeal to youth; and Prohibit marijuana use in public spaces

How first year target was achieved (optional):

Priority #: 8

Priority Area: Prescription Drugs

Priority Type:

Population(s): PP

Goal of the priority area:

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

Objective:

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

Strategies to attain the goal:

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

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

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Opioid Prescriptions in New Jersey.

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

First-year target/outcome measurement: A reduction of .75% below the baseline measure.

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

New Second-year target/outcome measurement(if needed): An additional reduction of 1.5% below the baseline measure.

Data Source:

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

New Data Source(if needed):

New Jersey Prescription Monitoring Program (NJMPMP) Data 2012-2022 from the NJ Division of Consumer Affairs.

Description of Data:

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

New Description of Data(if needed)

New Jersey Prescription Monitoring Program (NJMPMP) Data 2012-2022 from the NJ Division of Consumer Affairs.

Data issues/caveats that affect outcome measures:

None

New Data issues/caveats that affect outcome measures:

NJ CARES data regarding opioid prescriptions written in 2022 and 2023 are not available. Therefore, NJ PMP data for opioid prescription rates per 100 people will be used instead.

Report of Progress Toward Goal Attainment

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

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

How first year target was achieved (optional):

NJ CARES data regarding opioid prescriptions written in 2022 and 2023 are not available. Therefore, NJ PMP data for opioid prescription rates per 100 people will be used instead. There has been a downward trend since 2016 (56.2) through 2022 (28.6). Rates have been: 2017 (49.7), 2018 (43.5), 2019 (39.1), 2020 (34.4), 2021 (32.6), and 2022 (28.6). Based upon data from the PMP regarding the number of opioid prescriptions, the downward trend indicates that this goal was achieved. Opioid prescription rate for 2022 is 28.6 per 100. This is a reduction of approximately 12% below baseline measure of 32.6 per 100 for 2021.

Priority #: 9

Priority Area: Heroin

Priority Type:

Population(s): PP

Goal of the priority area:

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

Objective:

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

Strategies to attain the goal:

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

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

Annual Performance Indicators to measure goal success

Indicator #: 1

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

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

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

Second-year target/outcome measurement: An additional increase of .05% above the first year measure

New Second-year target/outcome measurement(if needed): No change beyond the second-year rate of 57.20 percent of the target population reporting Perceptions of Great Risk from Trying Heroin Once or Twice.

Data Source:

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

New Data Source(if needed):

Description of Data:

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

New Description of Data(if needed)

Data issues/caveats that affect outcome measures:

None

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

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

According to 2021-2022 NSDUH data, 57.20 percent of the target population reported Perceptions of Great Risk from Trying Heroin Once or Twice. This is a decrease of 3.76% below baseline measure. In 2018 NJ-DMHAS implemented programs that focus specifically on the misuse of opioid pain relievers among adolescents. These programs were updated in 2022. One program addresses perceptions of risk and harm regarding the use of opioid analgesics by young athletes for sports-related injuries. The positive effects of these updated programs might not yet be reflected in 2021-2022 NSDUH data. The prevention coalitions will provide increased education in schools and community-based organizations.

How first year target was achieved (optional):

Priority #: 10

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

Priority Type: MHS

Population(s): SED

Goal of the priority area:

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

Objective:

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

Strategies to attain the goal:

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

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

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The percentage of PPC-enrolled pediatricians who have made at least one referral for a youth to receive PPC services and/or supports will increase.

Baseline Measurement: For FY22, 45% of pediatricians enrolled in the PPC made at least one referral for a youth to receive services or supports from the PPC.

First-year target/outcome measurement: For FY24, the rate of pediatricians enrolled in the PPC who made at least one referral for a youth to receive services or supports from the PPC will increase to 48%.

Second-year target/outcome measurement: For FY25, the rate of pediatricians enrolled in the PPC who made at least one referral for a youth to receive services or supports from the PPC will increase to 50%.

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

Data Source:
The New Jersey Pediatric Psychiatry Collaborative

New Data Source(if needed):

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

New Description of Data(if needed)

Data issues/caveats that affect outcome measures:
None.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

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

How first year target was achieved (optional):

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

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

How second year target was achieved:

Priority #: 11

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

Priority Type: MHS

Population(s): SED

Goal of the priority area:

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

Objective:

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

Strategies to attain the goal:

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

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

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: A cohort of clinicians will be trained in the Attachment, Regulation, and Competency (ARC) Model, a subset of whom will also be trained to provide ARC Model training to other clinicians.

Baseline Measurement: 0

First-year target/outcome measurement: 40 clinicians will be trained in the ARC Model.

Second-year target/outcome measurement: Of the 40 clinicians trained in year 1, 10 will be provided "train-the-trainer" training to ensure sustainable capacity building.

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

Data Source:
Internal Data

New Data Source(if needed):

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

New Description of Data:(if needed)

Data issues/caveats that affect outcome measures:
None.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

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

How first year target was achieved (optional):

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

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

How second year target was achieved:

Priority #: 12

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

Priority Type: MHS

Population(s): SED

Goal of the priority area:
To increase capacity for youth-serving agencies to support families with children ages 0 to 5.

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

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

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

Annual Performance Indicators to measure goal success

Indicator #: 1

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

Baseline Measurement: 0

First-year target/outcome measurement: 40 clinicians and supervisors will be engaged in the Clinical Practice Series in Infant / Early Childhood Mental Health training.

Second-year target/outcome measurement: 40 clinicians and supervisors will complete the Clinical Practice Series in Infant / Early Childhood Mental Health training.

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

Data Source:

Internal Data

New Data Source(if needed):

Description of Data:

the number of clinicians who successfully completed 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/outcome was not achieved, and changes proposed to meet target/outcome:

How first year target was achieved (optional):

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

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

How second year target was achieved:

Priority #: 13

Priority Area: Housing Services in Community Support Services

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

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

Objective:

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

Strategies to attain the goal:

Community Support Services (CSS) is a mental health rehabilitation service that assists the consumer in achieving mental health rehabilitative and recovery goals as identified in an individualized rehabilitation plan (IRP). CSS promotes community inclusion, housing stability, wellness, recovery, and resiliency. Consumers are expected to be full partners in identifying and directing the types of support activities that would be most helpful to maximize successful community living. This includes use of community mental health treatment, medical care, self-help, employment and rehabilitation services, and other community resources, as needed and appropriate. The adoption of CSS supports an individual's ability to successfully live in independent, lease-based housing (e.g. supportive housing). The SMHA will utilize a number of strategies to help attain the objective. 1. The Office of Planning, Research, Evaluation, Prevention and Olmstead works collaboratively with provider agencies, state hospital key personnel, DMHAS staff and other Divisions across

the state to implement an overall paradigm of community integration. 2. Continued use of the Individual Needs for Discharge Assessment (INDA) facilitates the treatment and discharge planning processes. The INDA serves as both an assessment tool geared toward evaluating needs or barriers that the consumer may face upon discharge and a mechanism by which to assign state hospital consumers to prospective community service providers. The INDA will be continually used by the SMHA to facilitate transition into the community and anticipate and address any barriers that may hinder or preclude placement within the community. 3. Separation of Housing and Services in service delivery has enabled consumers to choose a housing provider and a different service provider. Consumers are not required to use a particular provider, and their refusal to receive services will not impact their housing. This separation enables the SMHA to track expenditures, utilization, outcomes, and demands for services. 4. The Bed Enrollment Data System (BEDS)/Vacancy Tracking System was developed to help DMHAS manage and track vacancies. The system has replaced the process of cold calls to agencies and the utilization of quickly outdated paper tracking sheets. Utilization of a web-based system provides real-time access to vacancy information and helps facilitate assignments and avoid outdated spreadsheets. Analysis of the utilization of Supportive Housing vs. supervised settings (e.g. group homes and supervised apartments) allows for assessment of the Division's progress toward community integration. The system will also enable planning at both the individual consumer level for placement purposes and system-wide for purposes of enhancements in community resources. 5. Assignment Process - In May 2015, New Jersey DMHAS revised its Administrative Bulletin 5:11 directing engagements of consumers by community providers. Under this revision, assignments of consumers replaced the concept of referrals to community providers by hospital treatment teams, requiring providers to either accept the assigned consumer or communicate their needs to DMHAS for additional supports necessary to serving the assigned consumer. The goal of this new policy was the early familiarity of consumers and providers through mandatory provider participation in the discharge planning process and engagements such as recreational day trips; visits to prospective apartments for rent; discharge preparations; and overnight visits (upon request of the consumer and/or hospital treatment team). SMHA staff will monitor the continued development of new Supportive Housing opportunities. The BEDS data system will foster more timely and accurate tracking of residential resources, as well as facilitate their more efficient utilization (e.g., to reduce vacancy rates and increase community placements), and enable monitoring of compliance with Administrative Bulletin 5:11 (Residential Placement from Psychiatric Hospital).

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

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Consumers who remain in Community Support Services (CSS) during the fiscal year as a proportion of total consumers served in Community Support Services.
Baseline Measurement:	The total number of clients served in CSS in SFY 2022 was 5575. The total number of individuals terminated (including individuals who left voluntarily, agency-initiated terminations and individuals who transitioned to a different level of care or service) in SFY 2022 was 808. Therefore, the percentage of consumers who remain in Community Support Services is 85.5%
First-year target/outcome measurement:	The percentage of consumers who remain in Community Support Services during SFY 2024 will be no less than 88% of total consumers served in Community Support Services.
Second-year target/outcome measurement:	The percentage of consumers who remain in Community Support Services during SFY 2025 will be no less than 88% of total consumers served in Community Support Services.
New Second-year target/outcome measurement(if needed):	
Data Source:	The number of consumers served by Community Support Services is tracked by the SMHA's QCMR database starting SFY 2018.
New Data Source(if needed):	
Description of Data:	The QCMR Database collects quarterly, cumulative, program-specific data from each of the service providers contracted by DMHAS. The current QCMR for Community Support Services contains 50 data elements. The key data fields relevant for this performance indicator are "Ending Active Caseload (Last Day of Quarter)" and Number of terminations in the Quarter. In SFY 2022, 39 agencies contracted by the SMHA to provide QCMR data for Community Support Services.
New Description of Data:(if needed)	
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/outcome was not achieved, and changes proposed to meet target/outcome:

How first year target was achieved (optional):

Priority #: 14

Priority Area: Early Serious Mental Illness (ESMI)

Priority Type: MHS

Population(s): ESMI

Goal of the priority area:

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

Objective:

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

Strategies to attain the goal:

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

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

Annual Performance Indicators to measure goal success

Indicator #: 1

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

Baseline Measurement: In SFY 2022, 359 individuals were in the CSC programs. 317 of the 359 individuals were taking or in need of antipsychotic medication for the treatment of their psychosis at intake. 91% (289) of the 317 individuals were adherent to their medication regimen.

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

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

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

Data Source:

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

New Data Source(if needed):

Description of Data:

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

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

New Description of Data:(if needed)

Data issues/caveats that affect outcome measures:

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

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

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

How first year target was achieved (optional):

Priority #: 15

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

Priority Type:

Population(s): BHCS

Goal of the priority area:

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

Objective:

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

Strategies to attain the goal:

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

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

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	988 Suicide and Crisis Lifeline statewide answer rate percentage

Baseline Measurement:

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

First-year target/outcome measurement:

In SFY 2024, it is anticipated that at least 85% of calls coming into the 988 Suicide and Crisis Lifeline from NJ will be answered by a center in-state.

Second-year target/outcome measurement:

In SFY 2025, it is anticipated that at least 90% of calls coming into the 988 Suicide and Crisis Lifeline from NJ will be answered by a center in-state.

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

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

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

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

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

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

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target:

☐

Achieved

☐

Not Achieved *(if not achieved,explain why)*

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

How first year target was achieved (optional):

Footnotes:

Priority Areas #10 to #15 are not applicable to this Report.

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

Center for Substance Abuse Treatment

Division of State and Community Systems

State Systems Partnership Branch

**FY 21 SABG ARP COVID Testing and Mitigation Supplemental Funding:
FY 25 Annual Report**

**Substance Use Prevention, Treatment, and Recovery Services Block Grant
(SUPTRS BG)**

Report Expenditure Period: **October 1, 2024 - September 30, 2025**

Report Submission Due Date: **Wednesday, December 31, 2025**

Name of SUBG Grantee: New Jersey
Name of State, DC, Territory, Associated State, or Tribe

Submitted By: Susannah Combs
Name and Title of Individual Submitting Report

Date Submitted: 12/23/2025

**Total FY 21 SABG ARP COVID Testing and Mitigation Supplemental Funding
Amount Awarded to This Grantee in August, 2021:**

\$ \$1,382,714.00

Instructions: For the FFY 2025, ending on 9/30/25, please complete this FY 25 Annual Report form for the FY 25 expenditures from the FY 21 SABG ARP COVID Testing and Mitigation Supplemental Funding. Please upload as a Word or PDF document in Table 1 of the 2026 SUPTRS BG Report that was submitted on or before 12/1/25. Please report on the FY 21 SABG ARP COVID Testing and Mitigation Supplemental Funding activities and expenditures by Wednesday, December 31, 2025. The period of performance for this report is October 1, 2024 through September 30, 2025. For further information , please feel free to contact your CSAT SPO.

Details for SUPTRS BG Grantees: After completing the table above, grantees are requested to upload this report document through a regular WebBGAS Revision Request that will be created by your CSAT SPO, as an Attachment to [Table 1 Priority Area and Annual Performance Indicators – Progress Report](#), of the 2026 SUPTRS BG Report Submitted, as a Word or PDF document. Please submit no later than 11:59 pm EST, on Wednesday, December 31, 2025.

For the expenditure period of October 1, 2024 through September 30, 2025, please include a complete listing of the expenditure of FY 21 SABG ARP COVID Testing and Mitigation Supplemental Funding, by expenditure dates, items and activities of expenditure, and amounts of expenditures. If no funds were expended during this period, please complete and upload this report document indicating "Not Applicable". Please feel free to address any questions or concerns to your CSAT SPO. Thank you.

FY 21 SABG ARP COVID Testing and Mitigation Supplemental Funding: FY 25 Annual Report Table			
#	FY 25 Date of Expenditure	FY 25 Item/Activity Description for Expenditure Period of 10/01/24 through 09/30/25	FY 25 Amount of Expenditure
1	5/21/2025	COVID-19 Rapid Testing	\$248.00
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Total			\$248.00

Background and Description of Funding: On August 10, 2021 SAMHSA released guidance on one-time funding for awards authorized under the American Rescue Plan (ARP) Act of 2021 (P.L. 117-2) and Section 711 of the Social Security Act (42 U.S.C. 711(c)) for the targeted support necessary for mental health and substance use disorder treatment providers to overcome barriers towards achieving and maintaining high COVID-19 testing rates (commonly referred to as COVID Testing and Mitigation funds). The total overall expenditure period performance period for this funding is September 1, 2021 – September 30, 2025, though the expenditure period for the report above is for FY 24 only, from 10/1/23 through 9/30/24.

As indicated in your SABG Notice of Award of August 10, 2021, States, DC, US Territories, Freely Associated States, and the Red Lake Band of Chippewa Indians are required to submit an Annual Report by December 31 of each year, until the funds expire. Grantees must upload a report including activities and expenditures to Table 1 of the 2025 Substance Use Block Grant Report filed on or before 12/2/24. A Revision Request will be sent to grantees by the CSAT SPO to upload the report.

12/17/2025: SUPTRS BG Grantee WebBGAS Revision Request will be created by the CSAT SPO for the grantee upload of the FY 25 SABG ARP COVID Testing and Mitigation Supplemental Funding Annual Report, for the FY 25 expenditure period of October 1, 2024 through September 30, 2025. Using the FY 25 Annual Report form provided to grantees by the CSAT SPO, grantees are requested to upload an Attachment to **Table 1 Priority Area and Annual Performance Indicators – Progress Report**, 2026 SUPTRS Report Submitted, as a Word or PDF document by 11:59 pm EST, on Wednesday, December 31, 2025. Please provide a complete list of the expenditure dates, items and activities of expenditure, and amounts of expenditures, between October 1, 2024 and September 30, 2025. If no activities were completed, please complete and upload the report document indicating “Not Applicable”.

Summary of the August 10, 2021 Guidance Letter:

Excerpts from the August 10, 2021 guidance letter to Single State Authority Directors and State Mental Health Authority Commissioners from Miriam E. Delphin-Rittmon, Ph.D., Assistant Secretary for Mental Health and Substance Use, regarding the use of this funding in as follows:

“People with mental illness and substance use disorder are more likely to have co-morbid physical health issues like diabetes, cardiovascular disease, and obesity. Such chronic illnesses are associated with higher instances of contracting coronavirus disease (COVID-19) as well as higher risk of death or a poor outcome from an episode of COVID-19. To address this concern, the U.S. Department of Health and Human Services (HHS), through the Substance Abuse and Mental Health Services Administration (SAMHSA), will invest \$100 million dollars to expand dedicated testing and mitigation resources for people with mental health and substance use disorders.

As COVID-19 cases rise among unvaccinated people and where the more transmissible Delta virus variant is surging, this funding will expand activities to detect, diagnose, trace, and monitor infections and mitigate the spread of COVID-19 in homeless shelters, treatment and recovery facilities, domestic violence shelters and federal, state and local correctional facilities—some of the most impacted and highest risk communities across the country. These funds will provide resources

and flexibility for states to prevent, prepare for, and respond to the COVID-19 public health emergency and ensure the continuity of services to support individuals connected to the behavioral health system.

This one-time funding for awards was authorized under the American Rescue Plan (ARP) Act of 2021 (P.L. 117-2) and Section 711 of the Social Security Act (42 U.S.C. 711(c)). SAMHSA will supplement the ARP funding for state grantees. The performance period for this funding is September 1, 2021 – September 30, 2025.

Targeted support is necessary for mental health and substance use treatment providers to overcome barriers towards achieving and maintaining high COVID-19 testing rates. From the provider perspective, these barriers include limited financial and personnel resources to support ongoing testing efforts. Providers have limited staff and physical resources and COVID-19 testing activities must be balanced against COVID-19 vaccinations and other health care services. From the consumer perspective, these barriers include hesitancy in accepting vaccines and challenges with health care access. Recipients may allocate reasonable funds for the administrative management of these grants. SAMHSA envisions the maximum support possible for COVID-19 testing and mitigation; toward that goal, recipients are encouraged to expend a minimum of 85 percent of funding for allowable COVID-19 testing and mitigation activities.

The list below includes examples of allowable activities. While this list is not exhaustive, any activity not included on this list must be directly related to COVID-19 testing and mitigation. All recipients are strongly encouraged to work with state or local health departments to coordinate activities. The state must demonstrate that the related expense is directly and reasonably related to the provision of COVID-19 testing or COVID-19 mitigation activities. The related expense must be consistent with relevant clinical and public health guidance. For additional examples, you can visit the CDC Community Mitigation Framework website. Funding may not be used for any activity related to vaccine purchase or distribution.

SAMHSA, through this supplemental funding, allocates \$50 million each for Mental Health Block Grant (MHBG) and Substance Abuse Prevention and Treatment Block grants (SABG) to the states. States have until September 30, 2025, to expend these funds. SAMHSA asks that states consider the following in developing a COVID-19 Mitigation Funding Plan:

- Coordinate and partner with state and local health departments/agencies on how to better align the state/provider mental health and substance use COVID-19 mitigation efforts and activities; develop guidance for partnering with state/local health departments; disseminating sample training curriculums.
- Testing education, establishment of alternate testing sites, test result processing, arranging for the processing of test results, and engaging in other activities within the CDC Community Mitigation Framework to address COVID-19 in rural communities.
- Rapid onsite COVID-19 testing and for facilitating access to testing services. Training and technical assistance on implementing rapid onsite COVID-19 testing and facilitating access to behavioral health services, including the development of onsite testing confidentiality policies; and implementing model program practices.
- Behavioral health services for those in short-term housing for people who are at high risk for COVID-19.

- Testing for staff and consumers in shelters, group homes, residential treatment facilities, day programs, and room and board programs. Purchase of resources for testing-related operating and administrative costs otherwise borne by these housing programs. Hire workers to coordinate resources, develop strategies and support existing community partners to prevent infectious disease transmission in these settings. States may use this funding to procure COVID-19 tests and other mitigation supplies such as handwashing stations, hand sanitizer and masks for people experiencing homelessness and for those living in congregate settings.
- Funds may be used to relieve the burden of financial costs for the administration of tests and the purchasing of supplies necessary for administration such as personal protective equipment (PPE); supporting mobile health units, particularly in medically underserved areas; and expanding local or tribal programs workforce to implement COVID-response services for those connected to the behavioral health system.
- Utilize networks and partners to promote awareness of the availability of funds, assist providers/programs with accessing funding, and assist with operationalizing the intent of said funding to ensure resources to mitigate the COVID-19 health impacts and reach the most underserved, under-resourced, and marginalized communities in need.
- Expanding local or tribal programs workforce to implement COVID-response services for those connected to the behavioral health system.
- Provide subawards to eligible entities for programs within the state that are designed to reduce the impact of substance abuse and mental illness; funding could be used for operating and administrative expenses of the facilities to provide onsite testing and mobile health services; and may be used to provide prevention services to prevent the spread of COVID-19.
- Develop and implement strategies to address consumer hesitancy around testing. Ensure access for specific community populations to address long-standing systemic health and social inequities that have put some consumers at increased risk of getting COVID-19 or having severe illness.
- Installing temporary structures, leasing of properties, and retrofitting facilities as necessary to support COVID-19 testing and COVID-19 mitigation.
- Education, rehabilitation, prevention, treatment, and support services for symptoms occurring after recovery from acute COVID-19 infection, including, but not limited to, support for activities of daily living.
- Other activities to support COVID-19 testing including planning for implementation of a COVID-19 testing program, hiring staff, procuring supplies to provide testing, training providers and staff on COVID-19 testing procedures, and reporting data to HHS on COVID-19 testing activities.
- Promote behaviors that prevent the spread of COVID-19 and other infectious diseases (healthy hygiene practices, stay at home when sick, practice physical distancing to lower the risk of disease spread, cloth face coverings, getting vaccinated).
- Maintain healthy environments (clean and disinfect, ensure ventilation systems operate properly, install physical barriers and guides to support social distancing if appropriate).
- Behavioral health services to staff working as contact tracers and other members of the COVID-related workforce. Maintain health operations for staff, including building measures to cope with employee stress and burnout.

- Investigate COVID-19 cases; the process of working with a consumer who has been diagnosed with COVID-19 and includes, but is not limited to:

- Discuss test result or diagnosis with consumers;
- Assess patient symptom history and health status;
- Provide instructions and support for self-isolation and symptom monitoring; and
- Identify people (contacts) who may have been exposed to COVID-19.

- Conduct contact tracing: the process of notifying people (contacts) of their potential exposure to SARS-CoV-2, the virus that causes COVID-19 and includes, but is not limited to:

- Provide information about the virus;
- Discuss their symptom history and other relevant health information; and
- Provide instructions for self-quarantine and monitoring for symptoms.

The following are ineligible costs for the purposes of this funding:

- Costs already paid for by other federal or state programs, other federal or state COVID-19 funds, or prior COVID-19 supplemental funding.
- Any activity related to purchasing, disseminating, or administering COVID-19 vaccines.
- Construction projects.
- Support of lobbying/advocacy efforts.
- Facility or land purchases.
- COVID-19 mitigation activities conducted prior to 9/1/2021.
- Financial assistance to an entity other than a public or nonprofit private entity.

C: 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 for primary prevention of substance use, treatment of SUD, and recovery support services for individuals with SUD. For detailed instructions, refer to those in the WebBGAS. Please note that this expenditure period is different from the reporting period on SUPTRS BG Table 4. The 2027 Report will not include COVID-19 or ARP Supplemental Funding, which expired in March 2025.

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

Activity	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, Medicare etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. COVID-19 ^a	I. ARP ^b
1. Substance Use Disorder Prevention ^c & Treatment	\$44,066,345.00		\$252,367,903.00	\$35,307,670.00	\$97,500,250.00	\$0.00	\$0.00	\$8,469,617.00	\$5,735,084.00
a. Pregnant Women and Women with Dependent Children (PWWDCC) ^d	\$5,986,385.00		\$0.00	\$0.00	\$1,508,109.00	\$0.00	\$0.00	\$786,731.00	\$291,121.00
b. All Other	\$38,079,960.00		\$252,367,903.00	\$35,307,670.00	\$95,992,141.00	\$0.00	\$0.00	\$7,682,886.00	\$5,443,963.00
2. Recovery Support Services ^e	\$5,044,014.00		\$0.00	\$10,649,770.00	\$14,564,505.00	\$0.00	\$0.00	\$0.00	\$960,999.00
3. Substance Use Primary Prevention ^f	\$12,170,637.00		\$0.00	\$8,821,855.00	\$1,494,595.00	\$0.00	\$0.00	\$2,936,774.00	\$1,626,593.00
4. Early Intervention Services Regarding the Human Immunodeficiency Virus (EIS/HIV) ^g	\$0.00		\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
5. Tuberculosis Services	\$0.00		\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
6. Other Capacity Building/Systems Development Activities	\$6,695,765.00		\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
7. State Hospital									
8. Other 24 Hour Care									
9. Ambulatory/Community Non-24 Hour Care									
10. Mental Health Primary Prevention									
11. Evidenced Based Practices for First Episode Psychosis (10% of the state's total MHBG award)									
12. Administration ^h	\$1,504,182.00		\$0.00	\$4,722,136.00	\$1,851,623.00	\$0.00	\$0.00	\$1,549,577.00	\$39,682.00
13. Total	\$69,480,943.00	\$0.00	\$252,367,903.00	\$59,501,431.00	\$115,410,973.00	\$0.00	\$0.00	\$12,955,968.00	\$8,362,358.00

Please indicate the expenditures are actual or estimated.

☒ Actual ☐ Estimated

^a Per the instructions, the reporting period is for the preceding 12-month period of the most recently completed SFY. Enter SUPTRS BG COVID-19 expenditures for the same one-year period. Note: COVID supplemental funds had an original award period of March 15, 2021 through March 14, 2023. States that were granted a second No Cost Extension (NCE) on March 14, 2024 had until March 14, 2025 to expend their COVID-19 supplemental funds. Those states expending supplemental funds under the second NCE are required to report expenditures made during SFY 2025, for most states that include expenditures between July 1, 2024 and March 14, 2025, in the COVID-19 designated column of the FY2026 Report.

^b Per the instructions, the reporting period is for the preceding 12-month period of the most recently completed SFY. Enter SUPTRS BG ARP expenditures for the same one-year period. Note: ARP supplemental funds had an award period of September 1, 2021 through March 24, 2025. States are required to report expenditures made during SFY 2025, for most states this is July 1, 2024 through March 24, 2025, in the ARP designated column in the FY2026 Report.

^c Prevention other than primary prevention.

^d Grantees must expend for Pregnant Women and Women with Dependent Children in compliance Women's Maintenance of Effort (MOE) over the one-year reporting period.

^e This expenditure category is mandated by Section 1243 of the Consolidated Appropriations Act, 2023 and includes an aggregate of expenditures allowable under The 2023 guidance, "Allowable Recovery Support Services (RSS) Expenditures through the SUBG and the MHBG." Only report RSS for those in need of RSS from substance use disorder. States are asked to begin reporting expenditures for RSS, previously reported under Row 1, Substance Use Disorder Prevention and Treatment, in the stand-alone Row 2. States are encouraged to begin reporting these expenditures in the 2026 SUPTRS BG Report, while required reporting will begin in 2027 and onward.

^f Row 3 should account for the 20% minimum primary prevention set-aside of SUPTRS BG funds to be used for universal, selective, and indicated substance use prevention activities.

^gThe most recent AtlasPlus HIV data report published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be required to set-aside 5% of their respective SUPTRS BG allotments to establish one or more projects to provide early intervention services regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment.

^hPer 45 CFR § 96.135 Restrictions on expenditure of the SUPTRS BG, the state involved will not expend more than 5% of the BG to pay the costs of administering the SUPTRS BG.

ⁱIf expenditures are estimated at time of reporting, the state must provide in the footnotes a date when the final actual expenditures are expected. Actual amounts are required to meet compliance with SUPTRS BG reporting.

Footnotes:

The \$ 154,148,317.00 SFY 2025 amount reported is the sum of \$115,410,973.00 reported in Table 2, Column E and New Jersey matched \$38,737,344 of the \$252,367,903 Medicaid funds included in Table 2 Column D in its MOE Methodology.

C: Expenditure Reports

Table 3a - Syringe Services Program (SSP) Expenditures by Program

States which have requested and been approved for expending SUPTRS BG and its supplemental funds on the support of Syringe Services Programs (SSP) must report the programs that are funded, including whether they provide treatment and the total expenditures spent by each program under the SUPTRS BG and its other supplemental funds. The 2027 Report will not include COVID-19 or ARP Supplemental Funding, which expired in March 2025.

Grantees approved for expending SUPTRS BG on SSPs are prohibited from using appropriated funds for the purchase of sterile needles or syringes for the hypodermic injection of any illegal drug as outlined in the Further Consolidated Appropriations Act, 2024, Title V, Sec. 526 (P.L. 118 - 47), March 23, 2024. In addition, states must note that no federal funding may be used directly or through subsequent reimbursement of grantees to purchase pipes in safer smoking kits. Grants include explicit prohibitions of federal funds to be used to purchase drug paraphernalia for administering any illegal drug. Grants also include explicit prohibitions of federal funds to be used to purchase drug paraphernalia used to administer any illegal drug.

Expenditure Start Date: 07/01/2024 Expenditure End Date: 06/30/2025

SSP Expenditures						
SSP Name	SSP Main Address	SUD Treatment Provider (Yes or No)	# Of locations (Include any mobile locations)	A. SUPTRS BG	B. COVID-19 ^a	C. ARP ^b
No Data Available						
Total						

^aPer the instructions, the reporting period is for the preceding 12-month period of the most recently completed SFY. Enter SUPTRS BG COVID-19 expenditures for the same one-year period.

Note: COVID supplemental funds had an original award period of March 15, 2021 through March 14, 2023. States that were granted a second No Cost Extension (NCE) on March 14, 2024 had until March 14, 2025 to expend their COVID-19 supplemental funds. Those states expending supplemental funds under the second NCE are required to report expenditures made during SFY 2025 (typically July 1, 2024–March 14, 2025) in the COVID-19 designated column of the FY2026 Report.

^bPer the instructions, the reporting period is for the preceding 12-month period of the most recently completed SFY. Enter SUPTRS BG ARP expenditures for the same one-year period.

Note: ARP supplemental funds had an award period of September 1, 2021 through March 24, 2025.

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Footnotes:
This table is not applicable. DMHAS does not use SUPTRS Block Grant funds for Syringe Services Programs.

C: Expenditure Reports

Table 3b - Syringe Services Program (SSP) Number of Individuals Served

States which have requested and been approved for expending SUPTRS BG and its supplemental funds on the support of Syringe Services Programs (SSP) must report the number of individuals served by service and activity type below. Grantees approved for expending SUPTRS BG on SSPs are prohibited from using appropriated funds for the purchase of sterile needles or syringes for the hypodermic injection of any illegal drug as outlined in the Further Consolidated Appropriations Act, 2024, Title V, Sec. 526 (P.L. 118-47), March 23, 2024. In addition, states must note that no federal funding may be used directly or through subsequent reimbursement of grantees to purchase pipes in safer smoking kits. Grants include explicit prohibitions of federal funds to be used to purchase drug paraphernalia for administering any illegal drug.

If a state does NOT use any SUPTRS BG and/or supplemental funds on SSP, indicate so in the footnote. The 2027 Report will not include COVID-19 or ARP Supplemental Funding, which expired in March 2025.

Expenditure Start Date: 07/01/2024 Expenditure End Date: 06/30/2025

SUPTRS BG							
Syringe Services Program Name	# of Unique Individuals Served		HIV Testing (Enter total number of individuals served)	Treatment for Substance Use Conditions (Enter total number of individuals served)	Treatment for Physical Health (Enter total number of individuals served)	STD Testing (Enter total number of individuals served)	Hep C (Enter total number of individuals served)
	0	ONSITE ^c	0	0	0	0	0
		REFERRAL OUT ^d	0	0	0	0	0
Total	0		0	0	0	0	0

COVID-19 ^a							
Syringe Services Program Name	# of Unique Individuals Served		HIV Testing (Enter total number of individuals served)	Treatment for Substance Use Conditions (Enter total number of individuals served)	Treatment for Physical Health (Enter total number of individuals served)	STD Testing (Enter total number of individuals served)	Hep C (Enter total number of individuals served)
	0	ONSITE ^c	0	0	0	0	0
		REFERRAL OUT ^d	0	0	0	0	0
Total	0		0	0	0	0	0

ARP ^b							
Syringe Services Program Name	# of Unique Individuals Served		HIV Testing (Enter total number of individuals served)	Treatment for Substance Use Conditions (Enter total number of individuals served)	Treatment for Physical Health (Enter total number of individuals served)	STD Testing (Enter total number of individuals served)	Hep C (Enter total number of individuals served)

		served)	(Enter total number of individuals served)	number of individuals served)	served)		
	0	ONSITE ^c	0	0	0	0	0
		REFERRAL OUT ^d	0	0	0	0	0
Total	0		0	0	0	0	0

^aPer the instructions, the reporting period is for the preceding 12-month period of the most recently completed SFY. Enter SUPTRS BG COVID-19 expenditures for the same one-year period. Note: COVID supplemental funds had an original award period of March 15, 2021 through March 14, 2023. States that were granted a second No Cost Extension (NCE) on March 14, 2024 had until March 14, 2025 to expend their COVID-19 supplemental funds. Those states expending supplemental funds under the second NCE are required to report expenditures made during SFY 2025, for most states that include expenditures between July 1, 2024 and March 14, 2025, in the COVID-19 designated column of the FY2026 Report.

^bPer the instructions, the reporting period is for the preceding 12-month period of the most recently completed SFY. Enter SUPTRS BG ARP expenditures for the same one-year period. Note: ARP supplemental funds had an award period of September 1, 2021 through March 24, 2025. States are required to report expenditures made during SFY 2025, for most states this is July 1, 2024 through March 24, 2025, in the ARP designated column in the FY2026 Report.

^cOnsite services are those conducted on premise of the SSP and are reimbursed through SUPTRS BG.

^dIn instances where the service is not provided directly onsite at the SSP, the SSP may refer individuals out to other providers. SSPs should document the number of referrals made out to other providers during the reporting period.

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Footnotes:
This table is not applicable. DMHAS does not use SUPTRS Block Grant funds for Syringe Services Programs.

C: Expenditure Reports

Table 3c - Risk Reduction Activities & Expenditures

States that use SUPTRS BG and/or its supplemental funds for the purchase and distribution of opioid overdose reversal kits and/or drug checking technologies, including test strips, must report the number purchased, distributed, and the related expenditures in the table below by provider/program. If a state does NOT use any SUPTRS BG and/or supplemental funds on Risk Reduction activities, please state so in the footnote. The 2027 Report will not include COVID-19 or ARP Supplemental Funding, which expired in March 2025.

Grantees approved for expending SUPTRS BG on SSPs are prohibited from using appropriated funds for the purchase of sterile needles or syringes for the hypodermic injection of any illegal drug as outlined in the Further Consolidated Appropriations Act, 2024, Title V, Sec. 526 (P.L. 118-47), March 23, 2024. In addition, states must note that no federal funding maybe used directly or through subsequent reimbursement of grantees to purchase pipes in safer smoking kits. Grants include explicit prohibitions of federal funds to be used to purchase drug paraphernalia for administering any illegal drug.

Appropriations Act, 2024, Title V, Sec. 526 (P.L. 118-47), March 23, 2024. In addition, states must note that no federal funding maybe used directly or through subsequent reimbursement of grantees to purchase pipes in safer smoking kits. Grants include explicit prohibitions of federal funds to be used to purchase drug paraphernalia for administering any illegal drug.

Expenditure Period Start Date: 07/01/2024 Expenditure Period End Date: 06/30/2025

Risk Reduction Activities								Expenditures		
Provider/Program Name	Main Address	SSP (Yes/No)	Number of Opioid Overdose Reversal Kits ^a Purchased	Number of Opioid Overdose Reversal Kits Distributed	Number of Overdose Reversals	Number of Drug Checking Technologies ^b Purchased	Number of Drug Checking Technologies Distributed	A. SUPTRS BG	B. COVID-19 ^c	C. ARP ^d
No Data Available										

^aOpioid overdose Reversal Kits may include naloxone, nalmefene, and other FDA approved overdose reversal medications approved by the FDA as specified. The range of FDA-approved opioid overdose reversal medications are supported and recommendations are that grantees fully assess specific community characteristics, available resources, and interest in different products and delivery routes, when determining the FDA-approved opioid overdose reversal medications to purchase and distribute. In addition, the use of Block Grant funds for the purchase of syringes for the intramuscular administration of naloxone is considered an allowable expense.

^bDrug checking technologies may include those technologies that are used to check for the presence of if certain chemicals or additives in one's personal supply of drugs. Examples of drug checking technologies includes fentanyl and xylazine test strips, among other drug checking technologies specified in federal guidance.

^cPer the instructions, the reporting period is for the preceding 12-month period of the most recently completed SFY. Enter SUPTRS BG COVID-19 expenditures for the same one-year period. **Note:** COVID supplemental funds had an original award period of March 15, 2021 through March 14, 2023. States that were granted a second No Cost Extension (NCE) on March 14, 2024 had until March 14, 2025 to expend their COVID-19 supplemental funds. Those states expending supplemental funds under the second NCE are required to report expenditures made during SFY 2025, for most states that include expenditures between July 1, 2024 and March 14, 2025, in the COVID-19 designated column of the FY2026 Report.

^dPer the instructions, the reporting period is for the preceding 12-month period of the most recently completed SFY. Enter SUPTRS BG ARP expenditures for the same one-year period. **Note:** ARP supplemental funds had an award period of September 1, 2021 through March 24, 2025. States are required to report expenditures made during SFY 2025, for most states this is July 1, 2024 through March 24, 2025, in the ARP designated column in the FY2026 Report.

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Footnotes:

C: Expenditure Reports

Table 4 - SUPTRS BG Expenditure Compliance Report

This table provides a description of SUPTRS BG expenditures for authorized activities to prevent and treat SUDs.

Expenditure Period Start Date: 10/1/2022 Expenditure Period End Date: 9/30/2024

Expenditure Category	FFY SUPTRS BG Award
1. Substance Use Disorder Prevention ^a and Treatment	\$33,703,751.00
2. Recovery Support Services ^b	\$0.00
3. Primary Prevention of Substance Use ^c	\$9,906,322.00
4. Early Intervention Services for the Human Immunodeficiency Virus (EIS/HIV) ^d	\$0.00
5. Tuberculosis Services	\$0.00
6. Other Capacity Building/Systems Development ^e	\$6,695,764.00
7. Administration ^f	\$2,190,623.00
8. Total^g	\$52,496,460.00

^aPrevention other than primary prevention. The amount reported in this row should reflect those expenditures made for direct services during the expenditure period, and otherwise reported on Table 7. Do not include expenditures made for other capacity building/systems development, those are required to be reported in Row 6 of this table.

^bThis expenditure category is mandated by Section 1243 of the Consolidated Appropriations Act, 2023 and includes an aggregate of expenditures allowable under The 2023 guidance, "Allowable Recovery Support Services (RSS) Expenditures through the SUBG and the MHBG." Only report RSS for those in need of RSS from substance use disorder. States are asked to begin reporting expenditures for RSS, previously reported under Row 1, Substance Use Disorder Prevention and Treatment, in the stand-alone Row 2. States are encouraged to begin reporting these expenditures as early as their 2026 SUPTRS BG Report, while required reporting will begin in 2027 and onward. States should use the footnotes to explain any challenges that that contribute to their inability to report RSS expenditures separately.

^cThe amounts reported here should reflect direct delivery of primary prevention to the population and be consistent with the expenditures found on Tables 5a. Do not include expenditures for other capacity building/systems development, those are required to be reported in Row 6 of this table.

^dThe most recent AtlasPlus HIV data report published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be required to set-aside 5% of their respective SUPTRS BG award to establish one or more projects to provide early intervention services for the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment.

^eOther capacity building/system development expenditures should reflect activities that support treatment, recovery support services, and primary prevention that are otherwise not direct services. The total found here should reflect the sum of expenditures found on Table 6 for treatment, recovery, and primary prevention.

^fPer **45 CFR § 96.135** Restrictions on expenditure of grant, the State involved will not expend more than 5% of the BG to pay the costs of SSA administering the SUPTRS BG.

^gThe total of this table should be consistent the state's Federal Financial Report (FFR) submitted at closeout of the award for which the state is reporting.
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Footnotes:

The TA amount is included in the other capacity building/systems development amount.

C: Expenditure Reports

Table 5a - Primary Prevention Expenditures by Strategy and Institute of Medicine (IOM) Categories

This table is for the reporting of expenditures on primary prevention activities associated with the SUPTRS BG 2023 Award during the two-year award period. The state or jurisdiction must complete SUPTRS BG Report Table 5a. Expenditures within each of the six strategies or by Institute of Medicine Model (IOM) classification should be directly associated with the cost of completing the activities or tasks. If a state used strategies not covered by these six categories or the state is unable to calculate expenditures by strategy, please report them under "Other." For detailed instructions, refer to those in the WebBGAS.

Expenditure Period Start Date: Expenditure Period End Date:

Strategy	IOM Classification	A. SUPTRS BG ^a	B. Other Federal	C. State	D. Local	E. Other	F. COVID- 19 ^b	G. ARP ^c
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	\$0.00	\$0.00
Education	Selective							
Education	Indicated							
Education	Universal							
Education	Unspecified							
Education	Total	\$0.00	\$0.00	\$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	\$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	\$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	\$0.00	\$0.00
Environmental	Selective							
Environmental	Indicated							
Environmental	Universal							
Environmental	Unspecified							
Environmental	Total	\$0.00	\$0.00	\$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	\$0.00	\$0.00
Other	Universal Direct							
Other	Universal Indirect							
Other	Selective							
Other	Indicated							
Other	Total	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	Grand Total							

^aThe total SUPTRS BG Award expenditures should equal the amount reported on Table 4, Row 3 and not include any expenditures otherwise spent on other capacity building/systems development.

^bPer the instructions, the reporting period is for the SUPTRS BG Award period. Enter SUPTRS BG COVID-19 expenditures for the same two-year period. **Note:** COVID supplemental funds had an original award period from March 15, 2021 through March 14, 2023. States that were granted a second No Cost Extension (NCE) on March 14, 2024 had until March 14, 2025 to expend their COVID-19 supplemental funds.

^cPer the instructions, the reporting period is for the SUPTRS BG Award period. Enter SUPTRS BG ARP expenditures for the same two-year period. **Note:** ARP supplemental funds had award period from September 1, 2021 through March 24, 2025.

Footnotes:

C: Expenditure Reports

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

The state or jurisdiction must complete SUPTRS Report Table 5b if it chooses to report primary prevention of substance use activities utilizing the Institute of Medicine Model (IOM) Model of Universal, Selective, and Indicated in SUPTRS Report Table 5a. Indicate how much funding supported each of the IOM classifications of Universal, Selective, or Indicated.

Expenditure Period Start Date: 10/1/2022 Expenditure Period End Date: 9/30/2024

Strategy	A. SUPTRS BG Award	B. COVID-19 ^a	C. ARP ^b
Universal Direct	\$1,981,246		
Universal Indirect	\$3,170,023		
Selective	\$2,971,896		
Indicated	\$1,783,138		
Column Total	\$9,906,303		
Total SUPTRS BG Award ^c	52496460.00		
Primary Prevention Expenditure Percentage ^d	18.87%		

^aPer the instructions, the reporting period is for the SUPTRS BG Award period. Enter SUPTRS BG COVID-19 expenditures for the same two-year period. Note: COVID supplemental funds had an original award period from March 15, 2021 through March 14, 2023. States that were granted a second No Cost Extension (NCE) on March 14, 2024 had until March 14, 2025 to expend their COVID-19 supplemental funds.

^bPer the instructions, the reporting period is for the SUPTRS BG Award period. Enter SUPTRS BG ARP expenditures for the same two-year period. Note: ARP supplemental funds had award period from September 1, 2021 through March 24, 2025.

^cTotal SUPTRS BG Award is populated from Report Table 4 SUPTRS BG Award Expenditure Compliance Report.

^dThe Primary Prevention Expenditure Percentage is the percentage amount the agency committed to for this reporting period.

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Footnotes:

C: Expenditure Reports

Table 5c - Primary Prevention Priorities

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 SUPTRS BG 2023 Award during the two-year award period. The purpose of the bottom half of the 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: 10/1/2022 Expenditure Period End Date: 9/30/2024

Priority Substances	A. SUPTRS BG	B. COVID-19 ^a	C. ARP ^b
Alcohol	☒	☒	☒
Tobacco/Nicotine-Containing Products	☒	☒	☒
Cannabis/Cannabinoids	☒	☒	☒
Prescription Medications	☒	☒	☒
Cocaine	☒	☐	☐
Heroin	☒	☒	☒
Inhalants	☒	☐	☐
Methamphetamine	☒	☐	☐
Fentanyl or Other Synthetic Opioids	☒	☒	☒
Other	☐	☐	☐
Priority Populations			
College Age Individuals (ages 18-26)	☒	☒	☒
Older Adults (age 55 and above)	☒	☐	☐
Military Families	☒	☐	☐
American Indian/Alaska Native	☐	☒	☒
African American	☒	☒	☒
Hispanic	☒	☒	☒
Persons Experiencing Homelessness	☒	☒	☒
Native Hawaiian/Pacific Islander	☒	☐	☐
Asian	☒	☐	☐
Rural	☒	☒	☒

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^aPer the instructions, the reporting period is for the SUPTRS BG Award period. Enter SUPTRS BG COVID-19 primary prevention priority areas for the same two-year period. **Note:** COVID supplemental funds had an original award period from March 15, 2021 through March 14, 2023. States that were granted a second No Cost Extension (NCE) on March 14, 2024 had until March 14, 2025 to expend their COVID-19 supplemental funds.

^bPer the instructions, the reporting period is for the SUPTRS BG Award period. Enter SUPTRS BG ARP primary prevention priority areas for the same two-year period. **Note:** ARP supplemental funds had award period from September 1, 2021 through March 24, 2025.

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C: Expenditure Reports

Table 6 - Other Capacity Building/Systems Development Activities

Expenditures in the following categories of SSA activities and subrecipient activities funded by the SSA through contracts, grants, or agreements with subrecipients. Expenditures should not duplicate any reporting of allocations to subrecipients that are listed in Table 7. Please utilize the following categories to describe the types of expenditures your state supports with Block Grant funds, and if the preponderance of the activity fits within a category. Other capacity building/systems development activities may not be used to meet set-aside requirements for EIS/HIV. For additional definitions and instructions on how to complete this table, please see the 'Instruction' tab above.

Expenditure Period Start Date: 10/01/2022 Expenditure Period End Date: 09/30/2024

Activity	A. SUPTRS BG Prevention ^a & Treatment	B. SUPTRS BG Recovery Support Services ^b	C. SUPTRS BG Primary Prevention ^c
1. Information Systems	\$1,289,446.00	\$0.00	\$0.00
a. Single State Agency (SSA)	\$0.00	\$0.00	\$0.00
b. All other subrecipient contracts	\$1,289,446.00	\$0.00	\$0.00
2. Infrastructure Support	\$0.00	\$0.00	\$0.00
a. Single State Agency (SSA)	\$0.00	\$0.00	\$0.00
b. All other subrecipient contracts	\$0.00	\$0.00	\$0.00
3. Partnerships, community outreach, and needs assessment	\$0.00	\$0.00	\$1,919,144.00
a. Single State Agency (SSA)	\$0.00	\$0.00	\$0.00
b. All other subrecipient contracts	\$0.00	\$0.00	\$1,919,144.00
4. Planning Council Activities	\$0.00	\$0.00	\$0.00
a. Single State Agency (SSA)	\$0.00	\$0.00	\$0.00
b. All other subrecipient contracts	\$0.00	\$0.00	\$0.00
5. Quality Assurance and Improvement	\$515,849.00	\$0.00	\$0.00
a. Single State Agency (SSA)	\$0.00	\$0.00	\$0.00
b. All other subrecipient contracts	\$515,849.00	\$0.00	\$0.00
6. Research and Evaluation	\$1,868,829.00	\$0.00	\$904,245.00
a. Single State Agency (SSA)	\$0.00	\$0.00	\$0.00
b. All other subrecipient contracts	\$1,868,829.00	\$0.00	\$904,245.00
7. Training and Education	\$198,251.00	\$0.00	\$0.00
a. Single State Agency (SSA)	\$0.00	\$0.00	\$0.00
b. All other subrecipient contracts	\$198,251.00	\$0.00	\$0.00
8. Total ^d	\$3,872,375.00	\$0.00	\$2,823,389.00

^aOther than primary prevention.

^bThis expenditure category includes those other capacity building/systems development activities that support recovery support direct service activities outlined under The 2023 guidance, "Allowable Recovery Support Services (RSS) Expenditures through the SUBG and the MHBG." Only report RSS for those in need of RSS from substance use disorder. States are asked to begin reporting expenditures for RSS, previously reported under Column A, 'SUPTRS BG Prevention and Treatment,' in the stand-alone Column B, 'SUPTRS BG Recovery Support Services.' States are encouraged to begin reporting these expenditures as early as their 2026 SUPTRS BG Report, while required reporting will begin in 2027 and onward. States should use the footnotes to explain any challenges that that contribute to their inability to report RSS expenditures separately.

^cExpenditures for other capacity building/systems development activities related to primary prevention only.

^dThe sum of all three columns should be equal to the amount reported on Table 4, Row 6.

Footnotes:

C: 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, treatment and recovery support services, as well as intermediaries/administrative service organizations. Table 7 excludes other capacity building/systems development expenditures found on Table 6.

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: 10/01/2022 Expenditure Period End Date: 09/30/2024

Source of Funds Substance Use Block Grant																	
	Entity Number	I-TF (formerly I-BHS)		Area Served (Statewide or SubState Planning Area)	Provider / Program Name	Street Address	City	State	Zip	A. All SUPTRS BG Funds	B. Prevention ^a and Treatment Services	C. Pregnant Women and Women with Dependent Children ^b	D. Opioid Treatment Programs (OTPs) ^c	E. Office- based opioid treatment (OBOTs) ^d	F. Recovery Support Services ^e	G. Primary Prevention ^f	H. Early Intervention Services for HIV ^g
	0000000	NJ103071	✓	Cape May County	Acenda Counseling and Wellness Centers	128 Crest Haven Road	Cape May Court House	NJ	08210	\$5,101.00	\$5,101.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	0000001	NJ108217	✓	Morris County	Acenda Integrated Health	340 West Hanover Avenue	Morristown	NJ	07960	\$1,713.00	\$1,713.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	NJ100642	NJ100642	✓	Ocean County	Agape Counseling Services Inc	815 U.S. Highway 9	Lanoka Harbor	NJ	08734	\$39,989.00	\$39,989.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	0000000	NJ902437	✓	Morris County	Alfre Inc	56 Mount Kemble Avenue	Morristown	NJ	07960	\$296,949.00	\$296,949.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	0000000	NJ106872	✓	Hunterdon County	Anderson House	P.O. Box 134	Whitehouse Station	NJ	08889-0134	\$266,009.00	\$266,009.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	0000000	NJ102850	✓	Essex County	Appropriate Place Inc	660 South 21st Street	Irvington	NJ	07111	\$582.00	\$582.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	0000000	NJ101850	✓	Atlantic County	Atlantic Prevention Resources Inc	1416 North Main Street	Pleasantville	NJ	08232	\$244,400.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$244,400.00	\$0.00
	100883	NJ101680	✓	Atlantic County	ATLANTICARE BEHAVIORAL HEALTH	6010 Black Horse Pike Suite B-10	Egg Harbor Township	NJ	08234-9752	\$277,313.00	\$277,313.00	\$35,055.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	0000000	NJ101656	✓	Hudson County	C Line Community Outreach Services	110 Martin Luther King Drive	Jersey City	NJ	07305	\$5,973.00	\$5,973.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	0000000	NJ101797	✓	Camden County	Camden County Council on Alcoholism	1 Alpha Avenue Suite 22	Voorhees	NJ	08043	\$267,500.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$267,500.00	\$0.00
	0000000	NJ000281	✓	Camden County	Camden Treatment Associates	508 Atlantic Avenue	Camden	NJ	08104-1108	\$119,484.00	\$119,484.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	0000000	NJ750133	✓	Cape May County	Cape May Council on	3819 New Jersey Avenue	Wildwood	NJ	08260	\$441,066.00	\$4,826.00	\$0.00	\$0.00	\$0.00	\$0.00	\$436,240.00	\$0.00
	0000000	NJ102403	✓	Cape May County	Cape Regional Medical Center	2 Stone Harbor Blvd	Cape May Court House	NJ	08210	\$177,700.00	\$177,700.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	0000000	NJ100629	✓	Bergen County	Care Plus NJ Inc	610 Valley Health Plaza	Paramus	NJ	07652	\$15,594.00	\$15,594.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	NJ100629	NJ100629	✓	99	Care Plus NJ Inc	610 VALLEY HEALTH PLAZA	PARAMUS	NJ	07652	\$324,334.00	\$324,334.00	\$324,334.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	0000000	NJ102278	✓	Mercer County	Catholic Charities Diocese of Trenton	P.O. Box 1423	Trenton	NJ	08607-1423	\$29,824.00	\$29,824.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	0000001	NJ102278	✓	Mercer County	Catholic Charities Diocese of Trenton	P.O. Box 1423	Trenton	NJ	08607-1423	\$111,700.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$111,700.00	\$0.00
	0000001	NJ100603	✓	Camden County	Center for Family Services	594 Benson Street	Camden	NJ	08103	\$909.00	\$909.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	0000002	NJ000121	✓	Camden County	Center for Family Services	108 Somerdale Road	Voorhees	NJ	08043	\$3,045.00	\$3,045.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00

	0000000	NJ100735	✓	Gloucester County	Center for Family Services	P.O. Box 1004	Williamstown	NJ	08094	\$1,319,556.00	\$1,319,556.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	0000003	NJ101537	✓	Warren County	Center For Family Services	108 Bilby Road Suite 302	Hackettstown	NJ	07840-4174	\$3,948.00	\$3,948.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	0000000	NJ107771	✓	Somerset County	Center for Great Expectations	19 Dellwood Lane Suite B	Somerset	NJ	08873	\$9,694.00	\$9,694.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	0000001	NJ107771	✓	Somerset County	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	\$0.00
	100853	NJ100853	✓	Sussex County	Center for Prevention and Counseling	61 Spring Street	Newton	NJ	07860-2072	\$328,700.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$328,700.00	\$0.00
	101804	NJ101804	✗	Warren County	COMMUNITY PREVENTION RESOURCES	20 West Washington Avenue	WASHINGTON	NJ	07882	\$142,700.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$142,700.00	\$0.00
	0000000	NJ100744	✓	Essex County	Community Psychiatric Institute	67 Sanford Street	East Orange	NJ	07018	\$564.00	\$564.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	NJ300715	NJ300715	✓	99	Corner House Behavioral Health	1 Monument Drive	Princeton	NJ	08540	\$3,595.00	\$3,595.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	0000000	NJ100392	✓	Monmouth County	CPC Behavioral Healthcare	270 Highway 35	Red Bank	NJ	07701	\$28,574.00	\$28,574.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	0000000	NJ102779	✓	Monmouth County	CPC Integrated Health	1088 Highway 34	Aberdeen	NJ	07747	\$7,091.00	\$7,091.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	0000000	NJ102895	✓	Monmouth County	CPC Integrated Health	4539 U.S. Highway 9	Howell	NJ	07731	\$3,996.00	\$3,996.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	0000000	NJ102886	✓	Monmouth County	CPC Integrated Health	22 Court Street	Freehold	NJ	07728	\$3,999.00	\$3,999.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	0000000	NJ750091	✓	Cumberland County	Cumberland County Alc and Drug	70 West Broad Street	Bridgeton	NJ	08302-2421	\$3,338.00	\$3,338.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	305300	NJ100756	✓	Essex County	CURA Inc	P.O. Box 180	Newark	NJ	07101-0180	\$415,535.00	\$415,535.00	\$177,722.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	0000000	NJ100868	✓	Essex County	CURA Inc	47 Lincoln Park	Newark	NJ	07102	\$722,127.00	\$722,127.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	0000000	NJ100477	✓	Monmouth County	Discovery Institute for	P.O. Box 177	Marlboro	NJ	07746	\$380,600.00	\$380,600.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	0000000	NJ105551	✓	Monmouth County	Discovery Institute for	P.O. Box 177	Marlboro	NJ	07746	\$47,795.00	\$47,795.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	1000063	NJ301028	✗	99	Dismas House for Drug Rehab	396 STRAIGHT ST	PATERSON	NJ	07501	\$346,346.00	\$346,346.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	0000000	NJ300806	✓	Essex County	East Orange Substance Abuse Trt Prog	110 South Grove Street 3rd Floor	East Orange	NJ	07018-4102	\$21,827.00	\$21,827.00	\$0.00	\$21,827.00	\$0.00	\$0.00	\$0.00	\$0.00
	0000001	NJ300806	✓	Essex County	East Orange Substance Abuse Trt Prog	110 South Grove Street 3rd Floor	East Orange	NJ	07018-4102	\$7,937.00	\$7,937.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	0000000	NJ101329	✓	Passaic County	Evas Village	393 Main Street	Paterson	NJ	07501	\$2,291,628.00	\$2,291,628.00	\$309,592.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	0000000	NJ300855	✓	Essex County	Family Connections Inc	7 Glenwood Avenue Suite 101	East Orange	NJ	07017	\$430,000.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$430,000.00	\$0.00
	0000000	NJ100555	✓	Warren County	Family Guidance Ctr of Warren Cnty	492 Route 57 West	Washington	NJ	07882	\$43,087.00	\$43,087.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	0000000	NJ101162	✓	Hunterdon County	Freedom House Halfway House	2004 State Route 31 Suite 9	Clinton	NJ	08809-2040	\$942,671.00	\$942,671.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	NJ101162	NJ101162	✓	Hunterdon County	Freedom House Halfway House	2004 State Route 31 Suite 9	Clinton	NJ	08809-2040	\$300,711.00	\$300,711.00	\$48,879.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	0000000	NJ101478	✓	Camden County	Genesis Counseling Center	1000 Atlantic Avenue 5th Floor	Camden	NJ	08104	\$17,832.00	\$17,832.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00

	NJ101899	NJ101899	✓	99	Genesis Counseling Center	566 Haddon Avenue	Collingswood	NJ	08108	\$33,953.00	\$33,953.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	8622554053	NJ101573	✓	99	Genesis Counseling Center	2003 Lincoln Drive West Suite C	MARLTON	NJ	08053	\$12,532.00	\$12,532.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	0000000	NJ101477	✓	Hunterdon County	Good News Home Inc	33 Bartles Corner Road	Flemington	NJ	08822	\$594,617.00	\$594,617.00	\$594,617.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	0000000	NJ105270	✓	Cape May County	Hendricks House Inc	542 NW Boulevard	Vineland	NJ	08360	\$660,424.00	\$660,424.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	0000000	NJ105270	✓	Cumberland County	Hendricks House Inc	542 NW Boulevard	Vineland	NJ	08360	\$510,556.00	\$510,556.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	NJ104276	NJ105270	✓	Cumberland County	Hendricks House Inc	542 NW Boulevard	Vineland	NJ	08360	\$46,783.00	\$46,783.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	0000001	NJ105270	✓	Cumberland County	Hendricks House Inc	542 NW Boulevard	Vineland	NJ	08360	\$990,499.00	\$990,499.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	0000002	NJ306357	✓	Camden County	Hispanic Family Center	PO Box 1590	Camden	NJ	08105-0590	\$272,000.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$272,000.00	\$0.00
	0000000	NJ100743	✓	Hunterdon County	Hunterdon Medical Center/Add Trt Servs	2100 Wescott Drive	Flemington	NJ	08822	\$1,134.00	\$1,134.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	ABI434276637	NJ100510	✓	Essex County	Integrity House	P.O. Box 510	Newark	NJ	07101	\$285.00	\$285.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	NJ100420	NJ103517	✓	Essex County	Integrity House	P.O. Box 510	Newark	NJ	07101	\$24,682.00	\$24,682.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	NJ100420	NJ107722	✓	Essex County	Integrity Inc	P.O. Box 510	Newark	NJ	07101	\$123,446.00	\$123,446.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	0000000	NJ103520	✓	Essex County	Integrity Inc	P.O. Box 510	Newark	NJ	07101	\$16,199.00	\$16,199.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	NJ100420	NJ107706	✓	Essex County	Integrity Inc	P.O. Box 510	Newark	NJ	07101	\$101,043.00	\$101,043.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	NJ100420	NJ103581	✓	Essex County	Integrity Inc	P.O. Box 510	Newark	NJ	07101	\$645,155.00	\$645,155.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	0000000	NJ100420	✓	Essex County	Integrity Inc	P.O. Box 510	Newark	NJ	07101	\$74,289.00	\$74,289.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	NJ100420	NJ103546	✓	Essex County	Integrity Inc	P. O. Box 510	Newark	NJ	07101	\$765,146.00	\$765,146.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	0000000	NJ103552	✓	Essex County	Integrity Inc	P.O. Box 510	Newark	NJ	07101	\$15,966.00	\$15,966.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	NJ100420	NJ100420	✓	99	Integrity Inc	P.O. Box 510	Newark	NJ	07101	\$678,893.00	\$678,893.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	0000000	NJ306209	✓	Hudson County	Inter County Council on Drug/Alc Abuse	480 Kearny Avenue	Kearny	NJ	07032	\$90,247.00	\$90,247.00	\$0.00	\$90,247.00	\$0.00	\$0.00	\$0.00	\$0.00
	NJ306209	NJ100594	✓	Hudson County	Inter County Council on Drug/Alc Abuse	480 Kearny Avenue	Kearny	NJ	07032	\$21,829.00	\$21,829.00	\$0.00	\$21,829.00	\$0.00	\$0.00	\$0.00	\$0.00
	NJ100714	NJ100714	✓	Union County	Intervention Specialists LLC	583 Cherry Street	Elizabeth	NJ	07208	\$3,211.00	\$3,211.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	0000000	NJ102035	✓	Monmouth County	Jewish Family and Childrens Services	705 Summerfield Avenue	Asbury Park	NJ	07712	\$18,271.00	\$18,271.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	0000000	NJ300103	✓	Atlantic County	John Brooks Recovery Center	1455 Pinewood Boulevard	Mays Landing	NJ	08330	\$509,938.00	\$509,938.00	\$0.00	\$509,938.00	\$0.00	\$0.00	\$0.00	\$0.00
	NJ300103	NJ300103	✓	Atlantic County	John Brooks Recovery Center	1455 PINEWOOD BOULEVARD	MAYS LANDING	NJ	08330	\$38,966.00	\$38,966.00	\$38,966.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	NJ300103	NJ300103	✓	99	JOHN BROOKS RECOVERY CENTER	1455 PINEWOOD BOULEVARD	MAYS LANDING	NJ	08330	\$169,836.00	\$169,836.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	0000000	NJ100156	✓	Monmouth County	JSAS Healthcare Inc	P.O. Box 884	Neptune	NJ	07753	\$365,321.00	\$365,321.00	\$0.00	\$365,321.00	\$0.00	\$0.00	\$0.00	\$0.00
	0000001	NJ100156	✓	Monmouth County	JSAS Healthcare Inc	P.O. Box 884	Neptune	NJ	07753	\$313,627.00	\$313,627.00	\$0.00	\$313,627.00	\$0.00	\$0.00	\$0.00	\$0.00
	0000000	NJ100475	✓	Burlington County	Legacy Treatment Services	1289 Route 38 West Suite 203	Hainesport	NJ	08036	\$300.00	\$300.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	0000000	NJ100404	✓	Essex County	Lennard Clinic Inc	164 Blanchard Street	Newark	NJ	07105	\$183,172.00	\$183,172.00	\$183,172.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	0000000	NJ306449	✓	Essex County	Lennard Clinic Inc	461 Frelinghuysen Avenue	Newark	NJ	07114	\$213,748.00	\$213,748.00	\$0.00	\$213,748.00	\$0.00	\$0.00	\$0.00	\$0.00

	NJ306449	NJ306449	✓	Essex County	Lennard Clinic Inc	461 Frelinghuysen Avenue	Newark	NJ	07114	\$226,433.00	\$226,433.00	\$0.00	\$226,433.00	\$0.00	\$0.00	\$0.00	\$0.00
	0000000	NJ103431	✓	Burlington County	Maryville Addiction Treatment Center	610 Pemberton Browns Mills Road	Pemberton	NJ	08068	\$111,657.00	\$111,657.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	1000002	NJ104097	✓	Camden County	Maryville Inc	129 Johnson Road Suite 7	Turnersville	NJ	08012	\$132,344.00	\$132,344.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	1000000	NJ107813	✓	Cumberland County	Maryville Inc	1173 East Landis Avenue Suite 202	Vineland	NJ	08360	\$19,251.00	\$19,251.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	1000004	NJ106237	✓	Gloucester County	Maryville Inc	1903 Grant Avenue	Williamstown	NJ	08094	\$197,239.00	\$197,239.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	0000000	NJ902924	✓	Mercer County	Mercer Council on Alcoholism and	408 Bellevue Avenue	Trenton	NJ	08618-4502	\$487,640.00	\$131,540.00	\$0.00	\$0.00	\$0.00	\$0.00	\$356,100.00	\$0.00
	0000000	NJ102794	✓	Bergen County	MMM Health Services Inc	96 Linwood Plaza Route 9W Suite 303	Fort Lee	NJ	07024	\$271.00	\$271.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	0000000	NJ100651	✓	Morris County	Morris County Aftercare Center	273 East Main Street	Denville	NJ	07834	\$223,264.00	\$223,264.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	NJ100651	NJ100651	✓	99	Morris County Aftercare Center	273 East Main Street	Denville	NJ	07834	\$411,089.00	\$411,089.00	\$0.00	\$411,089.00	\$0.00	\$0.00	\$0.00	\$0.00
	101818	NJ101818	✗	Morris County	Morris County Prevention is Key	25 West Main Street	Rockaway	NJ	7866	\$538,888.00	\$130,888.00	\$0.00	\$0.00	\$0.00	\$0.00	\$408,000.00	\$0.00
	0000000	NJ750299	✓	Bergen County	National Council on Alcoholism and	60 South Fullerton Avenue	Montclair	NJ	07042-2688	\$299,180.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$299,180.00	\$0.00
	1000000	NJ750299	✓	Essex County	National Council on Alcoholism and	60 South Fullerton Avenue	Montclair	NJ	07042-2688	\$783,674.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$783,674.00	\$0.00
	0000000	NJ302026	✓	Middlesex County	New Brunswick Counseling Center	320 Suydam Street	New Brunswick	NJ	08901	\$133,593.00	\$133,593.00	\$0.00	\$133,593.00	\$0.00	\$0.00	\$0.00	\$0.00
	0000001	NJ302026	✓	Middlesex County	New Brunswick Counseling Center	320 Suydam Street	New Brunswick	NJ	08901	\$57,219.00	\$57,219.00	\$0.00	\$57,219.00	\$0.00	\$0.00	\$0.00	\$0.00
	1000002	NJ302026	✓	Middlesex County	New Brunswick Counseling Center	320 Suydam Street	New Brunswick	NJ	08901	\$362,354.00	\$362,354.00	\$0.00	\$362,354.00	\$0.00	\$0.00	\$0.00	\$0.00
	1000008	NJ102467	✓	Monmouth County	New Hope Integrated Behavioral Health	80 Conover Road	Marlboro	NJ	07746	\$112,120.00	\$112,120.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	1000006	NJ102467	✓	Monmouth County	New Hope Integrated Behavioral Health	80 Conover Road	Marlboro	NJ	07746	\$18,947.00	\$18,947.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	1000005	NJ102467	✓	Monmouth County	New Hope Integrated Behavioral Health	80 Conover Road	Marlboro	NJ	07746	\$886,360.00	\$886,360.00	\$886,360.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	1000001	NJ102467	✓	Monmouth County	New Hope Integrated Behavioral Health	80 Conover Road	Marlboro	NJ	07746	\$426,185.00	\$426,185.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	0000000	NJ102467	✓	Monmouth County	New Hope Integrated Behavioral Health	80 Conover Road	Marlboro	NJ	07746	\$206,113.00	\$206,113.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	1000002	NJ102467	✓	Monmouth County	New Hope Integrated Behavioral Health	80 Conover Road	Marlboro	NJ	07746	\$14,751.00	\$14,751.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	1000003	NJ102467	✓	Monmouth County	New Hope Integrated Behavioral Health	80 Conover Road	Marlboro	NJ	07746	\$202,197.00	\$202,197.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
					New Hope												

	1000004	NJ102467	✓	Monmouth County	Integrated Behavioral Health	80 Conover Road	Marlboro	NJ	07746	\$113,385.00	\$113,385.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	1000007	NJ102467	✓	Monmouth County	New Hope Integrated Behavioral Health	80 Conover Road	Marlboro	NJ	07746	\$243,910.00	\$243,910.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	0000000	NJ100461	✓	Mercer County	New Horizon Treatment Services Inc	132 Perry Street	Trenton	NJ	08618	\$232,249.00	\$232,249.00	\$0.00	\$208,295.00	\$0.00	\$0.00	\$0.00	\$0.00
	1000000	NJ100461	✗	Mercer County	New Horizon Treatment Services Inc	144 Perry Street	Trenton	NJ	08618	\$1,877.00	\$1,877.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	1000002	NJ100461	✓	Mercer County	New Horizon Treatment Services Inc	132 Perry Street	Trenton	NJ	08618	\$31,241.00	\$31,241.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	101640	NJ101640	✗	Essex County	North Jersey Community Research Initiative, Inc.	393 Central Ave	Newark	NJ	7103	\$225,000.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$225,000.00	\$0.00
	0000000	NJ100487	✓	Passaic County	Northeast Life Skills Associates Inc	121 Howe Avenue	Passaic	NJ	07055	\$95,863.00	\$95,863.00	\$0.00	\$95,863.00	\$0.00	\$0.00	\$0.00	\$0.00
	NJ101965	NJ101965	✗	Burlington County	Oaks Integrated Care Inc.	770 Woodlane Road Suite 12	Mount Holly	NJ	08060-3804	\$15,792.00	\$15,792.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	NJ101965	NJ101965	✗	Camden County	Oaks Integrated Care Inc.	770 Woodlane Road Suite 12	Mount Holly	NJ	08060-3804	\$7,802.00	\$7,802.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	NJ101965	NJ101965	✗	99	Oaks Integrated Care Inc.	770 Woodlane Road Suite 12	Mount Holly	NJ	08060-3804	\$1,528.00	\$1,528.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	0000000	NJ100503	✓	Union County	Organization for Recovery	Organization for Recovery	Plainfield	NJ	07060-1416	\$435,428.00	\$435,428.00	\$0.00	\$435,428.00	\$0.00	\$0.00	\$0.00	\$0.00
	103309	NJ103309	✗	99	PARTNERS IN PREVENTION, Inc.	1108 Meadowlands Parkway, Suite 302	Secaucus	NJ	07094	\$196,706.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$196,706.00	\$0.00
	1000000	NJ101395	✓	Passaic County	Passaic Alliance	286 Passaic Street 1st Floor	Passaic	NJ	07055	\$143,431.00	\$143,431.00	\$0.00	\$143,431.00	\$0.00	\$0.00	\$0.00	\$0.00
	1000001	NJ101395	✓	Passaic County	Passaic Alliance	286 Passaic Street 1st Floor	Passaic	NJ	07055	\$46,430.00	\$46,430.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	1000000	NJ100495	✓	Passaic County	Paterson Counseling Center Inc	319-321 Main Street	Paterson	NJ	07505	\$100,469.00	\$100,469.00	\$0.00	\$100,469.00	\$0.00	\$0.00	\$0.00	\$0.00
	1000001	NJ101295	✓	Ocean County	Preferred Behavioral Health of NJ	700 Airport Road P.O. Box 2036	Lakewood	NJ	08701-1010	\$48,162.00	\$48,162.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	1000002	NJ101295	✓	Ocean County	Preferred Behavioral Health of NJ	700 Airport Road P.O. Box 2036	Lakewood	NJ	08701-1010	\$263,040.00	\$61,040.00	\$61,040.00	\$0.00	\$0.00	\$0.00	\$202,000.00	\$0.00
	1000000	NJ101295	✓	Ocean County	Preferred Behavioral Health of NJ	700 Airport Road P.O. Box 2036	Lakewood	NJ	08701-1010	\$1,170,000.00	\$770,000.00	\$0.00	\$0.00	\$0.00	\$0.00	\$400,000.00	\$0.00
	1000004	NJ101295	✓	Ocean County	Preferred Behavioral Health of NJ	700 Airport Road P.O. Box 2036	Lakewood	NJ	08701-1010	\$12,652.00	\$12,652.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	1000003	NJ101295	✓	Passaic County	Preferred Behavioral Health of NJ	700 Airport Road P.O. Box 2036	Lakewood	NJ	08701-1010	\$38,076.00	\$38,076.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	1000005	NJ101295	✓	Passaic County	Preferred Behavioral Health of NJ	700 Airport Road P.O. Box 2036	Lakewood	NJ	08701-1010	\$13,765.00	\$13,765.00	\$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	\$432,500.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$432,500.00	\$0.00
	101823	NJ101823	✗	Burlington County	PREVENTION PLUS OF BURLINGTON	5000 Sagemore Dr # 203,	Evesham	NJ	8053	\$454,408.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$454,408.00	\$0.00
	NJ750216	NJ750216	✓	Essex County	Prevention Resources	4 Walter Foran Boulevard Suite 410	Flemington	NJ	08822-1128	\$450,750.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$450,750.00	\$0.00
	0000000	NJ100920	✓	Monmouth County	Recovery Innovations Inc	1 Corbett Way Suite 1	Eatontown	NJ	07724-4247	\$12,155.00	\$12,155.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00

	1000000	NJ750687	✓	Mercer County	Rescue Mission of Trenton	98 Carroll Street P.O. Box 790	Trenton	NJ	08605	\$685,802.00	\$685,802.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	1000001	NJ750687	✓	Mercer County	Rescue Mission of Trenton	98 Carroll Street P.O. Box 790	Trenton	NJ	08605	\$21,197.00	\$21,197.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	1000002	NJ101115	✓	Mercer County	Rescue Mission of Trenton	P.O. Box 790	Trenton	NJ	08605-0790	\$71,127.00	\$71,127.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	1000003	NJ750687	✓	Mercer County	Rescue Mission of Trenton	98 Carroll Street P.O. Box 790	Trenton	NJ	08605	\$318,750.00	\$318,750.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	0000000	NJ903294	✓	Somerset County	Richard Hall CHWC	500 North Bridge Street	Bridgewater	NJ	08807	\$386.00	\$386.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	102934	NJ102934	✓	99	Rutgers State University of NJ	33 Knightsbridge Road 2nd Fl East Wing	Piscataway	NJ	08854	\$147,958.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$147,958.00	\$0.00
	1234	NJ1234	✗	Middlesex County	RUTGERS THE STATE UNIV RBHS	100 JOYCE KILMER AVE	PISCATAWAY	NJ	8854	\$744,646.00	\$744,646.00	\$400,203.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	0000000	NJ100747	✓	Middlesex County	Rutgers/UBHC	671 Hoes Lane West	Piscataway	NJ	08855	\$2,918,943.00	\$2,918,943.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	0000000	NJ100095	✓	Ocean County	RWJ Barnabas Hlth Behav Health Center	1691 U.S. Highway 9	Toms River	NJ	08755	\$3,845,896.00	\$2,638,954.00	\$0.00	\$0.00	\$0.00	\$0.00	\$1,206,942.00	\$0.00
	0000000	NJ750612	✓	Somerset County	Somerset Council on	34 West Main Street Suite 307	Somerville	NJ	08876	\$168,300.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$168,300.00	\$0.00
	NJ100693	NJ100693	✓	99	Somerset Treatment Services	118 West End Avenue	Somerville	NJ	08876	\$143,198.00	\$143,198.00	\$0.00	\$143,198.00	\$0.00	\$0.00	\$0.00	\$0.00
	0000000	NJ100677	✓	Cumberland County	South Jersey Drug Treatment Center	P.O. Box 867	Bridgeton	NJ	08302	\$49,873.00	\$49,873.00	\$0.00	\$49,873.00	\$0.00	\$0.00	\$0.00	\$0.00
	109876	NJ109876	✗	Camden County	Southern New Jersey Perinatal Cooperative	2500 McClellan Ave	Pennsauken	NJ	8109	\$482,633.00	\$482,633.00	\$482,633.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	0000000	NJ101309	✓	Cumberland County	Southwest Council Inc	1405 North Delsea Drive	Vineland	NJ	08360	\$1,130,192.00	\$189,792.00	\$0.00	\$0.00	\$0.00	\$0.00	\$940,400.00	\$0.00
	0000001	NJ306316	✓	Hudson County	Spectrum Healthcare	74 Pacific Avenue	Jersey City	NJ	07304	\$596,789.00	\$596,789.00	\$0.00	\$596,789.00	\$0.00	\$0.00	\$0.00	\$0.00
	0000000	NJ306316	✓	Hudson County	Spectrum Healthcare	74 Pacific Avenue	Jersey City	NJ	07304	\$122,290.00	\$122,290.00	\$0.00	\$122,290.00	\$0.00	\$0.00	\$0.00	\$0.00
	306258	NJ306258	✗	Passaic County	STRAIGHT & NARROW, INC.	P.O. Box 2738	Paterson	NJ	7509	\$1,715,936.00	\$1,715,936.00	\$1,715,936.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	0000000	306258	✗	Passaic County	Straight & Narrow, Inc.	P.O. Box 2738	Paterson	NJ	07509	\$1,080.00	\$1,080.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	306258	NJ306258	✗	99	STRAIGHT & NARROW, INC.	396 STRAIGHT STREET	Paterson	NJ	07501	\$57,373.00	\$57,373.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	0000000	NJ100720	✓	Bergen County	Team Management 2000 Inc	84 Main Street Private Building	Hackensack	NJ	07601	\$627.00	\$627.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	1000000	NJ100720	✓	Bergen County	Team Management 2000 Inc	84 Main Street Private Building	Hackensack	NJ	07601	\$1,477.00	\$1,477.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	1000002	NJ100720	✓	Bergen County	Team Management 2000 Inc	84 Main Street Private Building	Hackensack	NJ	07601	\$26,872.00	\$26,872.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	101830	NJ101830	✗	Bergen County	The Center for Alcohol and - Drug Resource	22-08 Route 208 South, Suite 7	Fair Lawn	NJ	7410	\$995,100.00	\$135,000.00	\$0.00	\$0.00	\$0.00	\$0.00	\$860,100.00	\$0.00
	0000000	NJ750182	✓	Union County	Trinitas Regional Medical Center	654 East Jersey Street 1st Floor	Elizabeth	NJ	07206	\$8,832.00	\$8,832.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	0000000	NJ750729	✓	Passaic County	Turning Point Inc	680 Broadway Suite 104	Paterson	NJ	07514-1526	\$5,855.00	\$5,855.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	NJ750729	NJ750729	✓	Passaic County	Turning Point Inc	680 Broadway Suite 104	Paterson	NJ	07514-1526	\$385,324.00	\$385,324.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	100939	NJ100939	✗	Camden County	Urban Renewal Corp	521 Washington St	Newark	NJ	7102	\$21,590.00	\$21,590.00	\$21,590.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00

	0000000	NJ102452	✓	Passaic County	Wayne Counseling and Family Services	1022 Hamburg Turnpike	Wayne	NJ	07470	\$4,290.00	\$4,290.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	0000000	NJ101836	✓	Passaic County	William Paterson University	300 Pompton Road Overlook South	Wayne	NJ	07470	\$141,064.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$141,064.00	\$0.00
	1000001	NJ101635	✓	Camden County	Women of Hope Resource Center Inc	331 White Horse Pike	Atco	NJ	08004	\$7,351.00	\$7,351.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	0000000	NJ103042	✓	Camden County	Work Group	3720-3708 Marlton Pike	Pennsauken	NJ	08110	\$8,334.00	\$8,334.00	\$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	\$7,496.00	\$7,496.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Total										\$43,610,073.00	\$33,703,751.00	\$5,467,099.00	\$4,622,861.00	\$0.00	\$0.00	\$9,906,322.00	\$0.00

* Indicates the imported record has an error.

^aOther than primary prevention. The amount reported in this row should reflect those expenditures made for direct services during the expenditure period, and otherwise reported on Table 4, Row 1. Do not include expenditures made for other capacity building/systems development.

^bExpenditures reported in the column are subcategory of expenditures reported for 'Prevention and Treatment Services' reported in Column B and meet the requirements of specialized services for pregnant women and women with dependent children.

^cIncludes 42 CFR 8.12: Federal Opioid Treatment Program (OTP) providers only. Expenditures reported in this column are a subcategory of total expenditures for 'Prevention and Treatment Services' reported in Column B.

^dIncludes all practitioners who have a current DEA registration that includes Schedule III authority and may prescribe buprenorphine for opioid use disorder in their practice if permitted under applicable state law. Expenditures reported in this column are a subcategory of total expenditures for 'Prevention and Treatment Services' reported in Column B.

^eThis expenditure category is mandated by Section 1243 of the Consolidated Appropriations Act, 2023 and includes an aggregate of expenditures allowable under The 2023 guidance, "Allowable Recovery Support Services (RSS) Expenditures through the SUBG and the MHBG." Only report RSS for those in need of RSS from substance use disorder. States are asked to begin reporting entity level expenditures for RSS, previously reported under Column B, 'Prevention and Treatment Services', in the stand-alone Column F. States are encouraged to begin reporting these expenditures as early as their 2026 SUPTRS BG Report, while required reporting will begin in 2027 and onward. States should use the footnotes to explain any challenges that that contribute to their inability to report RSS expenditures separately. The total of this column should be equal to that report on Table 4, Row 2 and should not include expenditures made for other capacity building/systems development.

^fThe amounts reported here should reflect direct delivery of primary prevention to the population and be consistent with the expenditures found on Table 4, Row 3, as well as Table 5a. Do not include expenditures for other capacity building/systems development.

^gThe most recent AtlasPlus HIV data report published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be required to set-aside 5% of their respective SUPTRS BG award to establish one or more projects to provide early intervention services for the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment.

Footnotes:

C: Expenditure Reports

Table 8a - Maintenance of Effort (MOE) for State Expenditures for Substance Use Disorder Prevention, Treatment, and Recovery Support Services

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.

Expenditure Period Start Date: 07/01/2024 Expenditure Period End Date: 06/30/2025

Total Single State Agency (SSA) Expenditures for Substance Abuse Prevention and Treatment		
Period	SSA State Expenditures (A)	<u>A1(2023) + A2(2024)</u> 2 (C)
SFY 2023	\$140,116,467.00	
SFY 2024	\$153,661,620.00	\$146,889,044
SFY 2025	\$154,148,317.00	

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

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

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 attachment.

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Footnotes:

The \$ 154,148,317.00 SFY 2025 amount reported is the sum of \$115,410,973.00 reported in Table 2, Column E and New Jersey matched \$38,737,344 of the \$252,367,903 Medicaid funds included in Table 2 Column D in its MOE Methodology.

MAINTENANCE OF EFFORT (MOE) CALCULATIONS FOR SFY 2025 SUBSTANCE ABUSE PREVENTION AND TREATMENT (SAPT) BLOCK GRANT

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

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

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
100-054-7700-175, Alcohol Education Rehabilitation and Enforcement Fund (AEREF)
100-054-7700-176, Alcohol Treatment Fund Program
100-054-7700-177, Drug Enforcement and Demand Reduction Fund
100-046-4290-212, Recovery Coach Program
100-054-7700-231, Supportive Housing Subsidies
100-054-7700-232, Recovery Housing
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
100-054-7700-285, Partnership for a Drug-Free New Jersey
760-054-7700-001, (4290-001) AEREF; funding for the Local Alcohol Authorities Expansion Program
100-054-7700-015, Opioid Control Account

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 (NJCFIS). 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.

C: Expenditure Reports

Table 8b – Base on Maintenance of Effort (MOE) for Expenditures for Services to Pregnant Women and Women with Dependent Children

This table provides a report of all state and SUPTRS BG funds expended on specialized SUD treatment and related services which meet the SUPTRS BG requirements for pregnant women and women with dependent children during the state fiscal year immediately preceding the FFY for which the state is applying for funds. Dates given are for the FY 2026 SUPTRS BG Report. For the FY 2027 SUPTRS BG Report, increase each year (other than the base year) by one.

Expenditure Period Start Date:

07/01/2024

Expenditure Period End Date:

06/30/2025

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

Maintenance			
Period	A. Total Women's Base	B. Total Expenditures	Expense Type
SFY 2023		\$ 8,093,363.00	Actual
SFY 2024		\$ 7,990,789.00	Actual
SFY 2025		\$ 7,494,494.00	☒ Actual ☐ Estimated
Enter the amount the State plans to expend in SFY 2026 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)): \$ 6,497,485.00;			

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

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

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).

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Footnotes:

See attached

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 2025.

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 2025, it totals \$7,494,494 as documented in Row B on Table 8d in Web BGAS.

D: Population and Services Reports

Table 9 - Prevention Strategy Report

This table requires additional information about the primary prevention activities conducted by the entities listed on SUPTRS BG Table 7.

Expenditure Period Start Date: 10/1/2022 Expenditure Period End Date: 9/30/2024

Risks	A. Strategies	B. Providers
Economically Disadvantaged [6]	1. Information Dissemination	
	1. Clearinghouse/information resources centers	16
	5. Community-Based Process	
	2. Systematic planning	16
Already Using Substances [9]	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 Use Substances [1]	2. Education	
	1. Parenting and family management	18
	2. Ongoing classroom and/or small group sessions	12
	3. Peer leader/helper programs	5
	4. Education programs for youth groups	6
	5. Mentors	24
	3. Alternatives	
	1. Drug free dances and parties	10
	2. Youth/adult leadership activities	4
	3. Community drop-in centers	3
	6. Environmental	
	1. Promoting the establishment or review of alcohol, tobacco, and drug use policies in schools	3
	2. Guidance and technical assistance on monitoring enforcement governing availability and distribution of alcohol, tobacco, and other drugs	7
Pregnant	2. Education	

Women/Teens [2]	1. Parenting and family management	5
	2. Ongoing classroom and/or small group sessions	5
People with Differing Physical Abilities [7]	2. Education	
	5. Mentors	4
	4. Problem Identification and Referral	
	2. Student Assistance Programs	3
People Who End High School Pre-Graduation [3]	1. Information Dissemination	
	2. Resources directories	1
	2. Education	
	2. Ongoing classroom and/or small group sessions	1
	5. Mentors	1
Violent and Delinquent Behavior [4]	2. Education	
	1. Parenting and family management	2
People Who Experience Abuse [8]	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 [10]	2. Education	
	2. Ongoing classroom and/or small group sessions	2
	3. Alternatives	
	3. Community drop-in centers	3
Mental Health Problems [5]	1. Information Dissemination	
	1. Clearinghouse/information resources centers	21
	2. Resources directories	21
	4. Brochures	1
	8. Information lines/Hot lines	21
	9. Multi-agency coordination and collaboration/coalition	6

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Footnotes:

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Table 10a - Treatment Utilization Matrix for Persons (Unduplicated Count) Admitted to Treatment for Alcohol and Other Substance Use Disorder in the Preceding 12-months by Level of Care
Table 10a is based on the required SSA reporting of data on SUD client treatment admissions and subsequent admissions to an episode of care that occur during the most recently completed SFY. Grantees must report data for SUD client treatment admissions and subsequent admissions to an episode of care during the period that were funded, in full or in part, with SUPTRS BG funding. Grantees are encouraged to use TEDS data when completing this table. If the SSA is unable to report SUD client treatment admissions that are limited to SUPTRS BG, COVID-19, or ARP funds, please briefly explain in Footnote below.

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

Level of Care	SUPTRS BG Number of Admissions > Number of Persons Served		COVID-19 ^a Number of Admissions > Number of Persons Served		ARP ^b Number of Admissions > Number of Persons Served		SUPTRS BG Service Costs			COVID-19 Costs ^a			ARP Costs ^b		
	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)
Withdrawal Management (24-HOUR CARE) ^c															
1. Hospital Inpatient	0	0													
2. Free-Standing Residential	187	166													
REHABILITATION/RESIDENTIAL ^c															
3. Hospital Inpatient	2	2			1	1									
4. Short-term (up to 30 days)	926	836			2	2									
5. Long-term (over 30 days)	1,402	1,285			68	68									
AMBULATORY (OUTPATIENT) ^c															
6. Outpatient	1,873	1,792	77	77	477	469									
7. Intensive Outpatient	1,343	1,270	79	77	231	216									
8. Withdrawal Management	7	7													
Medication for Opioid Use Disorder (MOUD) Treatment ^c															
9. Withdrawal Management with Opioid Agonist Medications	22	22													
10. Continuous MOUD and Other Services in Outpatient Settings	960	827													

^aPer the instructions, the reporting period is for the preceding 12-month period of the most recently completed SFY. Enter SUPTRS BG COVID-19 admissions, persons served, and expenditures for the same one-year period. Note: COVID supplemental funds had an original award period of March 15, 2021 through March 14, 2023. States that were granted a second No Cost Extension (NCE) on March 14, 2024 had until March 14, 2025 to expend their COVID-19 supplemental funds. Those states expending supplemental funds under the second NCE are required to report on admissions, persons served, and expenditures made during SFY 2025, for most states that include expenditures between July 1, 2024 and March 14, 2025, in the COVID-19 designated column of the FY2026 Report.

^bPer the instructions, the reporting period is for the preceding 12-month period of the most recently completed SFY. Enter SUPTRS BG ARP admissions, persons served, and expenditures for the same one-year period. Note: ARP supplemental funds had an award period of September 1, 2021 through March 24, 2025. States are required to report ARP admissions, persons served, and expenditures made during SFY 2025, for most states this is July 1, 2024 through March 24, 2025, in the ARP designated column in the FY2026 Report

^cIn FY2020 modifications were made to "Level of Care" (LOC) and "Type of Treatment Service/Setting" to "Medication-Assisted Treatment" and "Medication for Opioid Use Disorder" 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 Withdrawal Management," Row 9 and "MOUD Treatment Outpatient," Row 10. MOUD Withdrawal Management includes hospital withdrawal management, residential withdrawal management, or ambulatory withdrawal management services/settings AND Medications for Opioid Use Disorder Treatment. MOUD Treatment Outpatient includes outpatient services/settings AND MOUD Treatment. The change was made to better align with language that reflects that medications for opioid use disorder is a category of medications that are often provided in conjunction with other services in outpatient settings and more importantly convey those medications do not substitute one drug for another

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)

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Footnotes:

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Table 10b - Number of Persons Served (Unduplicated Count) Who Received Recovery Support Services for Substance Use Disorder by Age and Sex

This table provides an aggregate profile of the unduplicated persons that received recovery support services funded through the SUPTRS BG by age and sex. Grantees are requested to include data on Table 10b for individuals with SUD who received recovery support services that were funded, in full or in part, with SUPTRS BG funding. If data reported also includes data on SUD persons served in recovery support services that are funded with other sources of funding, please briefly explain in footnote below.

Expenditure Period Start Date: 07/01/2024 Expenditure Period End Date: 06/30/2025

	Age 0-5 ^a			Age 6-12		
	Female	Male	Not Available ^b	Female	Male	Not Available ^b
1. Peer-to-Peer Support Individual	0	0	0	0	0	0
2. Peer-Led Support Group	0	0	0	0	0	0
3. Peer-Led Training or Peer Certification Activity	0	0	0	0	0	0
4. Recovery Housing	0	0	0	0	0	0
5. Recovery Support Service Childcare Fee or Family Caregiver Fee	0	0	0	0	0	0
6. Recovery Support Service Transportation	0	0	0	0	0	0
7. Secondary School, High School, or Collegiate Recovery Program Service or Activity	0	0	0	0	0	0
8. Recovery Social Support or Social Inclusion Activity	0	0	0	0	0	0
9. Other Approved Recovery Support Event or Activity ^c	0	0	0	0	0	0
Total	0	0	0	0	0	0

^aAge category 0-5 years is not applicable.

	Age 13-17			Age 18-20		
	Female	Male	Not Available ^b	Female	Male	Not Available ^b
1. Peer-to-Peer Support Individual	0	0	0	6	0	0
2. Peer-Led Support Group	0	0	0	0	0	0
3. Peer-Led Training or Peer Certification Activity	0	0	0	0	0	0
4. Recovery Housing	0	0	0	3	10	0
5. Recovery Support Service Childcare Fee or Family Caregiver Fee	0	0	0	0	0	0
6. Recovery Support Service Transportation	0	0	0	0	0	0
7. Secondary School, High School, or Collegiate Recovery Program Service or Activity	0	0	0	0	0	0
8. Recovery Social Support or Social Inclusion Activity	0	0	0	0	0	0
9. Other Approved Recovery Support Event or Activity ^c	0	0	0	0	0	0
Total	0	0	0	9	10	0

	Age 21-24			Age 25-44		
	Female	Male	Not Available ^b	Female	Male	Not Available ^b
1. Peer-to-Peer Support Individual	33	0	0	110	0	0
2. Peer-Led Support Group	0	0	0	0	0	0
3. Peer-Led Training or Peer Certification Activity	0	0	0	0	0	0
4. Recovery Housing	17	31	0	162	378	3

5. Recovery Support Service Childcare Fee or Family Caregiver Fee	0	0	0	0	0	0
6. Recovery Support Service Transportation	0	0	0	0	0	0
7. Secondary School, High School, or Collegiate Recovery Program Service or Activity	0	0	0	0	0	0
8. Recovery Social Support or Social Inclusion Activity	0	0	0	0	0	0
9. Other Approved Recovery Support Event or Activity ^c	0	0	0	0	0	0
Total	50	31	0	272	378	3

	Age 45-64			Age 65-74		
	Female	Male	Not Available ^b	Female	Male	Not Available ^b
1. Peer-to-Peer Support Individual	0	0	0	0	0	0
2. Peer-Led Support Group	0	0	0	0	0	0
3. Peer-Led Training or Peer Certification Activity	0	0	0	0	0	0
4. Recovery Housing	55	149	0	2	7	0
5. Recovery Support Service Childcare Fee or Family Caregiver Fee	0	0	0	0	0	0
6. Recovery Support Service Transportation	0	0	0	0	0	0
7. Secondary School, High School, or Collegiate Recovery Program Service or Activity	0	0	0	0	0	0
8. Recovery Social Support or Social Inclusion Activity	0	0	0	0	0	0
9. Other Approved Recovery Support Event or Activity ^c	0	0	0	0	0	0
Total	55	149	0	2	7	0

	Age 75+			Age Not Available		
	Female	Male	Not Available ^b	Female	Male	Not Available ^b
1. Peer-to-Peer Support Individual	0	0	0	0	0	2011
2. Peer-Led Support Group	0	0	0	0	0	0
3. Peer-Led Training or Peer Certification Activity	0	0	0	0	0	0
4. Recovery Housing	0	0	1	0	0	0
5. Recovery Support Service Childcare Fee or Family Caregiver Fee	0	0	0	0	0	0
6. Recovery Support Service Transportation	0	0	0	0	0	0
7. Secondary School, High School, or Collegiate Recovery Program Service or Activity	0	0	0	0	0	14531
8. Recovery Social Support or Social Inclusion Activity	0	0	0	0	0	0
9. Other Approved Recovery Support Event or Activity ^c	0	0	0	0	0	0
Total	0	0	1	0	0	16,542

	Total		
	Female	Male	Not Available ^b
1. Peer-to-Peer Support Individual	149	0	2,011
2. Peer-Led Support Group	0	0	0
3. Peer-Led Training or Peer Certification Activity	0	0	0

4. Recovery Housing	239	575	4
5. Recovery Support Service Childcare Fee or Family Caregiver Fee	0	0	0
6. Recovery Support Service Transportation	0	0	0
7. Secondary School, High School, or Collegiate Recovery Program Service or Activity	0	0	14,531
8. Recovery Social Support or Social Inclusion Activity	0	0	0
9. Other Approved Recovery Support Event or Activity ^c	0	0	0
Total	388	575	16,546
Comments on Data (Age):			
Comments on Data (Sex):			
Comments on Data (Overall):			

^aAge category 0-5 years is not applicable. (Continued below).

^bThe 'Not Available' category is to be used only for cases where the requested field in state data systems is null or blank, an invalid value is added.

^c'Other' includes:

- Recovery Health and Wellness Educational Event or Activity
- Peer-Led Recovery Educational Workshop or Event
- Culturally Based Recovery Practice or Creative and Expressive Arts Recovery Activity
- Peer-Led Recovery Educational Workshop or Event; Recovery Friendly Workplace (RFW) Initiative, Activity, or Supportive Employment Service;
- Recovery Friendly Workplace (RFW) Initiative, Activity, or Supportive Employment Service;
- Recovery Community Organization (RCO) or Recovery Community Center (RCC) Service or Activity; as well as all
- Other approved SUD RSS Events or Activities through consultation with respective state SUPTRS BG Project Officer.

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Footnotes:

Peer-to-Peer Support Individual data from the Maternal Wraparound Program (MWRAP)

Recovery Housing data from the Oxford House program

Age Not Available/ Gender Not Available data for Peer-to-Peer Support Individual consists of 134 dependent children aged 1 to 17 served in MWRAP and 1,877 individuals served in the Intensive Recovery Treatment Support program

Age Not Available/ Gender Not Available data for Secondary School, High School, or Collegiate Recovery Program Service or Activity consists of 14,531 individuals served in the College Recovery Services program

D: Population and Services Reports

Table 11a – Number of Persons (Unduplicated Count) Admitted to Treatment for Alcohol and Other Substance Use Disorders in the Proceeding 12-months by Age, Sex, Race and Ethnicity – SUPTRS BG Expenditures Only

Table 11a is based on the required SSA reporting of data on SUD client treatment admissions and subsequent admissions to an episode of care during the period that occur during the most recently completed SFY. In Table 11a, each client admitted to treatment during the immediately prior completed SFY is to be reported. Grantees are requested to include data on Table 11a for those SUD client treatment admissions that were funded, in full or in part, with SUPTRS BG funds. If Table 11a includes additional data reporting on SUD client treatment admissions which are funded with other sources of funding, please briefly explain in the footnote below.

Expenditure Period Start Date: 07/01/2024 Expenditure Period End Date: 06/30/2025

SUPTRS BG Table 11a - Number of Persons (Unduplicated Count) Admitted to Treatment for Alcohol and Other Substance Use Disorders in the Proceeding 12-months by Age, Sex, Race and Ethnicity – SUPTRS BG Expenditures Only

	Total of Race				American Indian or Alaska Native		
	Female	Male	Not Available ^b	Total	Female	Male	Not Available ^b
0-5 years ^a	0	0	0	0	0	0	0
6-12 years	0	0	0	0	0	0	0
13-17 years	0	0	0	0	0	0	0
18-20 years	14	22	1	37	0	0	0
21-24 years	43	102	0	145	0	5	0
25-44 years	760	1,459	6	2,225	2	6	0
45-64 years	374	1,042	2	1,418	1	5	0
65-74 years	54	172	0	226	0	0	0
75+ years	2	12	0	14	0	0	0
Not Available	0	0	0	0	0	0	0
Total	1,247	2,809	9	4,065	3	16	0
Pregnant Women	52				0		
Number of Persons Served who were admitted in a Period Prior to the 12-month reporting Period							4047
Number of Persons Served outside of the levels of care described on SUPTRS BG Table 10							1

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

☒ Yes ☐ No

Comments on Data (Race and Ethnicity)	
Comments on Data (Sex)	
Comments on Data (Overall)	

^aAge category 0-5 years is not applicable.

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

SUPTRS BG Table 11a - Number of Persons (Unduplicated Count) Admitted to Treatment for Alcohol and Other Substance Use Disorders in the Proceeding 12-months by Age, Sex, Race and Ethnicity – SUPTRS BG Expenditures Only

	Asian			Black or African American		
	Female	Male	Not Available ^b	Female	Male	Not Available ^b
0-5 years ^a	0	0	0	0	0	0
6-12 years	0	0	0	0	0	0
13-17 years	0	0	0	0	0	0
18-20 years	0	0	0	4	11	1
21-24 years	1	1	0	16	21	0
25-44 years	7	18	0	150	320	0
45-64 years	1	5	0	131	344	1

65-74 years	0	0	0	12	77	0
75+ years	0	0	0	0	1	0
Not Available	0	0	0	0	0	0
Total	9	24	0	313	774	2
Pregnant Women	0			13		

^aAge category 0-5 years is not applicable.

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

SUPTRS BG Table 11a - Number of Persons (Unduplicated Count) Admitted to Treatment for Alcohol and Other Substance Use Disorders in the Proceeding 12-months by Age, Sex, Race and Ethnicity – SUPTRS BG Expenditures Only

	Native Hawaiian or Other Pacific Islander			White		
	Female	Male	Not Available ^b	Female	Male	Not Available ^b
0-5 years ^a	0	0	0	0	0	0
6-12 years	0	0	0	0	0	0
13-17 years	0	0	0	0	0	0
18-20 years	0	0	0	10	10	0
21-24 years	0	1	0	25	72	0
25-44 years	11	14	1	582	1,085	5
45-64 years	5	9	0	232	672	1
65-74 years	0	1	0	42	94	0
75+ years	0	0	0	2	11	0
Not Available	0	0	0	0	0	0
Total	16	25	1	893	1,944	6
Pregnant Women	1			37		

^aAge category 0-5 years is not applicable.

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

SUPTRS BG Table 11a - Number of Persons (Unduplicated Count) Admitted to Treatment for Alcohol and Other Substance Use Disorders in the Proceeding 12-months by Age, Sex, Race and Ethnicity – SUPTRS BG Expenditures Only

	Some Other Race			More than One Race Reported		
	Female	Male	Not Available ^b	Female	Male	Not Available ^b
0-5 years ^a	0	0	0	0	0	0
6-12 years	0	0	0	0	0	0
13-17 years	0	0	0	0	0	0
18-20 years	0	0	0	0	1	0
21-24 years	0	0	0	1	2	0
25-44 years	0	0	0	8	16	0
45-64 years	0	0	0	4	7	0
65-74 years	0	0	0	0	0	0
75+ years	0	0	0	0	0	0
Not Available	0	0	0	0	0	0
Total	0	0	0	13	26	0
Pregnant Women	0			1		

^aAge category 0-5 years is not applicable.

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

SUPTRS BG Table 11a - Number of Persons (Unduplicated Count) Admitted to Treatment for Alcohol and Other Substance Use Disorders in the Proceeding 12-months by Age, Sex, Race and Ethnicity – SUPTRS BG Expenditures Only

	Race Not Available			Not Hispanic or Latino		
	Female	Male	Not Available ^b	Female	Male	Not Available ^b
0-5 years ^a	0	0	0	0	0	0
6-12 years	0	0	0	0	0	0
13-17 years	0	0	0	0	0	0
18-20 years	0	0	0	9	13	1
21-24 years	0	0	0	27	56	0
25-44 years	0	0	0	609	1,023	4
45-64 years	0	0	0	333	815	2
65-74 years	0	0	0	54	158	0
75+ years	0	0	0	2	12	0
Not Available	0	0	0	0	0	0
Total	0	0	0	1,034	2,077	7
Pregnant Women	0			41		

^aAge category 0-5 years is not applicable.

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

SUPTRS BG Table 11a - Number of Persons (Unduplicated Count) Admitted to Treatment for Alcohol and Other Substance Use Disorders in the Proceeding 12-months by Age, Sex, Race and Ethnicity – SUPTRS BG Expenditures Only

	Hispanic or Latino			Hispanic or Latino Origin Not Available		
	Female	Male	Not Available ^b	Female	Male	Not Available ^b
0-5 years ^a	0	0	0	0	0	0
6-12 years	0	0	0	0	0	0
13-17 years	0	0	0	0	0	0
18-20 years	5	9	0	0	0	0
21-24 years	17	48	0	0	0	0
25-44 years	146	435	2	0	0	0
45-64 years	39	229	0	0	0	0
65-74 years	0	14	0	0	0	0
75+ years	0	1	0	0	0	0
Not Available	0	0	0	0	0	0
Total	207	736	2	0	0	0
Pregnant Women	11			0		

^aAge category 0-5 years is not applicable.

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

SUPTRS BG Table 11a - Number of Persons (Unduplicated Count) Admitted to Treatment for Alcohol and Other Substance Use Disorders in the Proceeding 12-months by Age, Sex, Race and Ethnicity – SUPTRS BG Expenditures Only

Total of Ethnicity			
	Female	Male	Not Available ^b

0-5 years ^a	0	0	0	0
6-12 years	0	0	0	0
13-17 years	0	0	0	0
18-20 years	14	22	1	37
21-24 years	44	104	0	148
25-44 years	755	1,458	6	2,219
45-64 years	372	1,044	2	1,418
65-74 years	54	172	0	226
75+ years	2	13	0	15
Not Available	0	0	0	0
Total	1,241	2,813	9	4,063
Pregnant Women	52			

^aAge category 0-5 years is not applicable.

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

Footnotes:

D: Population and Services Reports

Table 11b - Number of Persons (Unduplicated Count) Admitted to Treatment for Alcohol and Other Drug Use Disorders by Ages, Sex, Race and Ethnicity – COVID19^a</sup>
Supplemental Funding

This table provides an aggregate profile of the unduplicated number of admissions and persons for services funded using COVID-19 Relief Supplemental Funding. States that were granted a second No Cost Extension (NCE) on March 14, 2024 had until March 14, 2025 to expend their COVID-19 supplemental funds. Those expending supplemental funds under the second NCE are required to report individuals served from the start of SFY 2025 through March 14, 2025 in COVID-19 designated table (11b) for the SUPTRS BG 2026 Report.

Expenditure Period Start Date: 07/01/2024 Expenditure Period End Date: 06/30/2025

SUPTRS BG Table 11b - Number of Persons (Unduplicated Count) Admitted to Treatment for Alcohol and Other Drug Use Disorders by Ages, Sex, Race and Ethnicity – COVID19^a Supplemental Funding

	Total of Race				American Indian or Alaska Native		
	Female	Male	Not Available ^c	Total	Female	Male	Not Available ^c
0-5 years ^b	0	0	0	0	0	0	0
6-12 years	0	0	0	0	0	0	0
13-17 years	1	0	0	1	0	0	0
18-20 years	0	3	0	3	0	0	0
21-24 years	1	4	0	5	0	0	0
25-44 years	25	60	2	87	0	0	0
45-64 years	12	37	0	49	0	0	0
65-74 years	1	5	0	6	0	0	0
75+ years	0	0	0	0	0	0	0
Not Available	0	0	0	0	0	0	0
Total	40	109	2	151	0	0	0
Pregnant Women	1				0		

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)	

^aPer the instructions, the reporting period is for the preceding 12-month period of the most recently completed SFY. Enter SUPTRS BG COVID-19 admissions for the same one-year period. Note: COVID supplemental funds had an original award period of March 15, 2021 through March 14, 2023. States that were granted a second No Cost Extension (NCE) on March 14, 2024 had until March 14, 2025 to expend their COVID-19 supplemental funds. Those states expending supplemental funds under the second NCE are required to report on admissions made during SFY 2025, for most states that include admissions between July 1, 2024 and March 14, 2025, in the COVID-19 designated table (11b) of the FY2026 Report.

^bAge category 0-5 years is not applicable.

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

SUPTRS BG Table 11b - Number of Persons (Unduplicated Count) Admitted to Treatment for Alcohol and Other Drug Use Disorders by Ages, Sex, Race and Ethnicity – COVID19^a Supplemental Funding

	Asian			Black or African American		
	Female	Male	Not Available ^c	Female	Male	Not Available ^c
0-5 years ^b	0	0	0	0	0	0
6-12 years	0	0	0	0	0	0
13-17 years	0	0	0	0	0	0
18-20 years	0	0	0	0	2	0
21-24 years	0	0	0	0	0	0
25-44 years	1	1	0	6	10	0
45-64 years	0	5	0	2	6	0
65-74 years	0	0	0	0	0	0
75+ years	0	0	0	0	0	0

Not Available	0	0	0	0	0	0
Total	1	6	0	8	18	0
Pregnant Women	0			0		

^aPer the instructions, the reporting period is for the preceding 12-month period of the most recently completed SFY. Enter SUPTRS BG COVID-19 admissions for the same one-year period. Note: COVID supplemental funds had an original award period of March 15, 2021 through March 14, 2023. States that were granted a second No Cost Extension (NCE) on March 14, 2024 had until March 14, 2025 to expend their COVID-19 supplemental funds. Those states expending supplemental funds under the second NCE are required to report on admissions made during SFY 2025, for most states that include admissions between July 1, 2024 and March 14, 2025, in the COVID-19 designated table (11b) of the FY2026 Report.

^bAge category 0-5 years is not applicable.

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

SUPTRS BG Table 11b - Number of Persons (Unduplicated Count) Admitted to Treatment for Alcohol and Other Drug Use Disorders by Ages, Sex, Race and Ethnicity – COVID19^a Supplemental Funding

	Native Hawaiian or Other Pacific Islander			White		
	Female	Male	Not Available ^c	Female	Male	Not Available ^c
0-5 years ^b	0	0	0	0	0	0
6-12 years	0	0	0	0	0	0
13-17 years	0	0	0	1	0	0
18-20 years	0	0	0	0	1	0
21-24 years	0	0	0	1	4	0
25-44 years	0	0	0	18	48	1
45-64 years	0	0	0	9	25	0
65-74 years	0	0	0	1	5	0
75+ years	0	0	0	0	0	0
Not Available	0	0	0	0	0	0
Total	0	0	0	30	83	1
Pregnant Women	0			1		

^aPer the instructions, the reporting period is for the preceding 12-month period of the most recently completed SFY. Enter SUPTRS BG COVID-19 admissions for the same one-year period. Note: COVID supplemental funds had an original award period of March 15, 2021 through March 14, 2023. States that were granted a second No Cost Extension (NCE) on March 14, 2024 had until March 14, 2025 to expend their COVID-19 supplemental funds. Those states expending supplemental funds under the second NCE are required to report on admissions made during SFY 2025, for most states that include admissions between July 1, 2024 and March 14, 2025, in the COVID-19 designated table (11b) of the FY2026 Report.

^bAge category 0-5 years is not applicable.

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

SUPTRS BG Table 11b - Number of Persons (Unduplicated Count) Admitted to Treatment for Alcohol and Other Drug Use Disorders by Ages, Sex, Race and Ethnicity – COVID19^a Supplemental Funding

	Some Other Race			More than One Race Reported		
	Female	Male	Not Available ^c	Female	Male	Not Available ^c
0-5 years ^b	0	0	0	0	0	0
6-12 years	0	0	0	0	0	0
13-17 years	0	0	0	0	0	0
18-20 years	0	0	0	0	0	0
21-24 years	0	0	0	0	0	0
25-44 years	0	0	0	0	1	1
45-64 years	0	0	0	1	1	0
65-74 years	0	0	0	0	0	0
75+ years	0	0	0	0	0	0
Not Available	0	0	0	0	0	0
Total	0	0	0	1	2	1
Pregnant Women	0			0		

^aPer the instructions, the reporting period is for the preceding 12-month period of the most recently completed SFY. Enter SUPTRS BG COVID-19 admissions for the same one-year period. Note: COVID supplemental funds had an original award period of March 15, 2021 through March 14, 2023. States that were granted a second No Cost Extension (NCE) on March 14, 2024 had until March 14, 2025 to expend their COVID-19 supplemental funds. Those states expending supplemental funds under the second NCE are required to report on admissions made during SFY 2025, for most states that include admissions between July 1, 2024 and March 14, 2025, in the COVID-19 designated table (11b) of the FY2026 Report.

^bAge category 0-5 years is not applicable.

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

SUPTRS BG Table 11b - Number of Persons (Unduplicated Count) Admitted to Treatment for Alcohol and Other Drug Use Disorders by Ages, Sex, Race and Ethnicity – COVID19^a Supplemental Funding

	Race Not Available			Not Hispanic or Latino		
	Female	Male	Not Available ^c	Female	Male	Not Available ^c
0-5 years ^b	0	0	0	0	0	0
6-12 years	0	0	0	0	0	0
13-17 years	0	0	0	0	0	0
18-20 years	0	0	0	0	1	0
21-24 years	0	0	0	0	1	0
25-44 years	0	0	0	16	35	2
45-64 years	0	0	0	7	24	0
65-74 years	0	0	0	1	4	0
75+ years	0	0	0	0	0	0
Not Available	0	0	0	0	0	0
Total	0	0	0	24	65	2
Pregnant Women	0			1		

^aPer the instructions, the reporting period is for the preceding 12-month period of the most recently completed SFY. Enter SUPTRS BG COVID-19 admissions for the same one-year period. Note: COVID supplemental funds had an original award period of March 15, 2021 through March 14, 2023. States that were granted a second No Cost Extension (NCE) on March 14, 2024 had until March 14, 2025 to expend their COVID-19 supplemental funds. Those states expending supplemental funds under the second NCE are required to report on admissions made during SFY 2025, for most states that include admissions between July 1, 2024 and March 14, 2025, in the COVID-19 designated table (11b) of the FY2026 Report.

^bAge category 0-5 years is not applicable.

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

SUPTRS BG Table 11b - Number of Persons (Unduplicated Count) Admitted to Treatment for Alcohol and Other Drug Use Disorders by Ages, Sex, Race and Ethnicity – COVID19^a Supplemental Funding

	Hispanic or Latino			Hispanic or Latino Origin Not Available		
	Female	Male	Not Available ^c	Female	Male	Not Available ^c
0-5 years ^b	0	0	0	0	0	0
6-12 years	0	0	0	0	0	0
13-17 years	1	0	0	0	0	0
18-20 years	0	2	0	0	0	0
21-24 years	1	3	0	0	0	0
25-44 years	9	25	0	0	0	0
45-64 years	5	13	0	0	0	0
65-74 years	0	1	0	0	0	0
75+ years	0	0	0	0	0	0
Not Available	0	0	0	0	0	0
Total	16	44	0	0	0	0
Pregnant Women	0			0		

^aPer the instructions, the reporting period is for the preceding 12-month period of the most recently completed SFY. Enter SUPTRS BG COVID-19 admissions for the same one-year period. Note: COVID supplemental funds had an original award period of March 15, 2021 through March 14, 2023. States that were granted a second No Cost Extension (NCE) on March 14, 2024 had until March 14, 2025 to expend their COVID-19 supplemental funds. Those states

expending supplemental funds under the second NCE are required to report on admissions made during SFY 2025, for most states that include admissions between July 1, 2024 and March 14, 2025, in the COVID-19 designated table (11b) of the FY2026 Report.

^bAge category 0-5 years is not applicable.

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

SUPTRS BG Table 11b - Number of Persons (Unduplicated Count) Admitted to Treatment for Alcohol and Other Drug Use Disorders by Ages, Sex, Race and Ethnicity – COVID19^a Supplemental Funding

	Total of Ethnicity			
	Female	Male	Not Available ^c	Total
0-5 years ^b	0	0	0	0
6-12 years	0	0	0	0
13-17 years	1	0	0	1
18-20 years	0	3	0	3
21-24 years	1	4	0	5
25-44 years	25	60	2	87
45-64 years	12	37	0	49
65-74 years	1	5	0	6
75+ years	0	0	0	0
Not Available	0	0	0	0
Total	40	109	2	151
Pregnant Women	1			

^aPer the instructions, the reporting period is for the preceding 12-month period of the most recently completed SFY. Enter SUPTRS BG COVID-19 admissions for the same one-year period. Note: COVID supplemental funds had an original award period of March 15, 2021 through March 14, 2023. States that were granted a second No Cost Extension (NCE) on March 14, 2024 had until March 14, 2025 to expend their COVID-19 supplemental funds. Those states expending supplemental funds under the second NCE are required to report on admissions made during SFY 2025, for most states that include admissions between July 1, 2024 and March 14, 2025, in the COVID-19 designated table (11b) of the FY2026 Report.

^bAge category 0-5 years is not applicable.

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

Footnotes:

D: Population and Services Reports

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

This table requires designated states, as defined in section 1924(b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-24(b)), to provide information on Early Intervention Services for HIV including pre-test counseling, testing, post-test counseling, and the provision of therapeutic measures to diagnose the extent of deficiency in the immune system, to prevent and treat the deterioration of immune system, and to prevent and treat conditions arising from HIV/AIDS funded with SUPTRS BG funds.

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

1. Number of EIS/HIV projects among SUPTRS BG sub-recipients in the state	A. Statewide _____	B. 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 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 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.

D: 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 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: 7/1/2024 Expenditure Period End Date: 6/30/2025

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).
- ☐ Federal 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 2025. 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 use disorder 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 2025.

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Footnotes:

E: 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]	1,020	911
Total number of clients with non-missing values on employment/student status [denominator]	8,513	8,513
Percent of clients employed or student (full-time and part-time)	12.0%	10.7%
Notes (for this level of care):		
Number of CY 2024 admissions submitted:		11,611
Number of CY 2024 discharges submitted:		11,526
Number of CY 2024 discharges linked to an admission:		11,318
Number of linked discharges after exclusions (excludes: withdrawal management, rehabilitation/residential hospital, MOUD clients; deaths; incarcerated):		8,572
Number of CY 2024 linked discharges eligible for this calculation (non-missing values):		8,513

Source: SAMHSA/CBHSQ TEDS CY 2024 admissions file and CY 2
[Records received through 3/19/2026]

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]	1,123	1,613
Total number of clients with non-missing values on employment/student status [denominator]	5,189	5,189
Percent of clients employed or student (full-time and part-time)	21.6%	31.1%
Notes (for this level of care):		
Number of CY 2024 admissions submitted:		7,457
Number of CY 2024 discharges submitted:		7,290
Number of CY 2024 discharges linked to an admission:		7,189

Number of linked discharges after exclusions (excludes: withdrawal management, rehabilitation/residential hospital, MOUD clients; deaths; incarcerated):	5,289
Number of CY 2024 linked discharges eligible for this calculation (non-missing values):	5,189

Source: SAMHSA/CBHSQ TEDS CY 2024 admissions file and CY 2
[Records received through 3/19/2026]

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]	7,730	9,019
Total number of clients with non-missing values on employment/student status [denominator]	13,759	13,759
Percent of clients employed or student (full-time and part-time)	56.2%	65.5%
Notes (for this level of care):		
Number of CY 2024 admissions submitted:		25,626
Number of CY 2024 discharges submitted:		24,512
Number of CY 2024 discharges linked to an admission:		23,441
Number of linked discharges after exclusions (excludes: withdrawal management, rehabilitation/residential hospital, MOUD clients; deaths; incarcerated):		14,073
Number of CY 2024 linked discharges eligible for this calculation (non-missing values):		13,759

Source: SAMHSA/CBHSQ TEDS CY 2024 admissions file and CY 2
[Records received through 3/19/2026]

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]	4,817	6,461
Total number of clients with non-missing values on employment/student status [denominator]	13,562	13,562
Percent of clients employed or student (full-time and part-time)	35.5%	47.6%
Notes (for this level of care):		
Number of CY 2024 admissions submitted:		19,577
Number of CY 2024 discharges submitted:		18,981
Number of CY 2024 discharges linked to an admission:		18,904

Number of linked discharges after exclusions (excludes: withdrawal management, rehabilitation/residential hospital, MOUD clients; deaths; incarcerated):	14,102
Number of CY 2024 linked discharges eligible for this calculation (non-missing values):	13,562

Source: SAMHSA/CBHSQ TEDS CY 2024 admissions file and CY 2
[Records received through 3/19/2026]

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Footnotes:

E: 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]	5,415	7,459
Total number of clients with non-missing values on living arrangements [denominator]	8,513	8,513
Percent of clients in stable living situation	63.6%	87.6%
Notes (for this level of care):		
Number of CY 2024 admissions submitted:		11,611
Number of CY 2024 discharges submitted:		11,526
Number of CY 2024 discharges linked to an admission:		11,318
Number of linked discharges after exclusions (excludes: withdrawal management, rehabilitation/residential hospital, MOUD clients; deaths; incarcerated):		8,572
Number of CY 2024 linked discharges eligible for this calculation (non-missing values):		8,513

Source: SAMHSA/CBHSQ TEDS CY 2024 admissions file and CY 2
[Records received through 3/19/2026]

Long-term Residential(LR)

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

	At Admission (T1)	At Discharge (T2)
Number of clients living in a stable situation [numerator]	4,322	4,413
Total number of clients with non-missing values on living arrangements [denominator]	5,189	5,189
Percent of clients in stable living situation	83.3%	85.0%
Notes (for this level of care):		
Number of CY 2024 admissions submitted:		7,457
Number of CY 2024 discharges submitted:		7,290
Number of CY 2024 discharges linked to an admission:		7,189
Number of linked discharges after exclusions (excludes: withdrawal management, rehabilitation/residential hospital, MOUD clients; deaths; incarcerated):		5,289

Number of CY 2024 linked discharges eligible for this calculation (non-missing values):	5,189
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Source: SAMHSA/CBHSQ TEDS CY 2024 admissions file and CY 2
[Records received through 3/19/2026]

Outpatient (OP)

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

	At Admission (T1)	At Discharge (T2)
Number of clients living in a stable situation [numerator]	13,287	13,391
Total number of clients with non-missing values on living arrangements [denominator]	13,751	13,751
Percent of clients in stable living situation	96.6%	97.4%
Notes (for this level of care):		
Number of CY 2024 admissions submitted:		25,626
Number of CY 2024 discharges submitted:		24,512
Number of CY 2024 discharges linked to an admission:		23,441
Number of linked discharges after exclusions (excludes: withdrawal management, rehabilitation/residential hospital, MOUD clients; deaths; incarcerated):		14,073
Number of CY 2024 linked discharges eligible for this calculation (non-missing values):		13,751

Source: SAMHSA/CBHSQ TEDS CY 2024 admissions file and CY 2
[Records received through 3/19/2026]

Intensive Outpatient (IO)

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

	At Admission (T1)	At Discharge (T2)
Number of clients living in a stable situation [numerator]	12,505	12,667
Total number of clients with non-missing values on living arrangements [denominator]	13,556	13,556
Percent of clients in stable living situation	92.2%	93.4%
Notes (for this level of care):		
Number of CY 2024 admissions submitted:		19,577
Number of CY 2024 discharges submitted:		18,981
Number of CY 2024 discharges linked to an admission:		18,904
Number of linked discharges after exclusions (excludes: withdrawal management, rehabilitation/residential hospital, MOUD clients; deaths; incarcerated):		14,102
Number of CY 2024 linked discharges eligible for this calculation (non-missing values):		13,556

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Footnotes:

E: 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]	8,289	8,427
Total number of Admission and Discharge clients with non-missing values on arrests [denominator]	8,515	8,515
Percent of clients without arrests	97.3%	99.0%
Notes (for this level of care):		
Number of CY 2024 admissions submitted:		11,611
Number of CY 2024 discharges submitted:		11,526
Number of CY 2024 discharges linked to an admission:		11,318
Number of linked discharges after exclusions (excludes: withdrawal management, rehabilitation/residential hospital, MOUD clients; deaths; incarcerated):		8,575
Number of CY 2024 linked discharges eligible for this calculation (non-missing values):		8,515

Source: SAMHSA/CBHSQ TEDS CY 2024 admissions file and CY 2
[Records received through 3/19/2026]

Long-term Residential(LR)

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

	At Admission(T1)	At Discharge(T2)
Number of Clients without arrests [numerator]	4,956	5,142
Total number of Admission and Discharge clients with non-missing values on arrests [denominator]	5,219	5,219
Percent of clients without arrests	95.0%	98.5%
Notes (for this level of care):		
Number of CY 2024 admissions submitted:		7,457
Number of CY 2024 discharges submitted:		7,290
Number of CY 2024 discharges linked to an admission:		7,189

Number of linked discharges after exclusions (excludes: withdrawal management, rehabilitation/residential hospital, MOUD clients; deaths; incarcerated):	5,320
Number of CY 2024 linked discharges eligible for this calculation (non-missing values):	5,219

Source: SAMHSA/CBHSQ TEDS CY 2024 admissions file and CY 2
[Records received through 3/19/2026]

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]	13,670	13,719
Total number of Admission and Discharge clients with non-missing values on arrests [denominator]	13,977	13,977
Percent of clients without arrests	97.8%	98.2%
Notes (for this level of care):		
Number of CY 2024 admissions submitted:		25,626
Number of CY 2024 discharges submitted:		24,512
Number of CY 2024 discharges linked to an admission:		23,441
Number of linked discharges after exclusions (excludes: withdrawal management, rehabilitation/residential hospital, MOUD clients; deaths; incarcerated):		14,293
Number of CY 2024 linked discharges eligible for this calculation (non-missing values):		13,977

Source: SAMHSA/CBHSQ TEDS CY 2024 admissions file and CY 2
[Records received through 3/19/2026]

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]	13,348	13,475
Total number of Admission and Discharge clients with non-missing values on arrests [denominator]	13,787	13,787
Percent of clients without arrests	96.8%	97.7%
Notes (for this level of care):		
Number of CY 2024 admissions submitted:		19,577
Number of CY 2024 discharges submitted:		18,981
Number of CY 2024 discharges linked to an admission:		18,904

Number of linked discharges after exclusions (excludes: withdrawal management, rehabilitation/residential hospital, MOUD clients; deaths; incarcerated):	14,333
Number of CY 2024 linked discharges eligible for this calculation (non-missing values):	13,787

Source: SAMHSA/CBHSQ TEDS CY 2024 admissions file and CY 2
[Records received through 3/19/2026]

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Footnotes:

E: 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]	3,222	8,318
All clients with non-missing values on at least one substance/frequency of use [denominator]	8,367	8,367
Percent of clients abstinent from alcohol	38.5%	99.4%

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

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

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		5,100
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	5,145	
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]		3,218
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	3,222	
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T2 / #T1 x 100]		99.9%

Notes (for this level of care):

Number of CY 2024 admissions submitted:	11,611
Number of CY 2024 discharges submitted:	11,526
Number of CY 2024 discharges linked to an admission:	11,318
Number of linked discharges after exclusions (excludes: withdrawal management, rehabilitation/residential hospital, MOUD clients; deaths; incarcerated):	8,575
Number of CY 2024 linked discharges eligible for this calculation (non-missing values):	8,367

Long-term Residential(LR)

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

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

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol [numerator]	2,629	4,795
All clients with non-missing values on at least one substance/frequency of use [denominator]	4,849	4,849
Percent of clients abstinent from alcohol	54.2%	98.9%

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]		2,187
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	2,220	
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T2 / #T1 x 100]		98.5%

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

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

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		2,608
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	2,629	
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T2 / #T1 x 100]		99.2%

Notes (for this level of care):

Number of CY 2024 admissions submitted:	7,457
Number of CY 2024 discharges submitted:	7,290
Number of CY 2024 discharges linked to an admission:	7,189
Number of linked discharges after exclusions (excludes: withdrawal management, rehabilitation/residential hospital, MOUD clients; deaths; incarcerated):	5,320
Number of CY 2024 linked discharges eligible for this calculation (non-missing values):	4,849

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]	7,241	9,601
All clients with non-missing values on at least one substance/frequency of use [denominator]	10,556	10,556
Percent of clients abstinent from alcohol	68.6%	91.0%

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]		2,745
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	3,315	
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T2 / #T1 x 100]		82.8%

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]		6,856
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	7,241	
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T2 / #T1 x 100]		94.7%

Notes (for this level of care):

Number of CY 2024 admissions submitted:	25,626
Number of CY 2024 discharges submitted:	24,512
Number of CY 2024 discharges linked to an admission:	23,441
Number of linked discharges after exclusions (excludes: withdrawal management, rehabilitation/residential hospital, MOUD clients; deaths; incarcerated):	14,293
Number of CY 2024 linked discharges eligible for this calculation (non-missing values):	10,556

Source: SAMHSA/CBHSQ TEDS CY 2024 admissions file and CY 2
[Records received through 3/19/2026]

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]	5,900	8,577
All clients with non-missing values on at least one substance/frequency of use [denominator]	9,652	9,652
Percent of clients abstinent from alcohol	61.1%	88.9%

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]		3,003
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	3,752	
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T2 / #T1 x 100]		80.0%

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]		5,574
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	5,900	
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T2 / #T1 x 100]		94.5%
Notes (for this level of care):		
Number of CY 2024 admissions submitted:		19,577
Number of CY 2024 discharges submitted:		18,981
Number of CY 2024 discharges linked to an admission:		18,904
Number of linked discharges after exclusions (excludes: withdrawal management, rehabilitation/residential hospital, MOUD clients; deaths; incarcerated):		14,333
Number of CY 2024 linked discharges eligible for this calculation (non-missing values):		9,652

Source: SAMHSA/CBHSQ TEDS CY 2024 admissions file and CY 2
[Records received through 3/19/2026]

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Footnotes:

E: 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]	3,392	8,307
All clients with non-missing values on at least one substance/frequency of use [denominator]	8,367	8,367
Percent of clients abstinent from drugs	40.5%	99.3%

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

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

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator]		4,921
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	4,975	
Percent of clients abstinent from drugs at discharge among clients using Drug at admission [#T2 / #T1 x 100]		98.9%

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]		3,386
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	3,392	
Percent of clients abstinent from drugs at discharge among clients abstinent from Drug at admission [#T2 / #T1 x 100]		99.8%
Notes (for this level of care):		
Number of CY 2024 admissions submitted:		11,611
Number of CY 2024 discharges submitted:		11,526
Number of CY 2024 discharges linked to an admission:		11,318
Number of linked discharges after exclusions (excludes: withdrawal management, rehabilitation/residential hospital, MOUD clients; deaths; incarcerated):		8,575
Number of CY 2024 linked discharges eligible for this calculation (non-missing values):		8,367

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]	2,583	4,751
All clients with non-missing values on at least one substance/frequency of use [denominator]	4,849	4,849
Percent of clients abstinent from drugs	53.3%	98.0%

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

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

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator]		2,214
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	2,266	
Percent of clients abstinent from drugs at discharge among clients using Drug at admission [#T2 / #T1 x 100]		97.7%

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

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

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [numerator]		2,537
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	2,583	
Percent of clients abstinent from drugs at discharge among clients abstinent from Drug at admission [#T2 / #T1 x 100]		98.2%
Notes (for this level of care):		
Number of CY 2024 admissions submitted:		7,457
Number of CY 2024 discharges submitted:		7,290
Number of CY 2024 discharges linked to an admission:		7,189
Number of linked discharges after exclusions (excludes: withdrawal management, rehabilitation/residential hospital, MOUD clients; deaths; incarcerated):		5,320
Number of CY 2024 linked discharges eligible for this calculation (non-missing values):		4,849

Outpatient (OP)

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

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

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs [numerator]	7,234	8,922
All clients with non-missing values on at least one substance/frequency of use [denominator]	10,556	10,556
Percent of clients abstinent from drugs	68.5%	84.5%

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

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

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator]		2,216
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	3,322	
Percent of clients abstinent from drugs at discharge among clients using Drug at admission [#T2 / #T1 x 100]		66.7%

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

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

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [numerator]		6,706
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	7,234	
Percent of clients abstinent from drugs at discharge among clients abstinent from Drug at admission [#T2 / #T1 x 100]		92.7%

Notes (for this level of care):

Number of CY 2024 admissions submitted:	25,626
Number of CY 2024 discharges submitted:	24,512
Number of CY 2024 discharges linked to an admission:	23,441
Number of linked discharges after exclusions (excludes: withdrawal management, rehabilitation/residential hospital, MOUD clients; deaths; incarcerated):	14,293
Number of CY 2024 linked discharges eligible for this calculation (non-missing values):	10,556

Source: SAMHSA/CBHSQ TEDS CY 2024 admissions file and CY 2
[Records received through 3/19/2026]**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]	5,448	7,877
All clients with non-missing values on at least one substance/frequency of use [denominator]	9,652	9,652
Percent of clients abstinent from drugs	56.4%	81.6%

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]		2,835
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	4,204	
Percent of clients abstinent from drugs at discharge among clients using Drug at admission [#T2 / #T1 x 100]		67.4%

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

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

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [numerator]		5,042
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	5,448	
Percent of clients abstinent from drugs at discharge among clients abstinent from Drug at admission [#T2 / #T1 x 100]		92.5%

Notes (for this level of care):

Number of CY 2024 admissions submitted:	19,577
Number of CY 2024 discharges submitted:	18,981
Number of CY 2024 discharges linked to an admission:	18,904
Number of linked discharges after exclusions (excludes: withdrawal management, rehabilitation/residential hospital, MOUD clients; deaths; incarcerated):	14,333
Number of CY 2024 linked discharges eligible for this calculation (non-missing values):	9,652

Source: SAMHSA/CBHSQ TEDS CY 2024 admissions file and CY 2 [Records received through 3/19/2026]

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Footnotes:

E: 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]	746	4,833
Total number of Admission and Discharge clients with non-missing values on participation in self-help groups [denominator]	8,575	8,575
Percent of clients participating in self-help groups	8.7%	56.4%
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]	47.7%	
Notes (for this level of care):		
Number of CY 2024 admissions submitted:		11,611
Number of CY 2024 discharges submitted:		11,526
Number of CY 2024 discharges linked to an admission:		11,318
Number of linked discharges after exclusions (excludes: withdrawal management, rehabilitation/residential hospital, MOUD clients; deaths; incarcerated):		8,575
Number of CY 2024 linked discharges eligible for this calculation (non-missing values):		8,575

Source: SAMHSA/CBHSQ TEDS CY 2024 admissions file and CY 2
[Records received through 3/19/2026]

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]	1,799	4,191
Total number of Admission and Discharge clients with non-missing values on participation in self-help groups [denominator]	5,320	5,320
Percent of clients participating in self-help groups	33.8%	78.8%
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]	45.0%	
Notes (for this level of care):		
Number of CY 2024 admissions submitted:	7,457	
Number of CY 2024 discharges submitted:	7,290	

Number of CY 2024 discharges linked to an admission:	7,189
Number of linked discharges after exclusions (excludes: withdrawal management, rehabilitation/residential hospital, MOUD clients; deaths; incarcerated):	5,320
Number of CY 2024 linked discharges eligible for this calculation (non-missing values):	5,320

Source: SAMHSA/CBHSQ TEDS CY 2024 admissions file and CY 2
[Records received through 3/19/2026]

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]	2,196	2,546
Total number of Admission and Discharge clients with non-missing values on participation in self-help groups [denominator]	14,288	14,288
Percent of clients participating in self-help groups	15.4%	17.8%
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]	2.4%	
Notes (for this level of care):		
Number of CY 2024 admissions submitted:		25,626
Number of CY 2024 discharges submitted:		24,512
Number of CY 2024 discharges linked to an admission:		23,441
Number of linked discharges after exclusions (excludes: withdrawal management, rehabilitation/residential hospital, MOUD clients; deaths; incarcerated):		14,293
Number of CY 2024 linked discharges eligible for this calculation (non-missing values):		14,288

Source: SAMHSA/CBHSQ TEDS CY 2024 admissions file and CY 2
[Records received through 3/19/2026]

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]	4,395	4,898
Total number of Admission and Discharge clients with non-missing values on participation in self-help groups [denominator]	14,333	14,333
Percent of clients participating in self-help groups	30.7%	34.2%
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]	3.5%	
Notes (for this level of care):		
Number of CY 2024 admissions submitted:	19,577	

Number of CY 2024 discharges submitted:	18,981
Number of CY 2024 discharges linked to an admission:	18,904
Number of linked discharges after exclusions (excludes: withdrawal management, rehabilitation/residential hospital, MOUD clients; deaths; incarcerated):	14,333
Number of CY 2024 linked discharges eligible for this calculation (non-missing values):	14,333

Source: SAMHSA/CBHSQ TEDS CY 2024 admissions file and CY 2
[Records received through 3/19/2026]

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Footnotes:

E: 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
Withdrawal Management (24-HOUR CARE)				
1. Hospital Inpatient	4	3	4	5
2. Free-Standing Residential	7	5	6	8
REHABILITATION/RESIDENTIAL				
3. Hospital Inpatient	352	11	30	916
4. Short-term (up to 30 days)	19	13	18	26
5. Long-term (over 30 days)	82	21	51	123
AMBULATORY (OUTPATIENT)				
6. Outpatient	119	45	84	138
7. Intensive Outpatient	86	28	57	103
8. Withdrawal Management	36	8	17	31
Medication for Opioid Use Disorder (MOUD) Treatment				
9. Withdrawal Management with Opioid Agonist Medications	7	4	6	8
10. Continuous MOUD and Other Services in Outpatient Settings	265	49	126	333

Level of Care	2024 TEDS discharge record count	
	Discharges submitted	Discharges linked to an admission
Withdrawal Management (24-HOUR CARE)		
1. Hospital Inpatient	50	39
2. Free-Standing Residential	15497	11807
REHABILITATION/RESIDENTIAL		
3. Hospital Inpatient	7	7
4. Short-term (up to 30 days)	11526	11318

5. Long-term (over 30 days)	7290	7189
AMBULATORY (OUTPATIENT)		
6. Outpatient	24512	14319
7. Intensive Outpatient	18981	18904
8. Withdrawal Management	269	142
Medication for Opioid Use Disorder (MOUD) Treatment		
9. Withdrawal Management with Opioid Agonist Medications	0	3475
10. Continuous MOUD and Other Services in Outpatient Settings	0	9122

Source: SAMHSA/CBHSQ TEDS CY 2024 admissions file and CY 2
[Records received through 3/19/2026]
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Footnotes:

E: Performance Data and Outcomes

Table 21 – Substance Use Disorder Primary Prevention NOMs Domain: Reduced Morbidity – Drug Use/Alcohol Use Measure: 30-Day Use

A. Measure	B. Question/Response	C. Pre-populated Data	D. Supplemental Data, if any
1. 30-day Alcohol Use	Source Survey Item: NSDUH Questionnaire. "Think specifically about the past 30 days, that is, from [DATEFILL] through today. During the past 30 days, on how many days did you drink one or more drinks of an alcoholic beverage?[Response option: Write in a number between 0 and 30.]" Outcome Reported: Percent who reported having used alcohol during the past 30 days.		
	Age 12 - 20 - CY 2023		
	Age 21+ - CY 2023		
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 2023		
	Age 18+ - CY 2023		
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]^[a]?[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 2023		
	Age 18+ - CY 2023		
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 2023		
	Age 18+ - CY 2023		
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]^[b]?" 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 2023		

	Age 18+ - CY 2023		
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[a]NSDUH asks separate questions for each tobacco product. The number provided combines responses to all questions about tobacco products other than cigarettes.

[b]NSDUH asks separate questions for each illegal drug. The number provided combines responses to all questions about illegal drugs other than marijuana or hashish.

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Table 22 – Substance Use Disorder Primary Prevention NOMs Domain: Reduced Morbidity – Drug Use/Alcohol Use Measure: Perception of Risk/Harm of Use

A. Measure	B. Question/Response	C. Pre-populated Data	D. Supplemental Data, if any
1. Perception of Risk From Alcohol	Source Survey Item: NSDUH Questionnaire: "How much do people risk harming themselves physically and in other ways when they have five or more drinks of an alcoholic beverage once or twice a week?[Response options: No risk, slight risk, moderate risk, great risk]" Outcome Reported: Percent reporting moderate or great risk.		
	Age 12 - 20 - CY 2023		
	Age 21+ - CY 2023		
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 2023		
	Age 18+ - CY 2023		
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 2023		
	Age 18+ - CY 2023		

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Table 23 – Substance Use Disorder Primary Prevention NOMs Domain: Reduced Morbidity – Drug Use/Alcohol Use Measure: Age of First Use

A. Measure	B. Question/Response	C. Pre-populated Data	D. Supplemental Data, if any
1. Age at First Use of Alcohol	Source Survey Item: NSDUH Questionnaire: "Think about the first time you had a drink of an alcoholic beverage. How old were you the first time you had a drink of an alcoholic beverage? Please do not include any time when you only had a sip or two from a drink. [Response option: Write in age at first use.]" Outcome Reported: Average age at first use of alcohol.		
	Age 12 - 20 - CY 2023		
	Age 21+ - CY 2023		
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 2023		
	Age 18+ - CY 2023		
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] ^[a] ?[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 2023		
	Age 18+ - CY 2023		
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 2023		
	Age 18+ - CY 2023		
5. 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] ^[b] 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 2023		
	Age 18+ - CY 2023		

[a]The question was asked about each tobacco product separately, and the youngest age at first use was taken as the measure.

[b]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 – Drug Use/Alcohol Use Measure: Perception of Disapproval/Attitudes

A. Measure	B. Question/Response	C. Pre-populated Data	D. Supplemental Data, if any
1. Disapproval of Cigarettes	Source Survey Item: NSDUH Questionnaire: "How do you feel about someone your age smoking one or more packs of cigarettes a day?[Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove]" Outcome Reported: Percent somewhat or strongly disapproving.		
	Age 12 - 17 - CY 2023		
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 2023		
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 2023		
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 2023		
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 2023		

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Table 25 – Substance Use Disorder Prevention NOMs Domain: Employment/Education Measure: Perception of Workplace Policy

A. Measure	B. Question/Response	C. Pre-populated Data	D. Supplemental Data, if any
Perception of Workplace Policy	Source Survey Item: NSDUH Questionnaire: "Would you be more or less likely to want to work for an employer that tests its employees for drug or alcohol use on a random basis? Would you say more likely, less likely, or would it make no difference to you?[Response options: More likely, less likely, would make no difference]" Outcome Reported: Percent reporting that they would be more likely to work for an employer conducting random drug and alcohol tests.		
	Age 15 - 17 - CY 2023		
	Age 18+ - CY 2023		

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Table 26 – Substance Use Disorder Prevention NOMs Domain: Employment/Education Measure: Average Daily School Attendance Rate

A. Measure	B. Question/Response	C. Pre-populated Data	D. Supplemental Data, if any
Average Daily School Attendance Rate	Source: National Center for Education Statistics, Common Core of Data: <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 2024		

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

A. Measure	B. Question/Response	C. Pre-populated Data	D. Supplemental Data, if any
Alcohol-Related Traffic Fatalities	Source: National Highway Traffic Safety Administration Fatality Analysis Reporting System Measure calculation: The number of alcohol-related traffic fatalities divided by the total number of traffic fatalities and multiplied by 100.		
	CY 2024		

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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. Supplemental Data, if any
Alcohol- and Drug-Related Arrests	Source: Federal Bureau of Investigation National Incident-Based Reporting System Measure calculation: The number of alcohol- and drug-related arrests divided by the total number of arrests and multiplied by 100.		
	CY 2024		

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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. Supplemental Data, if any
1. Family Communications Around Drug and Alcohol Use (Youth)	Source Survey Item: NSDUH Questionnaire: "Now think about the past 12 months, that is, from [DATEFILL] through today. During the past 12 months, have you talked with at least one of your parents about the dangers of tobacco, alcohol, or drug use? By parents, we mean either your biological parents, adoptive parents, stepparents, or adult guardians, whether or not they live with you." [Response options: Yes, No] Outcome Reported: Percent reporting having talked with a parent.		
	Age 12 - 17 - CY 2023		
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?" [a][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 2023		

[a]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. Supplemental Data, if any
Exposure to Prevention Messages	Source Survey Item: NSDUH Questionnaire: "During the past 12 months, do you recall [hearing, reading, or watching an advertisement about the prevention of substance use] ^[a] ?" Outcome Reported: Percent reporting having been exposed to prevention message.		
	Age 12 - 17 - CY 2023		

[a]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

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

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- and Population-Based Programs and Strategies – Number of Persons Served by Age, Sex, Race, and Ethnicity	1/1/2023	12/31/2023
2.	Table 32 - Substance Use Disorder Primary Prevention Number of Persons Served by Type of Intervention	1/1/2023	12/31/2023
3.	Table 33 - Number of Programs and Strategies by Type of Intervention	1/1/2023	12/31/2023
4.	Table 34 - 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	10/1/2022	9/30/2024

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 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.

Multi-racial is one of the categories program participants can select when providing demographic information. The participants are included only in the "More than One Race" category.

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Table 31 – Substance Use Disorder Primary Prevention Individual- and Population-Based Programs and Strategies – Number of Persons Served by Age, Sex, Race, and Ethnicity

The reporting period for Tables 31 is Calendar Year (CY) 2023 which coincides with the reporting period for the pre-populated prevention NOMs in Tables 21-30. We understand that some states have reported on the state fiscal year (SFY) or federal fiscal year (FFY) for these tables in past SUPTRS BG Reports. If your state is unable to report on the calendar year, please indicate in this footnote why you are unable to report on the calendar year and the steps the state intends to take to make calendar year reporting possible in future years.

	Individual-Based Programs and Strategies-Number of Persons Served	Population-Based Programs and Strategies- Number of Persons Reached
A. Age	214,845	712,000
0-5	15,336	10,900
6-12	87,048	58,500
13-17	35,856	182,000
18-20	19,008	63,750
21-24	8,381	46,000
25-44	28,469	123,700
45-64	8,186	61,300
65-74	4,644	63,225
75+	6,717	19,450
Age Not Available ^a	1,200	83,175
B. Sex	214,845	712,000
Male	105,274	305,500
Female	109,571	319,500
Sex Not Available		87,000
C. Ethnicity	214,845	712,000
Hispanic or Latino	68,750	199,360
Not Hispanic or Latino	129,595	338,000
Ethnicity Not Available	16,500	174,640
D. Race	214,845	712,000
White	98,828	263,000
Black or African American	62,305	147,500
Native Hawaiian/Other Pacific Islander	2,315	8,300
Asian	15,039	127,500
American Indian/Alaska Native	715	2,800
More Than One Race	15,605	52,700

Some other Race		
Race Not Available	20,038	110,200

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Table 32 - Substance Use Disorder Primary Prevention Number of Persons Served by Type of Intervention

The reporting period for Tables 32 is Calendar Year (CY) 2023 which coincides with the reporting period for the pre-populated prevention NOMs in Tables 21-30. We understand that some states have reported on the state fiscal year (SFY) or federal fiscal year (FFY) for these tables in past SUPTRS BG Reports. If your state is unable to report on the calendar year, please indicate in this footnote why you are unable to report on the calendar year and the steps the state intends to take to make calendar year reporting possible in future years.

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	135,352	N/A
2. Universal Indirect	N/A	\$712,000.00
3. Selective	32,227	N/A
4. Indicated	47,266	N/A
5. Total	214,845	\$712,000.00

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Table 33 - Number of Programs and Strategies by Type of Intervention

The reporting period for Tables 33 is Calendar Year (CY) 2023 which coincides with the reporting period for the pre-populated prevention NOMs in Tables 21-30. We understand that some states have reported on the state fiscal year (SFY) or federal fiscal year (FFY) for these tables in past SUPTRS BG Reports. If your state is unable to report on the calendar year, please indicate in this footnote why you are unable to report on the calendar year and the steps the state intends to take to make calendar year reporting possible in future years.

Definition of Evidence-Based Programs and Strategies: Evidence-Based Prevention Programs (EBPs) are designed to prevent substance use and related negative outcomes. Most strategies are designed to be delivered in specific settings, to specific age groups, and to specific population. EBPs are prevention strategies that were reported as effective for your substance and population of focus. EBPs should be identified by one of three ways:

- 1. Inclusion in a formal registry of evidence-based interventions such as federal, state or foundation registries
- 2. Being Reported (with positive effects) in a peer-reviewed journal
- 3. Documentation of effectiveness based on one or more of the following guidelines:
 - Guideline 1:
The intervention is connected to a theory of change based upon a clear logic or conceptual model. The intervention should be informed by risk and protective factors research.
 - Guideline 2:
The intervention is similar in content and structure to interventions that appear in registries and/or the peer-reviewed literature.
 - Guideline 3:
The intervention is supported by documentation that it has been effectively implemented multiple times with results that show a consistent pattern of credible and positive effects.
 - Guideline 4:
The intervention is reviewed and deemed appropriate by a panel of informed prevention experts that may include: well-qualified prevention researchers who are experienced in evaluating prevention interventions similar to those under review; local prevention practitioners; or 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 must meet at least one of the criteria above.

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

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

	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 34 - 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

The reporting period for table 34 is the 24-month expenditure period of the FFY 2023 SUPTRS BG award.

	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	\$1,981,264.00
Universal Indirect	Total # 6	\$3,170,023.00
Selective	Total # 13	\$2,971,896.00
Indicated	Total # 8	\$1,783,138.00
Unspecified	Total # 0	\$0.00
	Total EBPs: 39	Total Dollars Spent: \$9,906,321.00

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Prevention Attachments

Submission Uploads

FFY 2026 Prevention Attachment Category A:		
File	Version	Date Added

FFY 2026 Prevention Attachment Category B:		
File	Version	Date Added

FFY 2026 Prevention Attachment Category C:		
File	Version	Date Added

FFY 2026 Prevention Attachment Category D:		
File	Version	Date Added

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