New Jersey
Substance Abuse Prevention and Synar Site Visit Report

March 14–18, 2016

Federal Fiscal Year 2016

Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Prevention

Contents

SITE VISIT SUMMARY

The Alcohol, Drug Abuse, and Mental Health Administration Reorganization Act (P.L. 102-321) enacted by Congress in July 1992 authorized the Substance Abuse Prevention and Treatment Block Grant (SABG) administered by the Substance Abuse and Mental Health Services Administration (SAMHSA). SAMHSA's Center for Substance Abuse Prevention (CSAP) is charged with providing policy and program guidance to help states[1] use and report on the 20-percent primary prevention set-aside of the SABG. CSAP is committed to providing support that can advance Single State Authority (SSA) and state substance abuse prevention systems. Toward this end, CSAP conducts site visits to 1) understand the SSA's progress in developing and sustaining strong, state prevention infrastructure; and 2) identify areas in which the state may need CSAP technical assistance (TA) to develop or enhance its prevention system and Synar program.

This report is a summary of the most recent CSAP site visit for New Jersey, which was conducted on March 14–18, 2016. The site visit involved discussions with state participants about the state's capacity for using performance management processes to achieve sustainable improvements in the substance abuse indicators and outcomes measured by SAMHSA's National Outcome Measures (NOMs), as well as other state-specific goals and objectives.

This Site Visit Report contains key findings related to state prevention system strengths, challenges, and unique and notable accomplishments. The Site Visit Report also contains recommendations intended to help New Jersey enhance its ability to implement the five steps of the Strategic Prevention Framework (SPF), or an equivalent planning process, to achieve population-level reductions in the incidence and prevalence of substance abuse and related problems and consequences. These findings and recommendations are discussed throughout the report and summarized in appendix A of this report.

Background

Although the Site Visit Report is intended to provide an accurate and objective analysis of the state prevention system and Synar program at the time of the visit, the report also reflects on findings from past site visit reports to document changes and trends in state system development over time.

New Jersey's state and substate prevention system is complex, and coordination of prevention efforts at both levels have been issues the SSA has worked to address since 2006. The 2012 CSAP site visit team noted that the SSA had made significant progress in this area, in part due to the development of the Prevention Unification Committee—a multiagency body formed to coordinate needs assessment processes and reduce duplication of efforts. The 2012 site visit team recommended that the Committee target and expand its coordination efforts beyond processes to include identification of common outcomes and shared resources.

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

The 2012 team also noted that the New Jersey SSA had enhanced its state leadership for substance abuse prevention by entering into new partnerships with the Department of Law and Public Safety (DLPS) and the Department of Health and Senior Services, and forming a task force on primary care and behavioral health to increase collaboration between mental health agencies and health care providers across the state.

In addition, the SSA had significantly increased the use of SABG funds to support environmental prevention strategies. This was a significant shift from 2009 when New Jersey's SABG funds were primarily supporting strategies targeting individuals identified as exhibiting early warning signs of substance abuse problems. The SSA had also made significant strides in using the SPF as an organizing framework for its SABG-funded providers, and SSA staff expressed plans to adopt the SPF for mental health and treatment planning as well.

Both the 2009 and 2012 CSAP site visit teams noted that the SSA appeared to not always display clarity as to what differentiated primary prevention from early intervention. The 2009 review team recommended that the SSA use substance abuse trend data to develop state-level prevention priorities that could have an impact on population-level change. The 2012 site visit team found that the SSA had indeed identified five overarching, data-driven substance abuse reduction priorities, and SSA staff reported that a statewide plan was under development.

There were no required followup actions or compliance issues for prevention identified during the 2009 and 2012 system reviews.

Prevention System Elements

Prevention System Organization

SSA Prevention System

The Division of Mental Health and Addiction Services (DMHAS) serves as the SSA for substance abuse and the State Mental Health Authority. DMHAS was created by merging the former Division of Addiction Services and the Division of Mental Health Services during state fiscal year 2011. DMHAS oversees the provision of a broad range of community mental health and addiction services throughout the state, and contracts with entities to provide and support community-based prevention, early intervention, treatment, education and recovery services.

DMHAS is housed within the New Jersey Department of Human Services (DHS), which is the largest state agency in New Jersey. Its eight divisions provide programs and services to approximately 1.5 million New Jerseyans, or about one of every six state residents. The Commissioner of DHS supervises the DMHAS/SSA Director and serves as a member of the Governor's Cabinet.

Since the last CSAP site visit in 2012, substance abuse and behavioral health programs serving children under the age of 18 were transferred to the Department of Children and Families (DCF) Children's System of Care. In June 2012, New Jersey's Governor signed a bill that further reorganized DCF into a single point of entry for all families with children, youth, and young adults with developmental disabilities and/or substance abuse disorders. The transition of these services from DHS to DCF began January 1, 2013.

While DMHAS has staff positions that are charged with outreach to veterans and multicultural groups, these efforts appear to be focused within the treatment system. DMHAS's Multicultural Services Group (MSG), for example, was formed in June 2015 to ensure quality of care and devise strategies that are culturally and linguistically appropriate to the behavioral health needs of New Jersey's diverse minority and cultural groups. Specifically, MSG is charged with conducting an agency self-assessment and developing the following: a mechanism to incorporate agency cultural competence plans into contracting, a strategic plan, and a training curriculum. Target populations for MSG efforts include racial and ethnic minority groups; persons identifying as lesbian, gay, bisexual, transgender, and questioning (LGBTQ); persons who are deaf and hard of hearing; and senior citizens. New Jersey's 2016 SABG application noted that MSG has broad representation from treatment providers, consumers, persons identifying as LGBTQ, administrators, and academics.

The Prevention and Early Intervention Services (PEIS) unit—which administers the SABG primary prevention set-aside, is housed within DMHAS's Office of Planning, Research, Evaluation, and Prevention (OPREP). OPREP is charged with promoting the use of data to guide policy, planning, and decisionmaking throughout DMHAS, and is responsible for a wide range of research activities. These include but are not limited to: designing research studies, protocols, and instruments; managing the State Epidemiological Outcomes Workgroup (SEOW); conducting surveys; overseeing Synar and Partnerships for Success (PFS) research; evaluating program effectiveness; and providing TA on research and evaluation methods.

PEIS is responsible for awarding funding to community prevention and early intervention providers for prevention education, resources, and early intervention services. It monitors over $16 million in funding to contracted provider agencies and coalitions that offer prevention programming and services to residents in all 21 counties of the state.

New Jersey's representative to the National Prevention Network (NPN) serves as the PEIS Director. The NPN supervises three Prevention Services Program Managers (one position was vacant at the time of the site visit) and a Program Support Specialist 1, as well as an Addiction Recovery Advocate involved in opioid overdose recovery, Medication-Assisted Treatment, addictions recovery, and recovery advocacy. Accordingly, only a portion of his time is dedicated to primary prevention. The NPN reports to a DMHAS Assistant Director, who reports to a DMHAS Deputy Director. The two Prevention Program Managers in place at the time of the site visit oversee and monitor all funded prevention services, administer and maintain the Prevention Outcomes Management System (POMS), and oversee the state's Council for Compulsive Gambling. The CSAP team noted that PEIS staff are knowledgeable and experienced and have a future-oriented vision for prevention. The team also noted, however, that there is a very small number of staff responsible for administering $15 million in contracts and grants funded through New Jersey's primary prevention SABG set-aside funds and other state and federal dollars.

Organizational charts for DHS and DMHAS are provided in appendix E.

DMHAS/PEIS administers a 5-year SAMHSA SPF PFS grant, which was awarded to New Jersey in September 2013. The purpose of the PFS is to: 1) strengthen and enhance the work of 17 Regional Coalitions; 2) further develop prevention data infrastructure and information

systems capacity at the state level; and 3) continue to develop and expand a unified statewide prevention planning and service delivery system.

DMHAS contracts with various centers and divisions of Rutgers University for statewide substance abuse services and special projects. These contracts are carried out through memorandums of understanding (MOUs) and agreement (MOAs), and include the following:

- Data collection needed to assess provider performance and report required Government Performance and Results Act measures, including the development of State- and Provider-Level Performance Management systems for treatment services (School of Social Work)
- Education, training, and technical assistance (T/TA) in community-based planning to professional behavioral health care planners, including county alcoholism and drug abuse directors (School of Social Work/Office of Continuing Education)
- Administration of the 2015 Middle School Risk and Protective Factor Survey. (Bloustein Center for Survey Research)
- Administration of the 2015 New Jersey Household Survey on Drug Use and Health (NJHSDUH). (Bloustein Center for Survey Research /Robert Wood Johnson [RWJ] Medical School)
- Data collection, evaluation, and support for the SPF-PFS grant, including: developing and conducting older adult and returning veterans surveys; updating DMHAS Chartbooks, Prevention Inventory, state Epidemiological Profile, and Social Indicators Database; developing a new SEOW website; providing evaluation guidance to regional coalitions; and conducting PFS performance assessment (School of Social Work)
- T/TA to SPF-PFS grantees (RWJ Medical School)
- T/TA to grantees on all aspects of the SPF (School of Social Work and the New Jersey Prevention Network (NJPN)
- Researching, recommending, and supporting the implementation of a post-conviction, evidence-based, intervention and education program for persons cited for driving under the influence (DUI) of alcohol. (The College of New Jersey)
- Substance Abuse Prevention Services and Study for Children With Conduct Disorder (Rutgers University Behavioral Healthcare)
- Screening Brief Intervention and Referral to Treatment Services (Rutgers University RWJ Medical School and Rowan University School of Osteopathic Medicine)
- Opioid Overdose Recovery Program evaluation (School of Social Work)

In addition to its multiple contracts with Rutgers University, DMHAS also has key partnerships with the Department of Health (DOH) and the Department of Education (DOE). DMHAS has had an MOU with DOH's Office of Tobacco Control (OTC)/Tobacco Age of Sale Enforcement (TASE) since 2004 to implement the state's Synar program. DMHAS also participates on an Opioid Data Study Team with DOH to identify and use data related to opioid use and misuse. Specifically, the team is geo-mapping drug arrest data and points of origination to identify

primary drug trafficking routes to help prioritize where state resources should be allocated to implement educational and interventional strategies.

DMHAS maintains an MOA with DOE's Division of Student and Field Services to partner on the implementation of a New Jersey Student Health Survey for high school students. This includes coordinating schedules for administering student surveys to minimize duplication of data collection efforts. DMHAS also partners with DOE to reduce risky behaviors and increase health enhancing behaviors by developing school health goals and priorities. DMHAS is also participating in a new DOE initiative involving the development of a Social and Emotional Learning curriculum to improve school climates and academic achievement for all children.

Other state agency partners cited by DMHAS staff during the site visit include DLPS, DCF, the Department of State, and the Office of the Attorney General (OAG) which is located in DLPS. DMHAS also partners with the New Jersey Governor's Council on Alcoholism and Drug Abuse (GCADA) to coordinate prevention planning and implementation of GCADA's *Blueprint for a Drug-Free New Jersey, 2020*.

DMHAS and GCADA have also been working to increase public awareness of substance abuse prevention and reduce the stigma associated with addiction. In line with these efforts to increase public awareness, DMHAS commissioned Rutgers University School of Social Work—which collaborated with NJPN—to create a prevention-focused mobile app for iPhone and Android smartphones called "Be the One." The app supports prevention messaging by enabling community members to express their points of view by photographing scenes that highlight themes of concern and uploading them for review and posting by the regional coalition that serves their area.

GCADA has identified the reduction of stigma associated with addiction as a top priority, and in 2014 unveiled the "Addiction Doesn't Discriminate" campaign to increase public awareness of substance abuse issues. The campaign represents a partnership between GCADA and DMHAS, DOE, the U.S. Attorney's Office/District of New Jersey, the Partnership for a Drug-Free New Jersey (PDFNJ), and multiple division of the OAG, including the State Police.

Behavioral Health Integration and Implementation of the Affordable Care Act

DMHAS is engaged in multiple efforts to integrate substance abuse and mental health services, as well as behavioral health and primary care. The State Mental Health Authority Medical Director's Office houses an Integration Office that is promoting coordination between behavioral health agencies and primary health care providers to increase access to primary care. The Integration Office is working closely with the Division of Medical Assistance and Health Services (DMAHS)—which serves as New Jersey's Medicaid Office—and DCF.

DMHAS and DMAHS have explored several models of integration, including a health home model targeting those with the highest need. DMHAS and DMAHS have also partnered to expand integrated care throughout the adult system. In January 2015, both agencies were awarded a joint grant from the National Academy of State Health Policy, which includes membership in a new learning collaborative led by the National Academy of State Health Policy for states developing and implementing programs to integrate primary care, behavioral health, and social services in ambulatory settings. DHS has invited DOH and the New Jersey Primary

Care Association to join the team, with the hopes of using the pilot model in Federally Qualified Health Centers, Community Health Centers, and other primary care settings.

In 2014, the New Jersey Mental Health Planning Council changed its name to the New Jersey Behavioral Health Planning Council (BHPC). Membership was also reconfigured to increase the representation of individuals impacted or associated with addiction services. The purposes of the combined Council include: 1) to review New Jersey's Federal Community Mental Health Services and SABG plans each year and make recommendations for improving the plans; 2) to serve as an advocate for consumers concerning state policy, legislation, and regulations affecting behavioral health; 3) to monitor, review, and evaluate the allocation and adequacy of behavioral health services in New Jersey; 4) to advise DHS and DMHAS on services and programs for persons with behavioral health disorders in the state; 5) to assist in the development of strategic plans for behavioral health services and advocate for the adoption of such plans to other state departments or branches of government; and 6) to exchange information and develop, evaluate, and communicate ideas about mental health, substance abuse and co-occurring planning and services.

New Jersey also maintains a Professional Advisory Committee which meets monthly to provide advice on treatment and prevention services to the SSA director. Its relationship to the Council is not clear.

SSA Approach to Prevention

Definition of prevention—DMHAS's community-based services scope of work contract defines prevention as a proactive, evidence-based process that focuses on increasing protective factors and decreasing risk factors that are associated with alcohol and drug abuse in individuals, families, and communities.

Definition for "Comprehensive Prevention"—While DMHAS does not appear to specifically define comprehensive prevention for subrecipients, state guidance clearly outlines a comprehensive approach. Information presented by DMHAS staff during the site visit noted that the agency "seeks to institutionalize a systematic approach to prevention." DMHAS's community-based services scope of work contract states, "Current research regarding prevention continues to prove that effective substance abuse prevention must include evidence-based strategies for addressing risk and protective factors across multiple domains." DMHAS funds coalitions to implement environmental strategies using a community perspective and encourages the selection of environmental strategies that complement other prevention programming already in place in local communities and schools to impact the target service population.

Vision and Mission—DMHAS's organizational vision and mission have remained unchanged since the 2012 site visit. Its vision is: "DMHAS envisions an integrated mental health and substance abuse service system that provides a continuum of prevention, treatment, and recovery supports to residents of New Jersey who have, or are at risk of, mental health, addictions or co-occurring disorders. At any point of entry the service system will provide prompt and easy access to appropriate and effective person-centered, culturally competent services delivered by a welcoming and well-trained work force. Consumers will be given the tools to achieve wellness and recovery, a sense of personal responsibility and a meaningful role in the community."

DMHAS's mission is: "DMHAS, in partnership with consumers, family members, providers and other stakeholders, promotes wellness and recovery for individuals managing a mental illness, substance use disorder or co-occurring disorder through a continuum of prevention, early intervention, treatment and recovery services delivered by a culturally competent and well-trained workforce."

***Operational Framework*—**State documents note that DMHAS uses SAMHSA's SPF as its framework for planning across the continuum of services. DMHAS has also worked with its partner county governments to establish standards to produce goal-oriented and data-driven county plans for the development of the full continuum of care from primary prevention through recovery support. DMHAS staff noted during the site visit, however, that additional buy-in for the use of the SPF is needed at the agency, coalition, municipal, county, and state levels.

***Theoretical Framework*—**DMHAS has historically endorsed the Hawkins and Catalano risk and protective factor framework, which identifies research-based risk and protective factors in the following four domains: Individual/Peer, Family, School Environment, and Community Environment. New Jersey's 2013 Strategic Plan for Prevention also noted the importance and utility of a public health approach.

***Definition of Evidence-Based Strategies*—**PEIS staff reported that they use the guidance on evidence-based strategies developed and issued by SAMHSA in 2009 to establish criteria for the selection and use of evidence-based strategies by funded prevention providers. The CSAP team noted, however, that DMHAS also directs providers to consider listing on SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP) as evidence of effectiveness in and of itself. While the NREPP website states that it is intended to serve as a resource to assist researchers, practitioners, and policymakers in using evaluation evidence for practical decisionmaking and program implementation, it also notes that NREPP is not intended to be an exhaustive list of programs that merit investment.

NREPP has gone through several major changes since its inception in 1997. Programs were originally designated as Model, Effective, or Promising, but these designations were discontinued in 2004 and a new 4-point rating system was introduced. A 4 represented the highest quality of evidence, and a 0 represented very poor quality of evidence. While all programs listed in the registry must have met NREPP's minimum requirements for review, the registry included all programs reviewed, including those with low scores for quality of evidence.

In 2014, NREPP went through a major redesign and relaunch, which involves using new guidelines to classify all newly reviewed and re-reviewed programs under these categories:

- ***Effective***—The evidence base produced strong evidence of a favorable effect.
- ***Promising***—The evidence base produced sufficient evidence of a favorable effect.
- ***Ineffective***—The evidence base produced sufficient evidence of a negligible effect, OR sufficient evidence of a possibly harmful effect.
- ***Inconclusive***—Limitations in the study design or a lack of effect size information preclude from reporting further on the effect.

The 356 programs reviewed under the previous criteria are now referred to as "legacy" programs which will be re-reviewed using the new guidelines. At the time of the New Jersey site visit, NREPP listed nine newly reviewed or re-reviewed substance abuse prevention programs.

DMHAS also directs community-based prevention service providers to select programs listed on one of the following registries:

- Blueprints for Healthy Youth Development
- U.S. Office of Juvenile Justice and Delinquency Prevention—Model Programs Guide
- Find Youth Info
- Effective Interventions.

The CSAP team noted that DMHAS's guidance on evidence-based prevention does not ensure that selected strategies are documented to have strong quality of research or documented outcomes, and suggested that expanded guidance could enhance DMHAS's ability to ensure that providers are using the strongest criteria to identify and select evidence-based strategies that are best aligned with local problems and conditions. As a start, DMHAS might review examples of guidance that have been developed by other states to see if there are components that might be useful for New Jersey.

Multiagency/State Prevention System

New Jersey has a number of statewide and/or multiagency bodies that have responsibilities for substance abuse, including GCADA, the SEOW, the Core Opioid Work Group, the Facing Addiction Taskforce, and PDFNJ.

GCADA is established by state law to serve as an active and collaborative participant in the planning and coordination of New Jersey's addiction prevention, treatment, prevention policy, and services. Accordingly, GCADA has three core functions: 1) policy and planning, including developing an annual Comprehensive State Alcoholism and Drug Abuse Master Plan (ADA Plan) for the Governor and state Legislature; 2) public awareness and education; and, 3) administration of the state's $10 million Alliance to Prevent Alcoholism and Drug Abuse Program (Municipal Alliance Program). GCADA membership includes representatives from DHS, DLPS, the Division of Consumer Affairs (DCA), DCF, DOE, DOH, the Administrative Office of the Courts; the Departments of Labor and Workforce Development, Corrections, and Military and Veteran's Affairs; and the New Jersey Higher Education President's Council.

GCADA is housed within the state Department of Treasury and employs five staff, including an executive director. Its membership meets monthly and maintains the following standing subcommittees that are charged with focusing on outcome-based planning, coordination of service, and collaboration with state, county, and federal agencies: Executive, Policy and Planning (PPC), and Prevention and Public Awareness. The latter includes representatives from the County Alliance Coordinators Association, the Student Assistance Professionals Association, NJPN, National Council on Alcoholism and Drug Dependence–New Jersey, and PDFNJ. This committee's responsibilities include supporting and advising GCADA and PPC by conducting the following activities:

- Reviewing prevention and public awareness services and planning activities, including:

    - Identifying gaps and best practices in alcohol and other drug (AOD) prevention and public awareness
    - Identifying and developing new, outcome-based prevention and public awareness initiatives and evaluation criteria
    - Reviewing the development of public awareness and educational materials related to alcoholism and drug abuse to enhance public awareness and reduce stigma.
- Reviewing the development of the ADA Plan in coordination with PPC.
- Reviewing the development of rules, regulations and administrative procedures for the operation of the Municipal Alliance Program, including the awarding of grants
- Assisting with planning and implementation of GCADA's Annual Summit.
- Establishing working groups as needed to carry out its duties.

New Jersey's 2016 SABG application notes that DMHAS and GCADA also convened a working committee that includes representation from County Alcohol and Drug Abuse Program Service Directors, County Municipal Alliance (MA) Coordinators, Rutgers University, and NJPN to review the following processes and guidelines to ensure that each process supports the others: the Regional Coalition Needs Assessment and planning process, the County Alcohol and Drug Services Planning Process Guidelines, and the pending Municipal Alliance Planning Process.

New Jersey's SEOW—which comprises staff from state and county-level departments and statewide provider agencies and organizations—collects and analyzes epidemiological data to assess the magnitude, incidence, and prevalence of substance use-related consequences and related substance use patterns and intervening variables. The SEOW was originally formed in 2006 as a requirement of New Jersey's SPF State Incentive Grant, and currently meets 10 times a year. Membership in the SEOW comprises government and community agency-based experts in the field of substance abuse.

Entities represented on the SEOW include: DMHAS, DOE, DOH, GCADA, the Department of Military and Veteran's Affairs, the New Jersey State Police, the Division of Highway Traffic Safety, the Juvenile Justice Commission, the New Jersey Prescription Drug Monitoring Program (NJPMP), the New Jersey Intoxicated Driving Program, the New Jersey Poison Information and Education System, the New York/New Jersey High Intensity Drug Trafficking Area (HIDTA), NJPN, the New Jersey Hospital Association Behavioral Health Group, Barnabas Health, RWJ Medical School, Rutgers University, Regional Coalitions, and the County Alcohol and Drug Directors Association.

New Jersey also maintains a separate Assessment Workgroup that is co-chaired by a DMHAS staff member and a community representative. According to New Jersey's 2016 SABG application, the workgroup analyzed state epidemiological and archival substance use data and presented its findings to the DMHAS's Strategic Planning Committee in 2012 to pinpoint substance abuse priorities. The SEOW provided a significant portion of the data and other resources used by the workgroup, including the New Jersey Epidemiological Profile for Substance Abuse. While the role of the workgroup was discussed during the site visit, it was not

clear to the CSAP site visit team whether the workgroup continues to exist and, if so, whether it has a formal relationship or connection with the SEOW.

DMHAS convenes and facilitates a monthly Core Opioid Workgroup, whose mission is to develop a comprehensive, strategic approach to the opioid epidemic. Group members include DOH, DCF, DMAHS, GCADA, OAG, the Juvenile Justice Commission, and the New Jersey State Police. New Jersey's 2016 SABG application states that the group has engaged the support and commitment of department-level commissioners in directing their agency resources and expertise to address opioid issues.

In October 2014, New Jersey's Governor signed an Executive Order to create a 12-member Facing Addiction Task Force charged with advising the Governor on matters related to stigma, addiction, and substance abuse, and developing: 1) prevention strategies and efforts, 2) strategies to reduce stigma associated with substance abuse and addiction, and 3) recommendations for strengthening the treatment system.

PDFNJ—which is funded by DMHAS—was founded in 1992 to localize, strengthen, and deepen drug-prevention media efforts in the state. Its website notes that New Jersey's print, billboard, radio, and television media outlets have donated more than $30 million in pro bono services for its antidrug messages since the organization's inception. Current media efforts include statewide campaigns aimed at reducing prescription drug abuse and opioid/heroin abuse.

Prevention is a shared priority and responsibility among state agencies in New Jersey. Agencies with significant substance abuse prevention responsibilities in addition to DMHAS include DOH/OTC and OAG, which houses the following entities: 1) DCA's New Jersey Drug Control Unit and NJPMP; 2) the Division of Alcoholic Beverage Control (ABC); and 3) the New Jersey State Police and its Regional Operations Intelligence Center (ROIC).

DOH/OTC is responsible for decreasing deaths, sickness, and disability among New Jersey residents who use tobacco or are exposed to environmental tobacco smoke. The TASE Program, which is housed in OTC, enforces New Jersey's tobacco control laws prohibiting the sale of tobacco to persons under the age of 19.

The New Jersey Drug Control Unit assists in the enforcement of the provisions of the New Jersey Controlled Dangerous Substances Act that relate to persons or firms that manufacture, prescribe, distribute, dispense, or conduct research or analysis using controlled substances. The New Jersey Drug Control Unit is also responsible for administering the New Jersey Prescription Blanks Program (NJBP). The Prescription Blanks Program implements and enforces the provisions of the Uniform Prescription Blanks Act, which involves regulating all approved printers that manufacture and distribute New Jersey Prescription Blanks to licensed health care practitioners authorized to write prescriptions for controlled dangerous substances, legend drugs, or other items.

The NJPMP, which is established in state law, is an important component of DCA's effort to comprehensively halt the diversion and abuse of prescription drugs. The NJPMP is a statewide database that collects prescription data on controlled dangerous substances and human growth hormone dispensed in outpatient settings in New Jersey, and by out-of-state pharmacies

dispensing into New Jersey. As of March 1, 2015, pharmacies are required to report information to the NJPMP on a daily basis, and prescriptions must be reported to the database no more than 1 business day after the date the controlled substance was dispensed.

The state's website notes that access to the NJPMP is granted to prescribers and pharmacists who are licensed by the State of New Jersey and in good standing with their respective licensing boards. Before issuing a prescription or dispensing a prescribed drug, qualified prescribers and pharmacists who have registered to use the NJPMP are able to access the its website and request the Controlled Dangerous Substances Act and human growth hormone prescription history of the patient. Patient information in the NJPMP is intended to supplement an evaluation of a patient, confirm a patient's drug history, or document compliance with a therapeutic regimen. When prescribers or pharmacists identify a patient as potentially having an issue of concern regarding drug use, they are encouraged to help the patient locate assistance and take any other action they deem appropriate.

ABC is responsible for alcohol licensing, enforcement/investigation of alcohol licensees, and public awareness and education. ABC shares the enforcement of laws involving retail alcohol sales with municipal ABC Boards which issue retail licenses within the municipality and enforce alcoholic beverage control laws. The municipal ABCs also have a fair degree of discretion to regulate local alcohol licenses and policies and the legislative power to pass ordinances.

The state ABC Director is appointed by the Governor with the consent of the Senate. The Director is required to supervise the manufacture, distribution, and sale of alcoholic beverages in such a manner as to fulfill the public policy and legislative purpose of the ABC law. Investigations of violations of the law are conducted by the ABC's Enforcement and Investigations Bureaus. ABC also administers the Cops in Shops program, a partnership of liquor retailers and the law enforcement community to prevent the illegal purchase of alcohol by or for underage persons. According to the state's website, the Cops in Shops program is in its 19th year and has accounted for more than 11,000 arrests for underage drinking in New Jersey.

The New Jersey State Police developed and administer the ROIC, which houses the state's Drug Monitoring Initiative. The Drug Monitoring Initiative was created in 2009 to address the epidemic of heroin and opiate use and the violent crimes and burglaries associated with it. The Drug Monitoring Initiative has robust multistate drug intelligence capability that collects and analyzes data to help law enforcement and public health care experts develop strategies to combat drug activity in their jurisdictions. Highlights of the initiative include the following:

- The incorporation of public health into the drug monitoring intelligence cycle
- The ability to coordinate the collection, analysis, and mapping of drug incidents statewide
- The expedited analysis of seized drugs to better direct investigators and health resources
- Training law enforcement, fire service, and emergency medical service personnel statewide.

There are no federally recognized tribes in New Jersey, but the state does recognize the Nanticoke Lenni-Lenape Tribal Nation, the Powhatan Renape Nation, and the Ramapough Lunaape Nation. The mission of the New Jersey Commission on American Indian Affairs, which

is housed within the Department of State, includes fostering close communication among the state's American Indian communities and the state and federal governments.

Substate Prevention System

New Jersey has a significant amount of substate prevention infrastructure. The portion funded by DMHAS includes community-based services in all 21 New Jersey counties, direct contracts with approximately 30 agencies for curriculum-based prevention programs, and 17 Regional Coalitions. DOH funds 21 county-based tobacco coalitions and five chronic disease coalitions, while several New Jersey counties are included in the New York/New Jersey HIDTA. Other key infrastructure consists of nearly 400 MAs encompassing more than 530 municipalities (which the state calls the largest network of community-based anti-drug coalitions in the nation) and 22 Drug Free Communities (DFC) Support Program grantees.

DMHAS collaborates with the counties in a joint, comprehensive behavioral health planning process intended to coordinate system development and service delivery at state and local levels and unify community-based planning for prevention and treatment. DMHAS provides state funding to each county government, which in turn subcontracts to providers for community-based services targeting high-risk populations. DMHAS funds 21 county governments with Alcoholism, Education, Rehabilitation, Enforcement Fund Act (AEREF) funding that requires each county to allocate 11.77 percent of their AEREF funds to prevention. A key component of the county planning system is the statutory Local Advisory Committee on Alcoholism and Drug Abuse (LACADA), which are independent citizen's advisory groups charged with developing and presenting a County Comprehensive Plan for adoption by their county boards of freeholders.

While DMHAS staff noted that LACADAs do not have a significant focus on prevention, they are required to establish a County Alliance Steering Subcommittee, which is the planning body for each county's MA. MAs are established by municipal ordinance, and an MA Coordinator is located in each county's alcohol and drug office. The MAs engage residents, local government and law enforcement officials, schools, nonprofit organizations, the faith community, parents, youth, and other allies in efforts to prevent alcoholism and drug abuse. MA volunteer activities include conducting data analysis and prevention service inventories as the basis for adopting local prevention priorities and recommending them to the LACADAs. The MA Network also helps advance GCADA's advocacy objective by educating legislators about the benefits of using evidence-based strategies to prevent alcohol, tobacco, and other drug (ATOD) problems among the residents of New Jersey.

MA plans are coordinated with the LACADA's County Comprehensive Plan through a process known as "Unification Planning." New Jersey's 2016 SABG application notes that historically there was little coordination of planning and service delivery among state and community-level entities implementing prevention programs and strategies. In early 2012, however, GCADA, DMHAS, NJPN, and representatives from county government came together to develop a unified, data-driven process to plan for and deliver services and strategies at the state, county, and municipal levels. Unification Planning is intended to help counties and municipalities: 1) identify and implement a greater number of evidence-based prevention programs, 2) establish environmental approaches to prevention planning, and 3) develop and operationalize community-based and culturally appropriate recovery support systems of care. This process continues with the current 2016–2019 cycle of Unification Planning.

DMHAS also supports community-based prevention efforts targeting priority substances and populations (e.g., families of military personnel residing in New Jersey, youth identifying as LGBTQ, and young adult opioid users). The 17 Regional Coalitions are charged with reducing underage drinking, the use of illegal substances, prescription medication misuse, and the use of new and emerging drugs of abuse. A Regional Coalition is defined as an association of organizations that collaborate in the delivery of environmental strategies to address and reduce substance misuse and abuse in a specific geographic area.

Since the 2012 CSAP site visit, the number of DFC grantees within New Jersey has more than tripled growing from 7 continuation grantees in 2011 to 22 grantees in 2015. The DFC Support Program is the nation's leading effort to mobilize communities to prevent youth drug use. It is directed by the Office of National Drug Control Policy in partnership with SAMHSA and provides grants to local drug-free community coalitions to increase collaboration among community partners and to prevent and reduce youth substance use.

The New York/New Jersey HIDTA comprises Bergen, Essex, Hudson, Mercer, Middlesex, Passaic, and Union counties in New Jersey. Key HIDTA-supported initiatives in the state include:

- The New Jersey Drug Trafficking Organization Task Force focuses on disrupting and dismantling major drug trafficking organizations in the NJ HIDTA region.
- The New Jersey Investigative Support Center provides HIDTA partners with drug intelligence.
- The Violent Enterprise Source Targeting Initiative brings together managers and investigators from federal, state, and local law enforcement agencies to identify major criminal targets in Newark and coordinate related investigations.
- Operation Medicine Cabinet, a drug take-back program that enables New Jersey residents to safely dispose of unused and expired prescription and over-the-counter medications.
- The New Jersey Domestic Highway Enforcement Initiative promotes coordinated, intelligence-led drug enforcement efforts on major roadways throughout the region.

Despite Unification Planning, coordination between the MAs, DFC grantees, DOH grantees, and DMHAS-funded prevention subrecipients continues to be limited. DMHAS staff acknowledged that this has been a historical issue but noted that they are working with Rutgers University to conduct a prevention resource assessment to collect information on and map all of the prevention efforts being carried out across the state.

New Jersey's ability to address the state policy issues that contribute to substance abuse problems and consequences and the significant burden they impose could be enhanced by more coordinated prevention efforts by the state's community coalitions and prevention providers, even though the issues addressed may share intervening variables that span municipal, county, and regional boundaries. As a key funder of—and leader in—coalition development and substance abuse prevention, DMHAS is well positioned to work with its partners to build the capacity and willingness of coalitions and substate prevention entities to coordinate their efforts.

Contextual Conditions and State Substance Abuse Trends

Contextual Conditions

Demographics

According to the 2010 U.S. Census, New Jersey's population of 8,791,936 residents was predominately White (68.6 percent), followed by Black/African American (13.7 percent). Asians made up 8.3 percent of the population, followed by residents identifying as two or more races (2.7 percent). Persons of Hispanic/Latino ethnicity represented 17.7 percent of the population.

The population of New Jersey is growing at a slower rate than the U.S. population overall. The U.S. Census Bureau estimates that the population of the state increased by 1.9 percent from 2010 to 2014. Census data also indicate that New Jersey's population has grown more diverse over time, with the largest increases seen among Asians, followed by multiracial residents, and Hispanic/Latinos. As one of the most diverse states in the country, New Jersey is home to many different ethnic enclaves, most notably Indians and Koreans. In 2010, undocumented immigrants accounted for 6.5 percent of the state's population, the fourth highest in the nation.

New Jersey's population is aging faster than the nation as a whole. In 2010, the median age was 39 years, which was 2 years older than the national median. From 2010 to 2013, New Jersey's senior citizen population (aged 65 years or higher) increased by 8.2 percent.

New Jersey is the most densely populated state in the country, with populations concentrated in counties surrounding New York City, Philadelphia, and the Jersey Shore. The four largest cities—Newark, Jersey City, Paterson, and Elizabeth—are all within 20 miles of New York City. The extreme southern and northwestern counties are relatively less populated. The CSAP site visit team noted that although New Jersey is densely populated, it is a relatively small state geographically, which should facilitate interaction among substate entities.

Geography and Substance Abuse Implications

According to the 2015 New York/New Jersey HIDTA Drug Threat Assessment, northern New Jersey's proximity to New York City has made the area an "epicenter" for drug trafficking. Urban areas of New Jersey, such as Newark, Paterson, Trenton, and Camden are considered major heroin distribution centers with significant heroin markets. Drug trafficking and importation of drugs in these areas is facilitated by major transportation networks, including two major international airports and several domestic airports; two major railroad complexes and hundreds of miles of subway tracks; an extensive waterfront with various points-of-entry, including the Port of New York (the third largest in the country); and a complex network of highways, bridges, and tunnels.

Economics

In 2014, New Jersey had a higher median income ($65,200) and lower poverty rate (11.3 percent) than the nation as a whole. The unemployment rate in November 2015 was 5.3 percent. New Jersey is also, however, characterized by economic inequality. Despite the state having the second highest median income in the nation from 2008 until 2012, in that same period the city of Newark was ranked the seventh poorest large city in the U.S., with a poverty rate of 30.4 percent.

New Jersey's largest economic sectors include the pharmaceutical industry and tourism, including casino-based tourism in Atlantic City. Hurricane Sandy, which occurred in October 2012, caused major economic disruption to the state and cost approximately $36.8 billion in damages. While the economic effects of the storm were mostly short-term, the U.S. Chamber of Commerce estimated that New Jersey lost $950 million dollars from tourist spending in 2013, which reduced total output by $1.2 billion and reduced employment for over 11,000 workers.

Special Populations

New Jersey is home to a joint base, as well as a naval weapons station, and an arsenal. Joint Base McGuire-Dix-Lakehurst, near Newark includes Air Force, Army, and Navy personnel with a combined population of 38,074 people. In addition, there are approximately 416,037 veterans residing in the state, the majority of whom are 65 years or older.

Problems with alcohol and other drug abuse have been well documented among service personnel. At greatest risk are formerly deployed personnel with combat exposures, as they are at highest risk for binge drinking and for developing alcohol- and drug-related problems. According to a recent report from the Institutes of Medicine (IOM), increases in drug abuse among veterans are due, in part, to a huge increase in the number of prescriptions for pain-relieving drugs to deal with combat injuries in Iraq and Afghanistan during the past decade.[2] Studies also show that between 36.9 and 50.2 percent of veterans in the Veterans Administration health care system who have served in Iraq and/or Afghanistan have received a mental disorder diagnosis, such as post-traumatic stress disorder or depression.[3]

New Jersey has 31 public and 35 independent higher education institutions that serve more than 440,000 students. The largest university system in the state, Rutgers, serves approximately 65,000 students. Substance abuse by college students has been a topic of national concern. Data from the national 2013 Core Institute survey, which measures AOD use among students in institutions of higher education, indicate that 60.3 percent of underage students reported consuming alcohol in the previous 30 days and 42.8 percent of students reported binge drinking[4] in the past 2 weeks. College students also report high rates of consequences because of alcohol and drug use: 30.7 percent of students reported some form of public misconduct (e.g., police involvement, fighting, vandalism, driving under the influence), and 21.5 percent reported experiencing serious personal problems (e.g., suicidality, injury, sexual assault, AOD dependence).[5]

State Policy Environment

The escalation of opioid and other drug use in New Jersey has resulted in numerous state-level initiatives in recent years. New Jersey's first recovery high school opened in 2015, and New

[2] https://www.nap.edu/resource/13441/SUD_rb.pdf. Institute of Medicine of the National Academies Report Brief released 9/17/2012.

[3] Cohen, B. E., Gima, K., Bertenthal, D., Kim, S., Marmar, C. R., & Seal, K. H. (2010). Mental health diagnoses and utilization of VA non-mental health medical services among returning Iraq and Afghanistan veterans. *Journal of General Internal Medicine*, 25 (1), 18–24.

[4] Binge drinking is defined in the survey as consuming five or more drinks in one sitting.

[6] http://core.siu.edu/_common/documents/2013.pdf

Jersey's Governor has expanded the state's Drug Court program to include mandatory treatment for all nonviolent offenders who are determined to have a substance use disorder.

New Jersey's Opioid Overdose Prevention Act, which was signed by the Governor in 2013, provides legal protection to people who are in violation of the law while they are attempting to help a drug overdose victim and also eliminates negative legal action against health care professionals or bystanders who administer overdose antidotes in life-threatening situations.

In 2015, an "Opioid Addiction and Abuse Prevention" package of bills was introduced to the Legislature. New Jersey has also enacted 911 Lifeline legislation that addresses both overdoses and underage drinking.

In December 2015, new requirements for the NJPMP took effect to increase participation, broaden access, and improve surveillance. The law also contains a physician mandate, requiring that the system be checked for new patients and chronic pain patients. In 2016, the Opioid and Health Addiction Prevention Act was introduced to redefine medical procedures and guidelines for patients who are experiencing temporary pain. In December 2015 the Legislature passed a bill raising the minimum tobacco purchase age from 19 to 21. This measure, however, was pocket vetoed by the Governor.

At the local level, a majority of municipalities in New Jersey have enacted Social Host and/or Private Property ordinances in recent years.

A summary of state laws related to alcohol and other drug abuse is provided in appendix F.

State Substance Abuse Trends and Issues

Several data sources show decreasing rates of alcohol use for New Jersey youth and adults. Data from the 2013–2014 National Survey on Drug Use and Health (NSDUH) showed mostly stagnating rates of past-30-day alcohol use among youth with an erratic drop in the last 2 years, while the 2013 Youth Risk Behavior Survey (YRBS) indicated declines over time in both past-30-day alcohol use and binge drinking. Trend data for adults are mixed. The 2012–2013 and 2013–2014 NSDUH results showed increasing reports of past-30-day alcohol use while the 2013 Behavioral Risk Factor Surveillance System (BRFSS) indicated a decline. NSDUH and YRBS show New Jersey youth reporting alcohol use and binge drinking at higher than national rates; however, NSDUH indicates that the percentage of adults aged 26 and older who reported past-month alcohol use was also significantly higher than the national average.

New Jersey youth and adults use tobacco at far lower rates than the nation as a whole. Among youth, both the 2013–2014 NSDUH and the 2013 YRBS show significant decreases in past-30-day cigarette use. Among adults, the 2013 BFRSS and the 2013–2014 NSDUH show rates of cigarette and other tobacco use to be well below national medians.

Similar to national trends, perceptions of harm from marijuana are dropping for both youth and adults in New Jersey. Both NSDUH and YRBS data show relatively stagnant rates of reported past-30-day marijuana use among youth, however, and both sources also indicate that youth marijuana use rates in New Jersey are below national averages. Among adults, NSDUH indicates an increase in marijuana use over time, but the rate is still lower than the national median.

Although the reported rate of illicit opioid use is decreasing in New Jersey and is below the national median, the state is experiencing an alarming rise in overdose deaths and drug treatment admissions due to heroin and prescription opiates. In 2013, New Jersey had the sixth highest teen drug overdose rate and the fourth highest drug overdose rate for young adult (19–25 years old) males in the country. New Jersey's heroin-related overdose death rate of 8.3 deaths per 100,000 people is triple that of the national rate. New Jersey's dubious distinction of having some of the least expensive, highest purity street heroin in the nation may be contributing to this epidemic. Street heroin in New Jersey may cost as little as $5 per "baggie" with a typical purity level of 40 percent. Heroin is by far the top reason for admission into state-funded treatment programs, representing 36.8 percent of admissions.

A fuller description of New Jersey trends and issues by substance is provided in appendix H.

Substance Abuse Needs Assessment

OPREP, the SEOW, and the Assessment Workgroup are the primary entities in New Jersey that collect and analyze archival, social indicator, and survey data on substance abuse. These entities have access to—and use—a wide variety of data on consumption and consequences of substances, as well as some data on intervening variables. DMHAS staff noted during the site visit that the SEOW is currently working to update the state's 2008 epidemiological profile.

Data sources used to determine priority substances and populations include national surveys (e.g., NSDUH, YRBS, BFRSS), statewide surveys (e.g., Middle and High School Risk and Protective Factor Student Surveys, New Jersey Student Health Survey, NJHSDUH), surveys on special populations (e.g., the Core Institute and Older Adults survey), state and federal administrative data (e.g., the New Jersey Substance Abuse Monitoring System [NJSAMS], New Jersey Center for Health Statistics [NJCHS], Intoxicated Driver Program [IDP] data, Treatment Episode Data Set, Uniform crime Report, as well as in-depth statistical and geographical analysis (e.g., ArcGIS and the Relative Needs Assessment Scale [RNAS]).

A summary of key data collection tools follows:

***Middle School Risk and Protective Factor Student Survey*—**DMHAS supported implementation of this survey, which is a modified Pride survey instrument, in 1999, 2001, 2003, 2007, 2010, and 2012. The survey assesses the current prevalence of problem behaviors related to ATOD use and other delinquent behaviors in the surveyed population, as well as risk and protective factors in the community, family, school, and peer/individual environments. NJPN and DMHAS worked together to incorporate many of the DFC-required outcome measures into the survey, and county-level reports are prepared where response rates are deemed sufficient. Random sampling is used to minimize the number of schools and students that participate, but in 2012 the final overall survey response rate was just 40.6 percent, and overall response rates of 36 percent were not reached in 6 of 21 counties. While the participation rates obtained in the study are improvements on the past, they are lower than those rates generally regarded as acceptable to considering results as representative to a broader population. DMHAS staff noted that statutory requirements for active parental consent inhibit student participation in the survey. Upcoming survey administration is scheduled to take place from October 2015 to May 2016.

***High School Risk and Protective Factor Student Survey*—**DMHAS's first high school survey was completed in June 2008, using the same survey instrument as the middle school survey. Participation in the survey, however, did not allow the data to be disaggregated below the state level. DMHAS staff reported that administration of multiple school-based surveys creates competition for time that inhibits participation by schools.

New Jersey Student Health Survey—Every odd numbered calendar year, DOE conducts a survey of student self-reported health behaviors using a core of questions from the YRBS and selected additional questions from other sources. In the years in which school and student survey participation rates have reached the 60 percent threshold established by the U.S. Centers for Disease Control and Prevention (CDC) for statistical comparisons of findings over time and between population groups, the New Jersey findings are published by CDC as YRBS results. (This threshold was met in 2013.) While the DOE does not sample at the county level, the findings provide state-level information on risk and protective factors for adolescent substance use in New Jersey. DMHAS provided financial assistance for the 2010–2011 and 2013 surveys.

***New Jersey Household Survey on Drug Use and Health*—**DMHAS conducts the NJHSDUH at 5-year intervals using a questionnaire developed by CSAT that is nearly identical to that used by NSDUH. The primary focus of the survey is the population distribution and prevalence of substance use and addiction, but survey data are also used to obtain treatment need estimates. The questionnaire includes sections on tobacco use and gambling behavior, as well as one or more special topics (e.g., the needs of pregnant women and veterans, obstacles to treatment access among persons who need but do not get care). For the 2013–2014 NJHSDUH, DMHAS staff said they planned to include a new permanent section on mental health treatment needs and access to community-based, mental health treatment opportunities, but administration of the survey was precluded by procurement issues. According to state documents, the 2016 survey will include questions designed to assess the mental health treatment needs of New Jersey's adult population.

***Older Adult Survey*—**DMHAS conducted an Older Adult Survey in 2012 using funding from a State Prevention Enhancement (SPE) grant from SAMHSA. Funds were insufficient, however, to obtain a large enough sample for reliable county-level estimates. DMHAS staff reported they intend to use PFS funding to re-administer the survey and obtain enough data to create small area estimates of the prevalence of substance abuse and mental illness among older adults in New Jersey. A telephone interview survey will be developed using random digit dialing with a multistage cluster design to generate probability-based samples of the adult population of each New Jersey County or relevant geographic area.

***New Jersey Substance Abuse Monitoring System*—**NJSAMS captures early intervention and treatment information on all individuals who enter publicly funded substance abuse treatment in New Jersey. DMHAS is also able to use NJSAMS data to estimate unmet treatment demand.

***New Jersey Center for Health Statistics*—**NJCHS collects, researches, analyzes, and disseminates health data and information, provides baseline and trend data to measure the impact of public health strategies for disease prevention and health promotion, and houses the Office of Injury Surveillance and Prevention, which is the state's central source for injury statistics.

Intoxicated Driver Program—IDP receives reports of DUI convictions from the courts and monitors the compliance of out-of-state residents and residents convicted of DUI out-of-state with the requirements of the law. IDP is also responsible for compiling an Annual Statistical

Summary Report on all IDP clients who attend Intoxicated Driving Resource Center education and evaluation sessions. The latest report was released in October 2014 for 2013 IDP activities.

Relative Needs Assessment Scale—The RNAS was first administered in 1995 and updated in 2008 and 2013. It uses social indicators of substance use-related mortality and morbidity to calculate relative risk for each county and municipality, permitting comparisons among counties and municipalities across the state. The RNAS is used to target prevention and treatment resources by location and socioeconomic characteristics of at-risk populations. In federal fiscal year (FFY) 2014, the SSA provided RNAS indexes down to the municipal level for use in the 2016–2019 County Comprehensive Plan process.

Returning veterans are a priority population for DMHAS's PFS initiative. To address the limited information on this population, DMHAS collaborated with Rutgers University to conduct a survey of returning veterans, which was administered in the summer of 2015 to persons who were either currently on active military duty or who previously served on active duty. Respondents were recruited in person, on the Internet, and by telephone. The survey collected data in several areas, including: military history and sociodemographic characteristics; physical and mental health characteristics; history of ATOD use and nonmedical use of prescription drugs; consequences related to ATOD use; anxiety and depression; a veteran's health module from the BRFSS; a post-traumatic stress disorder checklist; and a post-deployment social support scale. A total of 1,185 New Jersey veterans participated in the survey.

DMHAS used SPE funding to make numerous enhancements to its prevention infrastructure. In addition to the Older Adult Survey, these included: 1) addressing gaps in data on binge drinking rates among young adult women of child bearing age (21–29 years), 2) expanding the capacity of POMS to collect data on environmental strategies, and 3) updating DMHAS's Chartbooks of Social and Health Indicators to identify health problems related to substance use. Remaining data gaps identified by the SEOW—several of which reflect data that may be collected but not made available to or accessed by DMHAS—include the following:

- Medical Examiner data on the presence of AOD in the system of homicide victims and those dying from AOD-related deaths
- Data on secondary cause of death from alcohol
- Pedestrian fatalities and nonfatalities by age and substance
- ABC statistics on citations and fines
- Current ATOD use by high school students
- Prescription misuse and abuse patterns
- High school dropout rates.

Despite the abundance of data collected by the state, DMHAS staff noted that a critical challenge for the 17 Regional Coalitions, County Drug and Alcohol Directors, and MA Coordinators in New Jersey has been the lack of available data at specific and detailed geographic units of analysis (e.g., municipal, census tract, neighborhood). In addition, while some institutions of higher education appear to be conducting Core Institute or other drug/alcohol surveys, there was not general awareness of these survey efforts by DMHAS staff.

The SAMHSA site visit included a presentation by ROIC representatives. The mission of the ROIC, which was established by the State Police in 2006, includes serving as a primary point of contact for the collection, evaluation, analysis, and dissemination of intelligence data to detect and/or prevent criminal activity and solve crimes. This includes real-time collection and analysis of substance abuse and related crime data. The development and operation of the ROIC is closely linked with the State Police's Intelligence-Led Policing (ILP) initiative. According to state documents, ILP is a collaborative philosophy using improved intelligence operations to enable law enforcement to understand the changes in the operating environment and rapidly adjust to new circumstances. ILP requires police officers and investigators to become better data collectors and better consumers of intelligence-related products.

The CSAP site visit team found the operation of the ROIC to be an extremely unique and notable asset to the state's substance abuse prevention system—particularly with regard to the collection and use of real-time data to proactively identify and address emerging, escalating, and changing substance abuse trends. In addition, the philosophy of ILP mirrors the emphasis on data-driven planning and action that SAMHSA has encouraged state behavioral health systems to adopt.

Although ROIC and PMP data are made available to DMHAS, PEIS staff described the data to be overwhelming, and noted that they have not yet attempted to use them to guide their own actions or to supply them to subrecipients for use in local planning and implementation. The CSAP site visit team suggested that TA from SAMHSA/CSAP might be useful in helping DMHAS use ROIC and PMP data to great benefit and described similar CSAP-supported TA initiatives in states with similar issues and interests to New Jersey (i.e., escalating incidence and prevalence of opioid-related use and harm and interest in expanding the use of environmental prevention). The CSAP site visit team also suggested that DMHAS's Be the One mobile phone app, with its PhotoVoice capability, might have corollary benefit to ROIC operations by presenting yet another avenue for on-the-ground, grassroots data collection and sharing.

The CSAP team also encouraged DMHAS to work with state and local partners to develop a targeted plan for increasing middle school and high school survey participation. This could include ongoing communication, grassroots advocacy, and partnership between communities and their schools, as well as between DMHAS and DOE. Toward this end, DMHAS might benefit from a review of successful strategies other states have used to build school–community partnerships that support robust student survey participation to identify those that might work well in New Jersey. DMHAS is also encouraged to explore the extent to which data on AOD use by college students are available and how they can be accessed and shared as needed with substate prevention providers and coalitions to guide and inform their work.

Workforce Development and Capacity Building

Workforce Requirements, Assessment and Planning

At the time of the 2012 SAMHSA site visit, New Jersey's substance abuse workforce consisted of a vibrant, dynamic, and diverse array of paid staff, volunteers, coalitions, and organizations across a spectrum of disciplines and sectors at the municipal, county, regional, and state levels. Due to scarce resources, however, DMHAS defined its prevention workforce rather narrowly as those agencies and individuals funded through the SABG. Accordingly, DMHAS's T/TA system was designed to meet the needs of paid prevention staff through a certification process and

mandatory trainings supported by training and some TA. The 2016 CSAP site visit team noted that DMHAS continued to follow this general approach, and DMHAS staff advised the team that workforce planning is integrated into broader SSA planning efforts and overseen by DMHAS's Addictions Services Training and Workforce Development Coordinator.

The New Jersey Addiction Professionals Certification Board, Inc. coordinates prevention specialist certification. The Board uses International Certification & Reciprocity Consortium (IC&RC) standards. There are two levels of certification: the Associate Prevention Specialist (APS) and the Certified Prevention Specialist (CPS). The Associate Prevention Specialist requires 1 year of prevention experience and a 200-hour practicum completed within the past year. The CPS requires documentation of 2 years' full-time experience in prevention, including a 120-hour practicum, completion of 120 hours of preapproved coursework, a minimum of a bachelor's degree in a human services-related field, and successful completion of the IC&RC prevention written exam

According to state documents, National Council on Alcoholism and Drug Dependence of Middlesex County and the Center for Prevention and Counseling in Sussex County provide CPS classes, while NJPN tracks progress toward certification. DMHAS staff noted during the site visit that trainings required to earn the CPS credential are offered throughout the year at numerous sites in New Jersey.

DMHAS implemented a contractual requirement effective January 1, 2015, requiring all funded prevention providers to employ a staff member who has earned the CPS credential. Providers who did not meet this requirement by January 1, 2015, have until December 31, 2016, to hire a staff person or provide CPS training for an existing staff member. Credentials or degrees that are accepted in lieu of the CPS are the Certified Health Education Specialist, master's in public health, or a doctorate in the medicine or behavioral health. DMHAS staff noted this is being done in an effort to diversify the prevention workforce.

DMHAS has also identified core competencies for prevention professionals beyond those identified by IC&RC, to support the ability of the workforce to implement the SPF. These competencies are aligned with the following five SPF domains:

- ***Assessment*:** Data gathering, needs and resource identification, analysis, and problem definition
- ***Capacity Building/Building State and Community Systems:*** Collaboration, organizational advocacy, and organizational responsiveness
- ***Planning/Developing a Comprehensive Strategic Plan:*** Collaborative and strategic planning, cultural inclusion, systematic thinking, evidence-informed approaches, and facilitation
- ***Implementation:*** Cultural responsiveness, communications, collaboration, and change management
- ***Evaluation*:** Evaluation methods, data interpretation and use, data gathering.

Other cross-cutting competencies that DMHAS has identified as being needed for all five SPF domains include the following: Interdisciplinary Foundations (Substance Use Disorders/Mental

Health), Role of Multiple Systems/Systems Thinking, Family Dynamics, Ethical Practice and Professional Responsibility, Basic Knowledge, and Communication. While many of these competencies are included in traditional prevention workforce development efforts, the competency of systems and systems thinking are notable. DMHAS describes competency within this area as an ability to:

- Understand how things influence one another within a larger context
- Recognize that the component parts of a system will often act differently when isolated from their environment or other parts of the system
- Comprehend how changes in one area can and often will impact the other components.

The CSAP team noted that, despite its significant investment in T/TA, DMHAS does not appear to have a process for objectively identifying T/TA needs outside of an electronic survey issued once a year by NJPN to determine the self-identified training needs of the 17 Regional Coalitions. DMHAS also does not have a workforce development plan that is specific to the recruitment, T/TA, and retention needs of the prevention workforce. DMHAS staff did provide a draft workforce development plan dated August 2014, which includes a general goal to develop a well-trained, culturally competent, and respectful workforce in collaboration with stakeholders. The draft plan also identifies nine global areas for competency/training for prevention, treatment, and mental health professionals.

DMHAS's previous contract with NJPN also provides insight into its desired outcomes for prevention and treatment workforce development:

- **Objective 1:** To increase the number of addiction professionals by disseminating information regarding addiction field career options to the academic community, professional clinical associations, and other interested stakeholders by 10 percent by end of contract period.
- **Objective 2:** To increase the number of individuals who are Licensed Clinical Alcohol and Drug Abuse Counselors and Certified Alcohol and Drug Abuse Counselors or have obtained their CPS by 35 percent by end of contract period.
- **Objective 3:** To enhance skills and build capacity of the current certified and licensed addiction prevention and treatment professionals, providing specialized skill trainings to reach at least 180 professionals by end of contract period.
- **Objective 4:** Continue evaluation and systems coordination activities to ensure the effective implementation of this workforce development initiative.

The ability of DMHAS and its T/TA contractors to strategically maximize workforce development resources and T/TA to strengthen the prevention workforce across the state could benefit from the following actions:

1. A formal assessment of the prevention workforce needs based on identified core competencies to inform the scope and intensity of T/TA services needed to help funding recipients fully use the SPF and select and implement the evidence-based strategies most likely to be effective in addressing substance abuse priorities. As a starting point,

DMHAS might benefit from reviewing workforce assessment tools and plans developed by other states to determine the components most relevant for New Jersey.

2. The use of workforce assessment data to create a strategic workforce development plan that ensures T/TA services are targeting the most pressing workforce needs. Optimally, this plan would identify desired workforce outcomes that are measurable and time limited, as well as associated strategies for recruitment, T/TA, and retention, and providing and coordinating T/TA across organizations at the state and substate levels.

During the onsite discussions, DMHAS staff expressed interest in learning more about a current SAMHSA-supported TA effort which is being collaboratively funded by CSAP, CSAT, and CMHS to help another state develop and implement a workforce assessment and T/TA plan to build workforce competencies across primary, secondary, and tertiary prevention.

Workforce Training and Technical Assistance

DMHAS contracts with NJPN and Rutgers to develop and deliver provide T/TA to the prevention workforce throughout the year at numerous sites statewide. DMHAS Prevention Services Program Managers also provide T/TA to agencies and coalitions. According to state documents, training topics for 2016 address the following areas: community assessment, coalition building and maintenance, coordinating community prevention activities, introduction to methods and the impact of environmental change, assessment and planning of environmental strategies, implementing and enforcement of environmental change, cultural competency, and project sustainability. NJPN also coordinates an annual conference for addiction professionals throughout the state and has done so since 2000. According to its website, conference partners include treatment agencies and GCADA.

DMHAS has displayed a commitment to building cultural competency within its workforce. Its *Blueprint for Action Cultural Diversity Within DMHAS System of Care* provides general guidance on the components of a comprehensive training curriculum for cultural and linguistic competency and diversity, as well as a cultural and diversity self-assessment and a guide for developing an agency cultural and diversity competency plan. DMHAS also requires all of its grantees to participate in T/TA cultural competence training that promotes their ability to successfully meet defined standards.

Capacity Building

DMHAS also contracts with NJPN and RWJ Medical School to address the T/TA needs of the 17 Regional Coalitions. Coalitions receive guidance in addressing the components of the SPF process, tobacco prevention, GIS mapping, coalition development, sustainability, and cultural competence. As part of that scope of work, NJPN is tasked with coordinating quarterly, in-person trainings on universal topics that bring all coalition coordinators together to present successes, share ideas and resources, and network with peers. NJPN is also tasked with coordinating distance learning sessions that are web-based trainings or conference call sessions to offer additional opportunities for group discussion and learning for coalition coordinators.

DMHAS also has supported an education, training, and technical assistance initiative for county alcohol and drug abuse planners in conjunction with the Rutgers University Continuing Education Department. Planners who successfully completed the program earned a Certificate in

Community-Based Planning issued by the Rutgers University School of Social Work. The program was offered to County Alcohol and Drug Directors, County Mental Health Administrators, and will eventually be offered to DMHAS staff responsible for monitoring substance abuse agencies. An evaluation of the education, training, and technical assistance program is planned during FFY 2016 to determine if the needs of the participants were met and if the County Plans have improved as a result of the program.

State Strategic Plan

At the time of the 2012 CSAP site visit, DMHAS had developed a 2012 Substance Abuse Prevention Strategic Plan focused on the reduction of substance abuse. The 2012 CSAP site visit team noted that while the plan identified statewide priorities (i.e., reduce underage drinking, binge drinking, use of illegal substances, medication misuse, and use of new and emerging drugs of abuse), it did not include objectives, targeted outcomes, or an evaluation plan. In addition, DMHAS staff could not identify data sources to track progress in meeting the priorities.

After the 2012 site visit, SAMHSA's State TA Project helped DMHAS staff align New Jersey's five consequence and consumption priorities with outcomes through a logic model process, and also identify implementation criteria and process and outcome evaluation protocols. Identifying the data sources needed to track progress toward outcomes, however, remained as work still to be done by DMHAS and its strategic planning partners.

During the 2016 site visit, DMHAS staff reported that this plan—which has not been updated since the addition of logic models in 2012—continues to serve as the SSA's plan for prevention. DMHAS staff also noted a strong desire to incorporate mental health into the plan. The 2016 CSAP site visit team noted, however, that it is not clear how the plan can be used to guide prevention efforts since it is based on data from 2009–2010 and does not identify measurable, time-limited objectives and outcomes. In addition, the plan does not include information on how it will be implemented (e.g., roles, responsibilities and timelines for key strategies and activities needed to address the priorities) or how progress will be continuously evaluated so that midcourse corrections can be made as needed to ensure that outcomes are achieved. In sum, the state's planning process falls short of the process it requires of subrecipients.

As in 2012, the CSAP team noted that DMHAS's ability to reduce or prevent substance abuse problems, promote mental health, and strengthen its prevention system would be enhanced by a comprehensive strategic prevention plan that can be used to provide guidance and serve as a model for planning for the entire state prevention system. Optimally, the plan should be based on formal assessment and include the following components:

- A clear problem statement or statements that describes what currently exists that compromises health and/or organizational effectiveness and needs to be changed
- Clear goals describing desired changes in substance abuse behaviors, related problems and consequences, and state and substate prevention system behavior
- Clear objectives describing the changes in intervening variables that are needed in order to achieve the goals for substance abuse prevention and prevention system development

- Careful identification of the target populations that are involved in and/or impacted by the issue or issues identified in the problem statement
- Targeted and measurable outcomes that specify the degree of change sought and the timeframe in which it is to be achieved for each goal (long-term outcome) and objective (intermediate outcome), as well as changes in knowledge, skills, and abilities (immediate outcomes) needed to achieve the goals and objectives
- State-level strategies and activities that are logically linked to the achievement of desired goals, objectives, and outcomes
- An implementation component with clearly defined roles, responsibilities, and timelines
- An evaluation component sufficient to monitor progress toward outcomes and provide information for midcourse adjustments as needed
- A strategic financing component that analyzes all existing resources and infrastructure and aligns resources to support desired outcomes.

In addition to the SSA prevention plan, New Jersey had a number of other strategic plans addressing different aspects of behavioral health prevention and promotion at the time of the 2016 site visit. A brief summary of each plan follows:

The 2014 Heroin/Opiate Report is the result of 2 years of research, public hearings, and review by GCADA's Task Force on Heroin and Other Opiate Use by New Jersey's Youth and Young Adults. Task force members include Rutgers University, MAs, DMHAS, OAG, law enforcement, criminal justice, treatment agencies, and the New Jersey Association of Mental Health and Addiction Agencies. The report offers a range of recommendations for policies, strategies, and associated activities, but does not identify measurable, time-limited goals, objectives or outcomes to help the state target its efforts and evaluate progress toward success.

DMHAS 3-year strategic plan is a multiphased plan that outlines the work for the division from January 2014 through December 2016. It was developed with input from providers, consumers, family members and division staff, and identified three broad areas of system change: a move to managed care; workforce development; and community integration. Within these categories, the plan identifies 10 areas of system change, associated DMHAS tasks, start dates, and units involved. (PEIS is involved in a majority of the priority areas.)

Adult Suicide Prevention Plan 2014–2017 was developed by DMHAS's Suicide Prevention Committee. The plan includes suicide statistics using data from New Jersey's Violent Death Reporting System, and county-level data from NJCHS. The plan includes 10 broad goals and related objectives for preventing adult suicide statewide, including reducing stigma associated with being a consumer of substance use and suicide prevention services.

The 2015 New Jersey Strategy for Youth Suicide Prevention is an update to the 2011–2014 plan developed by DCF and the New Jersey Youth Suicide Prevention Advisory Council. (DCF's Division of Family and Community Partnerships is the lead agency for youth suicide prevention in the state.) The plan, which is similar in format to the Adult Suicide Plan, includes 12 broad goals and related objectives for preventing youth suicide.

New Jersey's FFY 2014–2015 SABG application notes two goals related to primary prevention: expand use of the SPF and further implement environmental prevention programs and strategies throughout New Jersey.

DMHAS staff also highlighted the following three planning processes they considered to be integrated in that they each assessed the needs of special priority populations:

- The New Jersey SPF Plan assesses the SEOW priority population of 18- to 25-year-olds
- The County Comprehensive Planning under AEREF assesses needs of seven subpopulations
- MA Plans assess special needs within their municipal jurisdiction.

Primary Prevention Set-Aside

At the time of the 2016 CSAP site visit, New Jersey's FFY 2016 SABG application was approved; accordingly, the compliance year used for the 2016 site visit was FFY 2013. New Jersey was found to be in compliance with all requirements of the primary prevention set-aside of the SABG.

Primary Prevention Set-Aside

New Jersey exceeds the 20-percent prevention set-aside requirement of the SABG. In FFY 2013, the SSA reported primary prevention expenditures of $12,011,726 out of a total SABG allocation of $44,113,253, or 27.23 percent.

Six CSAP Prevention Strategies

Historically, New Jersey has not elected to report expenditures by the six CSAP strategies and did not do so for compliance year 2013. Table 9 of New Jersey's FFY 2016 SABG report noted activity in all six strategies, however.

Public Review and Comment on SABG Application

DMHAS solicits comment from any interested person, including any federal or other public agency, during the development and after submission of the application to SAMHSA by posting a public notice on the DHS website. Those interested in viewing the SABG application are referred to WebBGAS and provided the login information. Written comments concerning the state application can also be sent to DMHAS via email or postal mail.

National Outcome Measures

DMHAS was able to report all required NOMs for compliance year 2013. In accordance with the SABG Report instructions, the reporting period used for the FFY 2013 SABG for NOMs data in Tables 31, 32, 33, and 34 of the SABG Behavioral Health Report was January 1, 2013–December 31, 2013. The reporting period used for Table 35 was October 1, 2012–September 30, 2013. DMHAS uses POMS and a manual process as its data collection and reporting system for prevention services.

Implementation

Prevention Budget and Funding

DMHAS staff reported that New Jersey's planned substance abuse prevention budget for FFY 2015 was $15,388,062, which consisted of $9,400,000 from SABG funds, $2,003,067 from federal PFS funds and $3,984,995 in state general funds.

State prevention funding to County Alcohol and Drug Abuse Directors also comes from AEREF, which is established in state law. AEREF is a nonlapsing, revolving trust fund into which $11 million is deposited annually from a tax on the sale of alcoholic beverages. Approximately $9 million from AEREF plus an additional $6.9 million in supplemental funds from the state treasury are distributed per statutory formula to the counties each year, for a total of $15.9 million for calendar year 2015. The funds support countywide needs assessment, planning, coordination, and provision of the full range of addiction services for indigent adult and adolescent county residents; counties are required to allocate 10 percent of AEREF to prevention information and education programs.

In order to participate in this county program, each county must develop a plan to deliver comprehensive addiction services across the full continuum of care, including prevention, early intervention, treatment, and recovery support, based on a county-sponsored, community-based needs assessment and planning process. Counties must match 25 percent of their respective annual AEREF allocation with a contribution of county revenues. OPREP is responsible for overseeing the county planning.

At the substate level, funding from the 22 DFC grants that were awarded to community coalitions in the state for FFY 2015 amounted to $2,750,000. New Jersey's MA program provides another $10 million annually in state funds to municipalities, with the majority of grants averaging between $10,000 and $20,000.

Funding Allocation Processes

DMHAS awards SABG prevention funds through competitive contracts to nonprofit agencies and municipal or county governments, which are based on statewide and/or county-specific assessment of needs. SABG prevention set-aside funds are used to support community-based services in all 21 counties and services for military and LGBTQ populations, while SABG prevention set-aside and PFS funds are jointly used to support regional prevention coalitions and T/TA and evaluation contracts. State funds are used to support college-based recovery support and environmental management strategies.

The 17 Regional Coalitions funded by DMHAS were selected through a competitive request for proposals (RFP) process in 2011 that used 2008 archival and social indicator data and composite incidents of risks to estimate the need for prevention services among New Jersey's 21 counties. Criteria included substance abuse treatment admissions and rates within the region and prevalence of alcohol and prescription drug misuse among middle and high school students. Each region had a minimum of one county, and according to the latest available data at the time the RFP was released, must have reported a minimum of 2,000 treatment admissions.

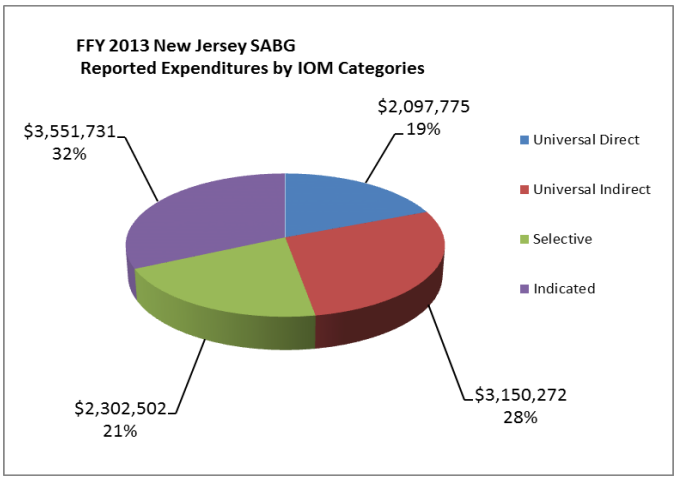
DMHAS's contracts with the 21 counties are each assigned a funding allocation from the total funds available based on relative need. The funding allocation is determined based on the presence and intensity of social indictors, past-30-day use rates, treatment admission rates, need, and risk factors within each county. Unless otherwise noted, funding requests must be submitted for a minimum of $50,000.

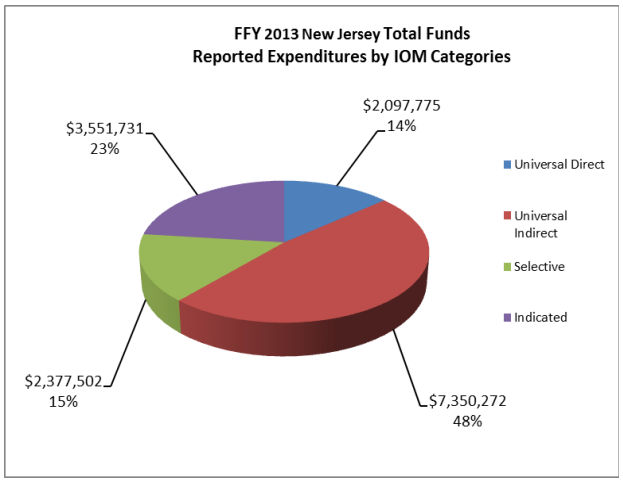
During the onsite discussions, DMHAS staff also noted that RNAS findings were used in 2008 and 2014 to allocate state and SABG funding. The CSAP team noted, however, that the current RNAS relies on 2003 substance abuse data collected through the NJHSDUH, even though 2009 data are available. While DMHAS staff reported that the data are manipulated to account for its age, the CSAP team questioned the utility of using 13-year-old data to calculate funding needs given the escalating trends in illicit drug use in the state. DMHAS was encouraged to consider updating the substance abuse data that is used to calculate the RNAS for New Jersey counties.

Prevention Expenditures and Allocations

Prevention Expenditures for Compliance Year 2013

As depicted in the pie chart below left, DMHAS reported the largest expenditures of SABG funds in FFY 2013 were for strategies targeting indicated populations, followed by universal indirect populations, selective populations, and universal direct populations.





Allocation of DMHAS's total prevention funds for FFY 2013 differed from the allocations patterns for SABG funds only, however, as depicted in the pie chart above right.

DMHAS reported funding the following strategies and activities for FFY 2013:

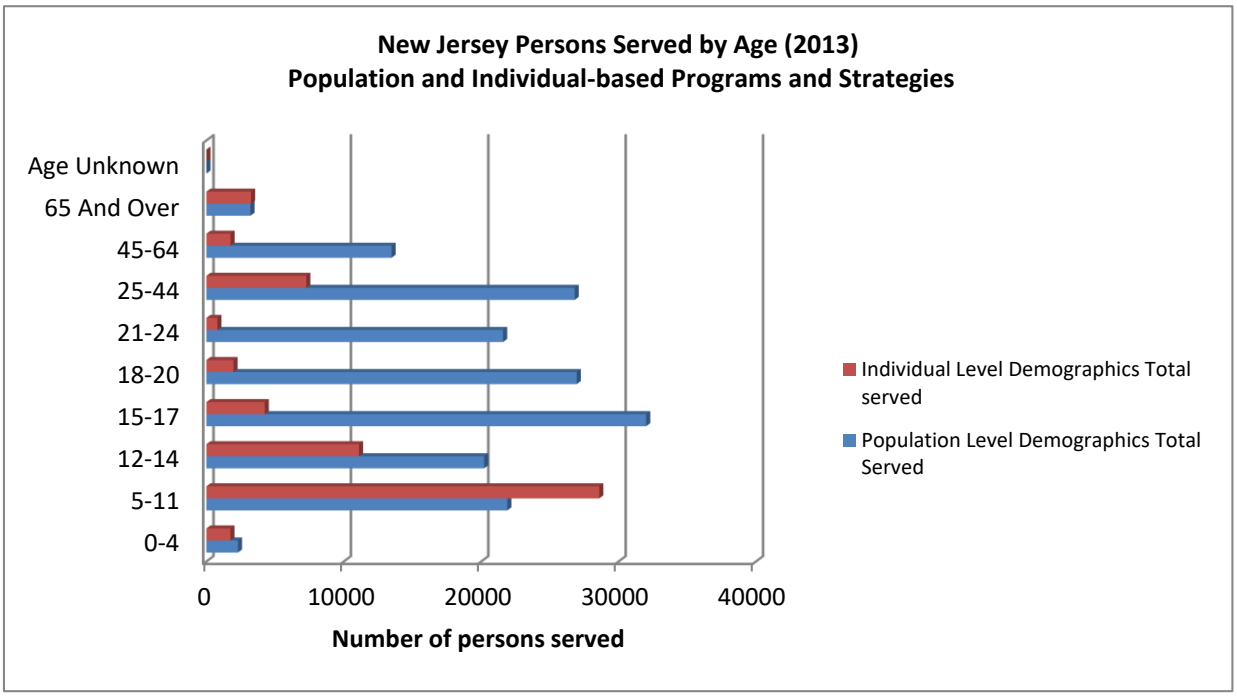
- ***Education:*** Parenting and family management, classroom and/or small-group sessions, education programs for youth groups, mentors
- ***Information Dissemination:*** Health fairs and other health promotion
- ***Alternative activities:*** Drug-free dances and parties, youth adult leadership activities, community drop-in centers, recreation activities
- ***Problem identification and referral:*** Employee assistance programs

- ***Community-based Process:*** Multiagency coordination and collaboration/coalition
- ***Environmental:*** Municipal ordinances, merchant education, beverage server training.

DMHAS reported that 100 percent of all prevention programs and strategies funded were evidence based. These consisted of six strategies for universal direct populations, seven strategies for universal indirect populations, seven strategies for selective populations, and eight strategies for indicated populations.

Persons Served in Compliance Year 2013

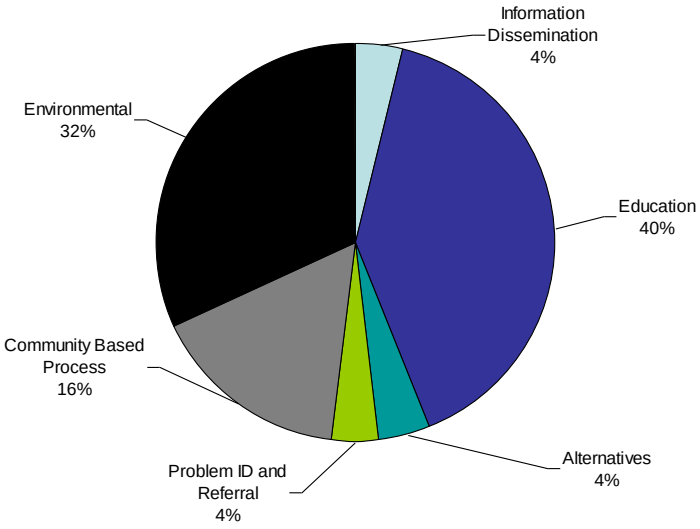
DMHAS reported serving 60,767 persons through individual-based strategies and 168,500 persons through population-based strategies in 2013. These figures represent only 0.7 and 1.9 percent of the state's population of 8.8 million residents, respectively. The small reach of prevention funds was also noted during the 2012 CSAP site visit. Given the much larger prevalence of reported substance abuse in the state, it could be difficult for DMHAS to reduce substance abuse problems and consequences if it does not increase the reach of funded prevention initiatives.



As indicated in the chart above, the majority of persons reported served by individual-based strategies were 5–11 years of age, while the majority of those reported reached by population-based strategies were 15–17 years of age.

Prevention Allocations for Current Year FFY 2016

For FFY 2016, DMHAS reported that SABG planned allocations for primary prevention will decrease to $11,130,986, which reflects 24 percent of SABG expenditures. No SABG funds were allocated for Section 1926/Tobacco efforts.



As depicted in the pie chart at left which was provided during the site visit, DMHAS reported the largest allocations of SABG funds in FFY 2016 were for education, followed by environmental strategies, and community-based process. Equal but minimal amounts of funding were allocated to information dissemination, problem identification and referral and alternative activities.

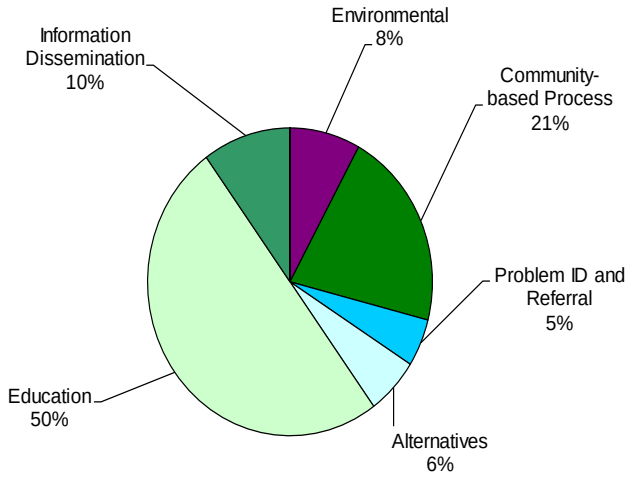
For the planning period October 1, 2015–September 30, 2017, New Jersey's 2016 BHAP noted the following priority substances and populations to be targeted: alcohol, tobacco, marijuana, prescription drugs, heroin, synthetic drugs, students in college, military families, and persons identifying as LGBTQ.

DMHAS's presentation during the site visit noted that the SSA funds over 60 curriculum-based prevention programs in community settings throughout the state, and noted the following categories of prevention funding for FFY 2016:

- **Community-based services**—These services target high-risk individuals/groups in each of New Jersey's 21 counties using evidence-based curricular programs. (DMHAS staff noted that three providers are focused on opioid prevention.) These services are funded by SABG Prevention set-aside funds.
- **Regional Prevention Coalitions**—Effective January 1, 2012, DMHAS awarded $3.65 million in addiction prevention contracts to develop 17 Regional Coalitions to use evidence-based prevention strategies to target at-risk groups and address statewide priorities in their region. These contracts are funded by SABG Prevention set-aside and PFS funds.
- **Training, Technical Assistance, and Evaluation Support for Regional Coalitions—** DMHAS contracts with the Institute for Families at Rutgers University, NJPN, and RWJ Medical School to support the work of the 17 Regional Coalitions. The Institute for Families and NJPN are both funded from SABG Prevention set-aside funds, while the RWJ Medical School is funded through PFS.

- **Prevention Services for Families of Military Personnel**—DMHAS provides funding to NJPN to provide two evidence-based programs—Coping With Work and Family Stress and the Strengthening Families Program—to military families who are living or stationed in New Jersey. Both programs are designed to enhance protective factors to help military members and their families make responsible parenting and individual choices with regard to AOD use. These programs are funded by SABG Prevention set-aside funds.
- **Services to LGBTQ Youth**—DMHAS provides funding to the North Jersey Community Research Initiative to expand their existing programs for high-risk LGBTQ youth in the Newark area by using a prevention model developed by the CDC (a modified version of Street Smarts), as well as early intervention services, social marketing, and structured recreational activities. These services are funded by SABG Prevention set-aside funds.
- **Recovery Support and Environmental Management Strategies at Rutgers University and The College of New Jersey—**DMHAS provides funding for recovery support and environmental management strategies at Rutgers University and The College of New Jersey to identify and help students who have a substance use disorder diagnosis, as well as those who intermittently abuse AODs. Each entity is required to provide individual and group substance abuse recovery-oriented programs and services, assessment, academic and personal counseling services, and offer recovery housing for students in recovery and substance-free housing options for students at risk of a substance use disorder and students not in recovery who choose not to misuse alcohol and illicit drugs. DMHAS staff noted that Rutgers was one of first universities in the country to develop recovery programs for students. Both contracts are supported by state funds.

In January 2016, DMHAS implemented a project focused on children with conduct disorders between the ages of 8 and 11 in collaboration with University Behavioral Health Care at Rutgers University. The project is implementing prevention interventions targeting risk factors for substance use and abuse in at-risk youth over the course of four-and-a-half years in order to identify and quantify outcomes for at-risk youth and their families. (As noted previously, DMHAS's prevention expenditures also include a significant number of contracts with different units of Rutgers University for statewide and project-specific services related to assessment, evaluation, T/TA, and other supportive services.)



DMHAS's allocation pattern reflects a comprehensive approach to prevention in that prevention providers are encouraged to use multiple strategies in multiple settings. Community-based prevention service grants are intended to coordinate their efforts with regional coalitions and MA prevention priorities. Special projects target priority populations (e.g., families of

military personnel, persons identifying as LGBTQ) and DMHAS has also funded services that target prescription drug misuse among the 60 and older population.

While a breakout of expenditures by six CSAP strategies was not available for FFY 2013, a comparison of changes in expenditure and allocation patterns between FFYs 2012 (see pie chart above) and 2016 (see pie chart page 30) indicate striking shifts by strategy types, with environmental strategies increasing from 8 percent in 2012 to 32 percent in 2016, while educational strategies decreased by 10 percentage points. DMHAS staff attributed this shift to the funding of Regional Coalitions.

While the increase in environmental strategies is a positive step in expanding the comprehensiveness of New Jersey's approach to environmental prevention, the CSAP team observed—and DMHAS staff concurred—that the definition of environmental prevention used by DMHAS and providers to classify strategies does not entirely follow the definitions established by SAMHSA. For example, media campaigns are classified as environmental strategies by DMHAS, rather than as information dissemination per federal definitions. As a result, the actual percentage of environmental strategies being implemented in the state may be less than what is being reported.

Given that the environmental module of POMs has not yet been finalized, the CSAP team suggested that this might be an opportune time for DMHAS to review and strengthen its guidance to providers for classifying and reporting environmental strategies. This will ensure accurate reporting that enables DMHAS to monitor the degree to which desired increases in the use of environmental strategies are in fact taking place.

Subrecipient Funding Requirements

In addition to the prevention credentialing requirements noted in the Workforce Development section of this report, DMHAS staff noted that subrecipients and contractors are required to use SAMHSA's SPF process to guide the development of their workplans. Requirements associated with each step of the SPF are noted below:

***Assessment*—**Regional Coalitions are required to use data provided by DMHAS to assess their region's substance abuse-related problems (i.e., the magnitude of the problem to be addressed, where the problem is greatest, and risk and protective factors associated with the problem).

Community-based Prevention Service and Special Project grantees are required to provide quantitative data to substantiate the need for the substance abuse prevention services within the community and population they intend to target with services. This includes the use of consequence and consumption data to determine prevalence of use within communities in its county and the risk and protective factors that predict population prevalence and social indicator data to demonstrate the prevalence of risk factors. Grantees are encouraged to further refine their selection of prevention priorities by examining substances most commonly used/abused that impact the greatest number of residents within the county and the substances that lead to the most severe consequences for the greatest numbers of residents in the county.

***Capacity development*—**Regional Coalitions must assess community assets and resources, gaps in services, and capacity and readiness to act. They are also required to provide a description of their plan to establish or strengthen collaborative relationships with other prevention and/or

public health-focused coalitions in the region. Coalition membership must include youth, parents, businesses, media, school, youth-serving organization, law enforcement, religious/fraternal organization, civic/volunteer group, health care field, state/local/tribal government agency with expertise in substance abuse (e.g., county alcohol and drug director and the MA coordinator), and other organizations involved in reducing substance abuse (MAs).

Community-based Prevention Services and Special Project grantees are required to identify the resources that currently exist in the community to address the problem they are targeting. These grantees are also encouraged to consider MA prevention priorities and coordinate their efforts.

***Strategic planning*—**Regional Coalitions are required to develop strategic plans that must include the following components and be approved by DMHAS before implementation occurs:

- A statement identifying the priority problem(s) identified and the coalition's commitment to addressing it/them
- Needs assessment results, including the identification of high-problem geographic areas (Regional Coalitions are also required to address the state priorities)
- Intervening variables that contribute to the harmful consequences of drug/alcohol use specific to the priority problem(s) identified
- Appropriate (i.e., logically connected and culturally competent) evidence-based environmental programs and strategies to address the priority issue
- A statement of the coalition's capacity to address the priority problem(s) identified (e.g., capacity to implement activities) as well as a plan to increase capacity as needed
- An evaluation plan that has been developed in collaboration with the research and evaluation unit at DMHAS to assess community-level processes and outcomes
- A discussion of how the coalition will develop a plan for sustaining the strategies after DMHAS funds have been depleted.

Community-based Prevention Services and Special Projects are required to develop data-driven goals and objectives for all services that are specific, measurable achievable, realistic, and time limited. Other proposal components include a narrative description of services, recruitment strategies, setting/location of services, how proposed services fit with other community prevention activities, start and end dates for services, and expected program achievements

***Implementation*—** Regional Coalitions, statewide programs, and community-based programs are all required to implement evidence-based strategies, and to describe how all curriculum components will be implemented with fidelity. Regional Coalitions are required to solely implement environmental strategies while Community-based Prevention Services and Special Projects must only implement curricular strategies. Regional Coalitions must also provide a realistic timeline for implementing their strategic plan.

***Evaluation*—**Regional Coalitions are required to monitor, evaluate, sustain, and improve or replace the components of their plans that fail. Regional Coalitions must also demonstrate a commitment to cultural competence and develop a plan for how they will sustain successful programs/strategies.

The CSAP team noted that requirements for use of the SPF appear less rigorous for grantees

other than Regional Coalitions. For example, Community-based Prevention Services and Special Projects grantees are not required to identify targeted and measurable outcomes or engage in evaluation to the degree that Regional Coalitions must. And while County Alcohol and Drug Directors are required to create a county plan, they appear to be largely exempt from requirements to implement the SPF. While the lack of adherence to performance management processes and expectations for outcomes is not unusual in states that statutorily mandate funding to substate political subdivisions, it can represent a missed opportunity to ensure that public funds are having their greatest impact in improving behavioral and public health and well-being within the communities served.

DMHAS is encouraged to use lessons learned from the Regional Coalitions to strengthen requirements for the use of the SPF in future RFPs for Community-based Prevention Services and Special Projects, as well as to strengthen requirements for intermediate and long-term outcome evaluation among all grantee types. In addition, DMHAS is encouraged to work with its state and county partners to increase political will and readiness for increased use of the SPF in prevention planning and implementation.

Evaluation

DMHAS has strong protocols in place for monitoring subrecipients and collecting process data for programs, although it is unclear to what extent the monitoring processes extend to prevention programs. In addition, while DMHAS has invested significantly in evaluation services, these efforts only include the PFS grantees and the 17 Regional Coalitions. DMHAS cannot, at this time, determine whether all funded prevention programs are achieving intended outcomes with regard to reductions in substance abuse and related problems and consequences.

Subrecipient Evaluation

State documents supplied by DMHAS note that all SABG subrecipients are monitored by a staff of six Program Management Officers and one supervisor. Onsite visits are made to each SABG recipient a minimum of one time per calendar year, although more frequent reviews may be conducted on an as-needed basis for agencies identified as needing additional TA or monitoring because of violations, other deficiencies, or special grant requirements.

The CSAP team noted that DMHAS has strong subrecipient requirements in place, and the state cited the annual prevention performance monitoring protocol of the Office of Prevention, Early Intervention, and Community Services. State documents describing DMHAS monitoring process and protocols appear to be for treatment services only and it was unclear what protocols DMHAS has for enforcing the terms of prevention subrecipient or contractor funding awards.

In addition, while DMHAS produces State- and Provider-Level Performance Management reports, DMHAS staff explained during the site visit that these reports apply only to treatment providers and are not used to gauge or monitor the performance of prevention providers. DMHAS staff noted that they would like to develop an outcomes module for POMS and expressed interest in information on how other states are evaluating SABG-funded outcomes.

DMHAS uses POMS to collect the following process data for individual and family programs: gender, age, race/ethnicity, curriculum, date(s) the service was provided, CSAP strategy, and

total number of sessions attended. DMHAS staff reported that these data are analyzed to assure that agencies are serving the appropriate population, delivering the required number of sessions, and serving the appropriate number of individuals or families in the program. The data also allow DMHAS to determine if the individuals who participate in the program are reflective of the community in which the program is being delivered.

A 38-item SPF module was added to POMS in March 2013 as one of the deliverables for the SPE grant. Regional Coalitions are required to complete this module quarterly and are encouraged to use the information reported to modify their logic models and plans as needed. A module on environmental prevention has been under development and is expected to be active soon. DMHAS has a training manual for using POMS that was last updated in January 2016, which provides screenshots and instructions related to basic data fields. In addition, DMHAS created a manual in December 2015 to cover the SPF module of POMS.

Coalitions are encouraged to allocate funds toward evaluation, and DMHAS contracts with the Institute for Families at Rutgers University to provide evaluation support to Regional Coalitions that includes the creation of evaluation and community-level outcome measure tracking plans. Each plan is based on the coalition's logic model and includes process measures for documenting the nature, extent, and quality of program implementation. The Rutgers University evaluation team also reviews coalition documents and provides individual feedback as well as universal lists of suggested revisions based on identified areas of common need.

SSA/State Evaluation

While DMHAS clearly appears to be invested in evaluating and monitoring prevention outcomes, this is an area of continuing development. The 2016 CSAP site visit team noted that DMHAS does not have a comprehensive evaluation system capable of measuring the effectiveness of its portfolio of prevention initiatives and is not currently able to evaluate the actual outcomes produced by SABG-funded grantees in terms of changes in problems and consequences, consumption, or intervening variables. Specifically, the current evaluation system does not include all funded prevention initiatives and does not appear to be sufficient for measuring change at the population level and correlating that change with strategies funded by the SSA. DMHAS staff reported during the site visit that it is interested in identifying standardized outcomes for prevention programs targeting individuals and families.

DMHAS staff noted that the Center for the Application of Prevention Technologies will be providing the following services in 2016 to build the capacity of Rutgers in the following areas:

- Use of small area estimate models
- Methods for assessing local fidelity for evidence-based programs and for measuring SPF fidelity at the state level
- An evaluation plan for New Jersey's "Be the One" mobile application and for New Jersey's SEOW website.

DMHAS's ability to evaluate the return on investment from its portfolio of preventive initiatives could be enhanced by the development of a comprehensive evaluation system capable of monitoring and documenting intermediate and long-term outcomes in reduced substance abuse-

related problems and consequences for all funded prevention grants and contracts. Toward that end, DMHAS is encouraged to:

1. Require all grantees to identify—and monitor progress toward—desired reductions in substance abuse-related problems, consumption and use, and related intervening variables
2. Develop a performance monitoring and feedback system for prevention grantees similar to the State- and Provider-Level Performance Management systems that are used for treatment.

Summary and Technical Assistance Themes

Since the last CSAP site visit in 2012, DMHAS has significantly expanded its approach to prevention, transitioning from a primary focus on individual-based strategies to a more comprehensive system of substance abuse prevention and mental health promotion across the lifespan that includes greater use of environmental prevention.

Despite significant coordination, partnerships and efforts at the state level, however, an ongoing issue in New Jersey is the lack of coordination among the more than 500 coalitions, providers, and political subdivisions funded to provide prevention services and strategies within the state's 8,729 square miles (an average of one for every 17 square miles). While the state invests a significant amount of its own funding for substance abuse prevention, the lack of a coordinated response to address issues and intervening variables that cross municipal and county boundaries compromises its ability to achieve desired ATOD outcomes.

The stakes are high. Although general prevalence of reported alcohol use among New Jersey youth and adults has been declining, the rates remain significantly higher than the national median and the state's opioid overdose death rate is three times the national median. These problems are burdening New Jersey's publicly funded treatment system and exacting a toll on the lives of its citizens. Solving them will require a statewide, coordinated system of prevention that can strategically target resources and initiatives.

DMHAS's support for prevention Unification Planning and the use of the SPF or a similar performance-based management framework provides a strong foundation for what could become a truly united, coordinated and highly effective state prevention system. DMHAS's effort to identify and build the core competencies needed to enhance workforce performance further strengthens that foundation. Toward that end, the recommendations in this report seek to build on New Jersey's many strengths and offer an outside perspective on key steps that could be taken to significantly reduce ATOD-related problems and consequences across the state.

Many of the recommendations for enhancing New Jersey's ability to prevent substance abuse rely on access to valid and representative assessment data for planning and evaluation. Although DMHAS has access to a rich array of data—and has implemented efforts to collect data on priority populations—issues with student survey participation limit the usefulness of those data for assessment, planning, and evaluation purposes at the local levels. In addition, real-time data sets on opiates and other drug use and prescription drug misuse are not being used to their fullest advantage by DMHAS and local prevention efforts due to the complexity involved in turning the data into actionable information.

In addition, while DMHAS has engaged in strategic planning processes to address substance abuse prevention, its existing plan is not based on current data and does not identify measurable, time-limited objectives and outcomes that quantify success. The plan also lacks information on how it will be implemented (e.g., roles, responsibilities and timelines for key strategies and activities needed to address the priorities) and how progress will be continuously evaluated so that midcourse corrections can be made as needed to ensure that prevention goals are met.

New Jersey's ability to reduce substance abuse-related problems could be enhanced by more comprehensive strategic prevention planning. Although this recommendation was also noted during the 2012 CSAP site visit, DMHAS may be better positioned to pursue this now than it was in the past. Core components of a comprehensive strategic plan would include:

- A clear problem statement or statements that describes what currently exists that compromises health and/or organizational effectiveness and needs to be changed
- Clear goals describing desired changes in substance abuse behaviors, related problems and consequences, and state and substate prevention system behavior
- Clear objectives describing the changes in intervening variables that are needed in order to achieve the goals for substance abuse prevention and prevention system development
- Careful identification of the target populations that are involved in and/or impacted by the issue(s) identified in the problem statement
- Targeted and measurable outcomes that specify the degree of change sought and the timeframe in which it is to be achieved for all goals and objectives
- State-level strategies and activities that are logically linked to the achievement of desired goals, objectives, and outcomes
- An implementation component with clearly defined roles, responsibilities, and timelines
- An evaluation component sufficient to monitor progress toward outcomes and provide information for midcourse adjustments as needed
- A strategic financing component that analyzes all existing resources and infrastructure and aligns resources to support desired outcomes.

Other recommendations identified by the CSAP team to help DMHAS lead the effort to reduce behavioral health problems in New Jersey include:

- Increased use of ROIC and PMP data to guide local planning and action
- Increased grassroots advocacy and mobilization for student survey participation
- Increased guidance and requirements for the use of the SPF and evidence-based strategies across prevention subrecipients
- A formalized system of prevention workforce assessment and planning
- A state-level evaluation system that can monitor all prevention investments, including subrecipient and contractor outcomes.

A full summary of all site visit findings is provided in appendix A of this report.

Synar Program Development, Organization, Compliance, and Support

Synar Program Development and Organization

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

DOH is the primary agency responsible for tobacco in the state. They also house the Office of Tobacco Control Nutrition and Fitness (OTCNF) Tobacco Age of Sale Enforcement Program (TASE) program which focuses on youth tobacco prevention, providing tobacco cessation support, decreasing exposure to environmental exposure to tobacco smoke, and reducing disparities related to tobacco use among different populations in New Jersey.

DMHAS has a memorandum of understanding (MOU) with OTCNF/TASE to conduct Synar inspections, enforce state youth tobacco access laws, and conduct merchant and community education. However, this MOU has not been updated since 2004. OTCNF/TASE also has a contract with the Food and Drug Administration (FDA). Furthermore, OTCNF coordinates the New Jersey Strategic Advisory Group on Tobacco Prevention (SAG) which has guided OTCNF/TASE programming by identifying short- and long-term program goals.

Description of Trends in the State's Retailer Violation Rate and Other Tobacco Outcomes

Retailer Violation Rates for Federal Fiscal Years 1997–2016 (in percent)

	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Target	–	35	28	26	25	24	20	20	20	20	20	20	20	20	20	20	20	20	20	20
Reported	44.4	27	26.5	23.2	24.6	22.1	15.9	13	12.6	15.6	11.2	12.2	11.9	4.6	8.5	10.2	7.7	11.6	8.5	18.6

With a retailer violation rate (RVR) of 18.6 percent (see table), New Jersey is in compliance with Synar regulatory requirements. New Jersey reported a baseline RVR of 44.4 percent in (Federal Fiscal Year (FFY) 1997. In FFY 2007, the state achieved a rate below the 20 percent target (11.2 percent), and the rate has remained between 12.2 and 4.6 percent ever since. Since FFY 2010, it appears that the RVR is trending steadily upward. New Jersey's RVR has increased significantly in the past year (10 percentage points). The weighted FFY 2016 RVR is 18.5 percent, which is a 10 percentage point increase from FFY 2015. The state is beginning to use Synar data to identify the factors that may be driving the increase in its RVR; such as, changes in policies, budgets, and enforcement presence and is encouraged to continue that analysis and develop an action plan to reverse the current upwards trend.

According to the National Survey on Drug Use and Health, the percentage of 12-17 year olds in New Jersey that report using cigarettes in the last 30 days decreased between FFY 2002-2003 (12.2 percent) and FFY 2012-2013 (5.2 percent). The percentage of youth using tobacco products other than cigarettes has decreased between FFY 2002-2003 (3.7 percent) and FFY

2012-2013 (2.4 percent). The percent of youth who perceived moderate or great risk of harm from smoking one or more packs of cigarettes decreased between FFY 2002-2003 (92.7 percent) and FFY 2012-2013 (92.2 percent).

Summary of Synar Program

State Synar Program Compliance

Youth Access Law

TASE is responsible for enforcing the state's youth tobacco law, which prohibits the sale or distribution of tobacco products to persons under the age of 19. The youth tobacco access law includes graduated fines for a person who sells tobacco to minors; however, in practice, only store owners are cited for violations. The state has the power to cite both the employee and the licensee; however, the state has made the decision to only cite licensees. New Jersey has identified an interest in citing clerks as well as owners, and has requested information on how other states implement citations to clerks.

Violations are assessed as civil penalties and begin at $250 for a first violation, moving to $500 for a second offense, and $1,000 for a third and each subsequent violation. In addition, New Jersey judges have the ability to increase fines above the minimum. Fines are collected by the municipality in which the violation occurred. Municipal courts may add additional fines to the minimum, which can be allocated to community based programs. In addition, The Division of Taxation in the Department of the Treasury may suspend or, after a second or subsequent violation, revoke the license of a retailer dealer following a hearing by the municipality. The state does not allow for the use of an affirmative defense.

A $50 annual license fee is required for each retail location and license. The Treasury manages the licensing process, maintains the list of licensed outlets, and collects license fees. Currently, $40 from each tobacco license is routed to TASE for youth tobacco access efforts. The remaining $10 of the annual license fee is provided to Department of Treasury.

Enforcement

Enforcement is always combined with the Synar survey. TASE implements the Synar inspections and conducted 345 Synar inspections in calendar year 2015.

If an inspection results in a sale, the tobacco inspectors file a complaint in the municipality in which the violation occurred and re-inspect the outlet within 90 days. The retailer then receives a summons from the municipal court, and a fine is ordered by the municipal judge. As reported in the FFY 2016 Annual Synar Report, New Jersey issued a total of 59 citations for violations of youth tobacco access laws in previous FFY 2015; all to store owners and none to salesclerks. Twenty fines were assessed; all to store owners and. No licenses were suspended or revoked. While several outlets have met the criteria for having a license suspended, it has been difficult to revoke licenses due to the administrative burden required to implement this penalty.

Random, Unannounced Inspections and Valid Probability Sample

New Jersey uses a list frame as the basis of the Synar survey. The list frame is based on the tobacco retailer license list maintained by the Treasury and included 8,319 outlets in FFY 2016. This list is updated annually based on license renewal forms. The state reports limitations on completeness and accuracy of list of tobacco outlets that TASE receives from the DOT. Comparing the license list to corrections made the previous year is difficult and time consuming for DMHAS staff.

DMHAS draws the Synar sample using a stratified simple random sample design. New Jersey has three defined strata based on the distribution of outlets throughout the state. Stratum 1 is defined as counties with 6 percent of the outlets in the state or less; Stratum 2 is defined as counties with 6 to 10 percent of the outlets in the state; and stratum 3 is defined as counties that have more than 10 percent of the state's outlets. Vending machines are included in the sample.

New Jersey conducted a coverage study in FFY 2013 using a stratified simple random sample. 137 areas were canvassed and 125 outlets were located. Of those outlets, 125 matched to the sampling frame, resulting in a coverage rate of 91 percent. The state is planning to conduct their next coverage study in FFY 2016.

The sampling design as described onsite is consistent with the description that is provided in Appendix B of the ASR.

Synar inspections are conducted July 1st- Sept 30th. DMHAS provides the Synar sample to TASE, and then TASE distributes the sample list proportionally to six adult inspectors who arrange Synar inspections with youth inspectors, referred to in the state as student associates.

The inspection team consists of a TASE adult inspector, and a student associate (youth inspector). Student associates are recruited from schools, community groups and faith-based organizations, and must be at least 16 years old but less than 18 years. Seventeen year olds should be at least 3 months away from their 18th birthday.

The TASE adult inspectors are trained by the OTCNF Program Coordinator and staff and follow the New Jersey Guidelines for Prohibiting the Sale of Tobacco Products to Minors training manual developed by TASE. The student associates receive training, which includes review of inspection forms and real time mock visits. In addition, the student associates are trained in person by a TASE adult inspector.

New Jersey requires that TASE keep a current dated photograph of each student inspector on file with a copy of his or her birth certificate and signed parental consent. TASE policies states that safety and efficiency should be prime consideration when conducting an inspection. In situations where the student associate or the accompanying TASE adult inspector feels that it would be unsafe to complete the inspection, the student associate must exit the store and the inspection is not conducted. Student associates are not permitted to carry identification during inspections. New Jersey conducts consummated buys during Synar inspections.

If no sale is made, the student associate will retain the money until the next inspection. If a sale is made, the student associate will return to the car with the tobacco product. The inspector then

provides the manager with the Notice of Inspection Results form, which provides an immediate record to the store that indicates the site is not in compliance with the law. If a sale is not made, the Notice of Inspection Results form is provided indicating that the store is in compliance with the law.

After an inspection citation, the TASE adult inspector will file a notice of failed inspection at the municipal court, where both fines and notice to appear in court are then mailed to the store. Merchant education material is provided to the site; however, new merchant material has not been printed and TASE inspectors are quickly exhausting their supply of materials to provide to merchants.

TASE uses scannable paper forms to collect their Synar inspection data. The inspection forms are provided to DMHAS for scanning, data analysis and importing into the Synar Survey Estimation System (SSES) Data Entry Template. DMHAS is responsible for processing all the inspection forms, entering data into SSES, and analyzing the data.

Members of the system review team pulled a random sample (10 percent) of the completed inspection sheets and reviewed them for completeness and then compared them with the SSES raw data submitted in the FFY 2016 Annual Synar Report to verify data accuracy. The result of this review found one inspection where student associate's gender was misclassified; the male inspector was listed as female on the SSES.

Members of the system review team observed five Synar inspections conducted by the inspection team, which consisted of one enforcement officer, a female and male student associate. Two sales were made during these inspections. All five observed inspections followed the approved protocol with zero exceptions.

Retailer Violation Rate

In FFY 2016, New Jersey reported a retailer violation rate of 18.6 percent with a standard error of 1.6 percent, which is below the Substance Abuse and Mental Health Services Administration (SAMHSA) target rate.

Reporting

The ASR was completed and submitted on time, December 12th, 2015, and was made available for public comment before submission to SAMHSA, as required, by being placed on file for public review and through the State of New Jersey's Web site: http://state.nj.us/humanservices/dmhas/provider/notices/grants/public.

State Synar Program Support

Synar Budget and Funding

New Jersey plans to spend $409,000 on the Synar program and support strategies in FFY 2016. Of those funds, no Substance Abuse Block Grant (SABG) funds will be allocated towards the Synar program. DOH receives funds from license fees to fund tobacco enforcement, the state's merchant education efforts, and other youth tobacco access related activities.

In FFY 2016, DOH will allocate a total of $307,284 to be spent on staffing and management; $105,000 in new funding from the Centers for Disease Control and Prevention (CDC) will support community education; $40,000 will be spent on inspections; and $35,000 has been allocated to fund the printing of merchant education materials. TASE is currently exploring ways to increase the license fee, which would provide additional revenue for the program.

As a result of the elimination of the state excise tax appropriation for OTCNF from the New Jersey FFY 2011 budget, New Jersey has a decrease in funds available for Synar programming. In addition, a decrease in the number of retail license applications has resulted in a decrease in revenue. DMHAS Tobacco licenses are down from 20,000 to 8,600, resulting in almost $500,000 reduction in available funding.

Strategic Planning

OTCNF has a tobacco prevention and control plan that includes goals, measurable objectives, activities and actions for those activities. Activities include increasing the number of municipal ordinances that target the tobacco retail environment to restrict minor access. In addition, this plan highlights the decrease of tobacco usage per county, and addresses implementation and delivery of the policies and OTCNF grantee partners' delivery of activities.

Policy Development and Education

New Jersey is one of four states that have increased the minimum age of sale of tobacco products from 18 to 19. Additionally, 15 northern and central cities in New Jersey have passed policies to increase the minimum age to purchase cigarettes to age 21. Coalitions continue to educate policymakers on the benefit of increasing the age of sale at the municipalities as well as at the state level.

Vape shops, which are not licensed, are growing exponentially. The state is exploring licensing vape shops with the expectation that the revenue may be an added funding source for tobacco prevention efforts.

State Youth Tobacco Access Support Strategies

New Jersey does not conduct statewide merchant education due to lack of funding and nonparticipation of local health departments. Instead, merchant education is provided by tobacco inspectors upon completion of inspections, when they provide previously generated "Look, See, Check ID" flyers and age of sale stickers. At the time of the visit, TASE did not have funds available to print additional materials or to develop new materials.

Community education is conducted as part of the comprehensive tobacco prevention and control program funded by CDC. Effective March 29, 2015, OTCNF and grantee partners use the tobacco control message "Tobacco Free for a Healthy New Jersey" through SAG. Grantee

partners include such organizations as Americans for Nonsmokers rights, Atlantic Prevention Resources, and The Center for Prevention and Counseling. Partner activities include mobilizing communities to restrict minors' access to tobacco products, advocating for stronger local laws directed at retailers, active enforcement, and retailer education with positive reinforcement. The DHS provided a webinar to prevention coalition members through Rutgers University's Division of Addiction Psychiatry entitled "Look, See, Check ID: A Tool for Communities and Retailers."

APPENDIX A

Site Visit Recommendations

New Jersey Substance Abuse Prevention Site Visit Analysis

March 14–18, 2016

Prevention Analysis

Prevention System Organization

SSA Prevention System

STRENGTHS

The Center for Substance Abuse Prevention (CSAP) team noted that Prevention and Early Intervention Services (PEIS) staff are knowledgeable and experienced and have a future-oriented vision for prevention.

The National Prevention Network representative, the two Prevention Coordinators, and the Program Support Specialist 1 in place at the time of the site visit have years of prevention experience and display significant dedication and passion for their work.

The Division of Mental Health and Addiction Services (DMHAS) has key partnerships with several state agencies.

These partnerships include the Departments of Health (DOH), Education, Children and Families, and Law and Public Safety; the Office of the Attorney General (OAG), and the Governor's Council on Alcoholism and Drug Abuse (GCADA).

CHALLENGES

A very small number of Prevention and Early Intervention Section staff members are tasked with overseeing a large number of initiatives.

The CSAP site visit team noted that a very small number of staff members are responsible for administering $15 million in contracts and grants funded through New Jersey's primary prevention Substance Abuse Prevention and Treatment Block Grant (SABG) set-aside funds, as well as other state and federal prevention dollars.

SSA Approach to Prevention

STRENGTHS

DMHAS supports a comprehensive, community-based approach to prevention.

Prevention providers are encouraged to use multiple strategies in multiple settings, and to work collaboratively toward common goals across the lifespan.

DMHAS is working with its subrecipients and partners to develop and implement performance-based operating standards.

DMHAS has adopted the Substance Abuse and Mental Health Services Administration's (SAMHSA's) Strategic Prevention Framework (SPF) as its operational framework for prevention services and has incorporated expectations for the use of the SPF throughout its Request for Proposals (RFP) processes for coalitions. DMHAS is working to expand the use of the SPF among funded county governments and prevention providers.

CHALLENGES

Commitment to the use of the SPF or a similar performance management approach is inconsistent among the state's prevention workforce.

DMHAS staff noted during the site visit that additional buy-in for the use of the SPF is needed at the agency, coalition, municipal, county, and state levels.

DMHAS is currently using listing on SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP) as evidence of effectiveness in and of itself, which is contrary to guidance.

While the NREPP website states that it is intended to serve as a resource to assist researchers, practitioners, and policymakers in using evaluation evidence for practical decisionmaking and program implementation, it notes that NREPP is not intended to be an exhaustive list of programs that merit investment. In addition, NREPP is currently undergoing a major redesign and only included information on nine reviewed substance abuse prevention strategies at the time of the site visit.

DMHAS's definition of environmental prevention does not adhere to CSAP's definitions for the six strategies.

Currently, prevention providers in New Jersey are counting media campaigns as environmental prevention, which is counter to federal definitions that consider them to be information dissemination strategies.

Multiagency/State Prevention System

STRENGTHS

Prevention is a shared priority and responsibility among state agencies in New Jersey.

State agencies with significant substance abuse prevention responsibilities—in addition to DMHAS—include DOH and its Office of Tobacco Control, and the OAG, which is housed within the New Jersey Department of Law and Public Safety. The OAG contains the following entities: 1) the Division of Consumer Affairs' (DCA's) New Jersey Drug Control Unit; 2) DCA's New Jersey Prescription Monitoring Program (NJPMP); 3) the Division of Alcoholic Beverage Control (ABC); and 4) the New Jersey State Police, which houses the Highway Traffic Safety Unit and the Regional Operations Intelligence Center.

GCADA serves as a multiagency coordinating body for substance abuse prevention and treatment policy and services.

GCADA is established in state law to serve as an active and collaborative participant in the planning and coordination of New Jersey's addiction prevention, treatment, prevention policy, and services. Accordingly, GCADA has three core functions: 1) policy and planning, including the development of a Comprehensive State Alcoholism and Drug Abuse Master Plan, which is submitted annually to the Governor and State Legislature; 2) public awareness and education; and 3) the administration of the state's $10 million Alliance to Prevent Alcoholism and Drug Abuse Program.

New Jersey has an active State Epidemiological Workgroup (SEOW) that has been sustained since its original grant funding.

The SEOW was originally formed in 2006 as a requirement of New Jersey's Strategic Prevention Framework State Incentive Grant, and the workgroup currently meets 10 times a year. Membership in the SEOW comprises government and community agency-based experts in the field of substance abuse who come from diverse entities, including universities, research institutions, government

agencies, and private organizations.

Substate Prevention System

STRENGTHS

New Jersey has a significant amount of substate infrastructure for prevention.

The portion funded by DMHAS includes community-based services in all 21 of New Jersey's counties, direct contracts with approximately 30 agencies for curriculum-based prevention programs, and 17 regional coalitions. Other key infrastructure consists of nearly 400 Municipal Alliances (MAs) encompassing more than 530 municipalities (termed by the state to be the largest network of community-based anti-drug coalitions in the nation) and 22 Drug-Free Communities (DFC) grantees. In addition, DOH funds 21 county-based tobacco coalitions and 5 chronic disease coalitions, while several New Jersey counties are included in the New York/New Jersey High Intensity Drug Trafficking Area (HIDTA).

Since the last CSAP site visit in 2012, DMHAS has expanded the substate prevention infrastructure by funding 17 regional coalitions.

DMHAS supports the 17 regional coalitions charged with reducing underage drinking, the use of illegal substances, prescription medication misuse across the lifespan, and the use of new and emerging drugs of abuse across the lifespan. A regional coalition is defined as an association of organizations that collaborate in the delivery of environmental strategies to address and reduce substance misuse and abuse in a specific geographic area.

DMHAS, GCADA, the New Jersey Prevention Network (NJPN), and representatives from county government have developed a unified process to plan for and deliver services and strategies at the state, county, and municipal levels.

"Unification planning" is intended to help counties and municipalities: 1) identify and implement a greater number of evidence-based prevention programs, 2) establish environmental approaches to prevention planning, and 3) develop and operationalize community-based and culturally appropriate recovery support systems of care.

CHALLENGES

The CSAP team noted that DMHAS's guidance for subrecipients on evidence-based prevention does not ensure that selected strategies are documented to have strong quality of research or proven outcomes due to DMHAS's use of inclusion of listing on NREPP alone as a qualifying criterion.

There is very little coordination or collaboration among substate prevention organizations in New Jersey.

Despite efforts to conduct unification planning, there continues to be limited coordination between the MAs, DFC grantees, DOH grantees, and DMHAS-funded prevention subrecipients, even though the issues addressed by the organizations may share intervening variables that span municipal, county, and regional boundaries. While DMHAS staff members have been involved in efforts to address this limited coordination, they acknowledged that this has been an ongoing issue.

Potential Enhancements for Prevention System Organization

1	**Expanded guidance for evidence-based strategies** DMHAS's ability to ensure that prevention providers are using the strongest criteria to identify

	and select evidence-based strategies that are best aligned with local problems and conditions might benefit from expanded guidance. As a start, DMHAS might review examples of strong guidance that has been developed by other states to determine if there are components that might be useful for New Jersey.
2	**Increased coordination and collaboration among substate prevention organizations** New Jersey's ability to address the state policy issues that contribute to substance abuse problems and consequences and the significant burden they impose could be enhanced considerably by more coordinated prevention efforts by the state's community coalitions and prevention providers. As a key funder of—and leader in—coalition development and substance abuse prevention, DMHAS is well positioned to work with its partners to build the capacity and willingness of coalitions and substate prevention entities to coordinate their efforts.

Key Contextual Conditions and State Substance Abuse Trends

Key Contextual Conditions

STRENGTHS

New Jersey is a relatively small state geographically, which facilitates interaction among substate entities.

As of 2010, New Jersey was the 11th most populous state in the United States, and the most densely populated, at 1,185 residents per square mile. Most of the state's population resides in the counties surrounding New York City and Philadelphia and along the eastern Jersey Shore, while the extreme southern and northwestern counties are less densely populated.

Municipalities in New Jersey have been active in implementing local laws and policies to reduce harms associated with alcohol abuse.

A majority of municipalities in New Jersey have enacted social host and/or private property ordinances in recent years.

New Jersey has implemented several state-level initiatives to address the escalation of opioid and other drug use and associated harms.

New Jersey's first recovery high school opened in 2015, and New Jersey's Governor has continued to expand the state's Drug Court program to include mandatory treatment for all nonviolent offenders who are determined to suffer from a substance use disorder. New Jersey's Opioid Overdose Prevention Act, which was signed by the Governor in 2013, provides legal protection to people who are in violation of the law while they are attempting to help a drug overdose victim, and also eliminates negative legal action against health care professionals or bystanders who administer overdose antidotes in life-threatening situations. New Jersey has also enacted 911 Lifeline legislation that addresses both overdoses and underage drinking. In December 2015, new requirements for the New Jersey Prescription Drug Monitoring Program took effect in order to increase participation, broaden access, and improve surveillance. The law also contains a physician mandate, which requires that the system be checked for new patients and chronic pain patients.

CHALLENGES

Northern New Jersey's proximity to New York City has made the area an "epicenter" for drug trafficking.

According to the 2015 New York/New Jersey HIDTA Drug Threat Assessment, urban areas of New Jersey, such as Newark, Paterson, Trenton, and Camden, are considered major heroin distribution

centers with significant heroin markets. Drug trafficking and importation of drugs in these areas is facilitated by major transportation networks.

New Jersey is characterized by economic inequality.

Despite the state having the second highest median income in the nation from 2008 until 2012, in that same period the city of Newark was ranked the seventh poorest large city in the United States, with a poverty rate of 30.4 percent.

New Jersey has significant populations that are considered to be at higher risk for substance abuse.

New Jersey is home to a joint base, as well as a naval weapons station and an arsenal. Joint Base McGuire-Dix-Lakehurst, near Newark, includes Air Force, Army, and Navy personnel with a combined population of 38,074. In addition, there are approximately 416,037 veterans residing in the state, the majority of whom (55 percent) are 65 years or older. The state also has 31 public and 35 independent higher education institutions that serve more than 440,000 students.

State Substance Abuse Trends

STRENGTHS

Tobacco use in New Jersey is lower than the national median for youth and adults.

Among youth, data from both the 2013/2014 National Survey on Drug Use and Health (NSDUH) and the 2013 Youth Risk Behavior Survey (YRBS) show significant decreases in past-30-day cigarette use among youth. Data from the 2013 Behavioral Risk Factor Surveillance System and the 2013/2014 NSDUH show rates of cigarette use, as well as other tobacco use, among adults to be well below the national medians.

Marijuana use in New Jersey remains below the national median.

Similar to national trends, although perceptions of harm from marijuana are dropping for both youth and adults in New Jersey, both NSDUH and YRBS data show relatively stagnant rates of reported past-30-day marijuana use among New Jersey youth and both sources indicate that youth marijuana use rates are below national averages. Among New Jersey adults, although the NSDUH indicates an increase in marijuana use over time the rate is still lower than the national median.

CHALLENGES

New Jersey's opioid overdose death rate is triple the national median.

Although the rate of illicit opioid use is decreasing in New Jersey and is below the national median, the state is experiencing an alarming rise in opiate-related overdose deaths. In 2013, New Jersey had the sixth highest teen drug overdose rate and the fourth highest drug overdose rate for young adult males in the country. Contributing to this epidemic may be New Jersey's dubious distinction of having some of the least expensive, highest purity street heroin in the nation. Street heroin in New Jersey may cost as little as $5 per "baggie," with a typical purity level of 40 percent. Heroin is by far the top reason for admission into state-run treatment programs.

Rates of alcohol consumption by youth and adults—although decreasing—remain much higher than national medians.

Both the NSDUH and YRBS show New Jersey youth reporting alcohol use and binge drinking at higher than national rates, while NSDUH data indicate that the percentage of adults aged 26 and older who reported past-month alcohol use was also significantly higher than the national median.

Substance Abuse Needs Assessment

UNIQUE AND NOTABLE ACCOMPLISHMENTS

The New Jersey Regional Operations and Intelligence Center (ROIC) collects, analyzes, and makes accessible real-time, actionable data on substance use in New Jersey, particularly for drugs such as opioids.

The CSAP site visit team found the operation of the ROIC to be an extremely unique and notable asset to the state's substance abuse prevention system—particularly with regard to the collection and use of real-time data to proactively understand and address emerging, escalating, and changing substance abuse trends. In addition, the ROIC philosophy of Intelligence-Led Policing—which is a collaborative philosophy based on improved intelligence operations to aid in understanding changes in the operating environment that enable interveners to rapidly adjust to new circumstances—closely mirrors the emphasis on data-driven planning and action that SAMHSA is encouraging state behavioral health systems to adopt. The CSAP team noted that the "Be the One" social media app developed by DMHAS has the potential to complement ROIC activities by providing real-time, on-the-ground, community-based data to supplement ROIC operations.

STRENGTHS

DMHAS is attempting to use survey data to identify the needs of some populations that may be at higher risk for substance abuse.

DMHAS conducted an Older Adult Survey in 2012 but was unable to obtain a large enough sample to produce reliable county-level estimates. DMHAS intends to re-administer the survey using random digit dialing with a multistage cluster design to obtain enough data to create small area estimates of the prevalence of substance abuse and mental illness among older adults in New Jersey. Additionally, DMHAS collaborated with Rutgers University to conduct a survey of returning veterans in the summer of 2015. The survey collected demographic data on a number of issues, including history of alcohol, drugs, and tobacco use; nonmedical use of prescription drugs; and consequences of drinking and drug use.

CHALLENGES

Collection of data on alcohol and other drug use by youth and young adults in New Jersey is inhibited by multiple challenges.

Participation in the state's long-standing Middle School Risk and Protective Factor Student Survey—while reportedly improving—remains insufficient to generate a weighted sample of data that can be generalized to students at the state or county levels. In addition, statutory requirements for active parental consent inhibit student participation in the survey. The High School Risk and Protective Factor Student Survey also did not generate sufficient participation to allow the data to be disaggregated below the state level. DMHAS staff reported that administration of multiple school-based surveys creates competition for time that is a factor in inhibiting participation by schools. Finally, while some institutions of higher education appear to be conducting Core Institute or other drug/alcohol surveys, there was no general awareness of these survey efforts by DMHAS staff.

DMHAS staff noted that a lack of data at the substate level remains a critical challenge, while the SEOW has identified key gaps in data at the state level.

DMHAS staff reported that a lack of available substate data at specific and detailed geographic units

of analysis (e.g., municipal, census tract, neighborhood) remains a key issue impacting the ability of 17 regional coalitions, County Drug and Alcohol Directors, and MA Coordinators to conduct data-driven planning and evaluate their results. Data gaps identified by the SEOW include medical examiner data on the presence of alcohol and other drugs in the system of homicide victims and those dying from alcohol and other drug-related deaths, prescription misuse and abuse patterns, and ABC statistics on citations and fines.

DMHAS is not currently using ROIC or NJPMP data to guide state or substate prevention planning and/or implementation.

Although NJ ROIC and NJPMP data is made available to DMHAS, PEIS staff described the data to be overwhelming, and noted that they have not yet attempted to use it to guide their own actions, or to supply it to subrecipients for use in local planning and implementation.

Potential Enhancements for Substance Abuse Needs Assessment

3	**Increased use of ROIC and NJPMP data** DMHAS's ability to use ROIC and NJPMP data strategically at the state and substate levels might benefit from CSAP-supported technical assistance (TA). In particular, DMHAS staff expressed interest in learning more about current CSAP-supported TA that is assisting states in helping communities use environmental prevention to address escalating incidence and prevalence rates of opioid-related use and harm.
4	**Increased student survey participation** DMHAS is encouraged to work with state and local partners to develop a targeted plan for increasing middle school and high school survey participation. This could include ongoing communication, grassroots advocacy, and partnerships between communities and their schools, as well as between DMHAS and the Department of Education. Toward this end, DMHAS might benefit from a review of successful strategies other states have used to build school–community partnerships that support robust student survey participation and identify those strategies that might work well in New Jersey. DMHAS is also encouraged to explore the extent to which data on alcohol and other drug use by college students is available, and how the data can be accessed and shared with substate prevention providers and coalitions, as needed, to guide and/or inform their work.

Workforce Development and Capacity Building

Workforce Development

STRENGTHS

DMHAS has established minimum criteria for New Jersey's prevention workforce.

DMHAS implemented a contractual requirement effective January 1, 2015, requiring all DMHAS-funded prevention providers to employ a staff member who has earned the Certified Prevention Specialist (CPS) credential. Credentials or degrees that are accepted in lieu of the CPS are the Certified Health Education Specialist credential, master of public health degree, and doctoral degree in medicine, health, or behavioral sciences.

DMHAS has identified core competencies in addition to those covered by the International Certification & Reciprocity Consortium that are specific to the skills needed to implement the SPF.

These competencies are aligned with five SPF domains, and include other crosscutting competencies such as systems thinking, which DMHAS describes as an ability to: 1) understand how things influence one another within a larger context; 2) recognize that the component parts of a system will often act differently when isolated from its environment or other parts of the system; and 3) make use of insights into human and social systems, understandings of the linkages and interactions that comprise the systems, and comprehension of how changes in one area can and often will impact the other components.

DMHAS has committed significant resources to support training and technical assistance (T/TA) for its workforce.

DMHAS contracts with NJPN and Rutgers to provide T/TA to the prevention workforce. DMHAS Prevention Services Program Managers also provide T/TA to agencies and coalitions. According to state documents, training topics for 2016 address the following areas: community assessment, coalition building and maintenance, coordinating community prevention activities, introduction to methods and the impact of environmental change, assessment and planning of environmental strategies, implementing and enforcement of environmental change, cultural competency, and project sustainability.

DMHAS has displayed a commitment to building cultural competency within its workforce.

DMHAS' *Blueprint for Action: Cultural Diversity within DMHAS System of Care* provides general guidance on the components of a comprehensive training curriculum for cultural and linguistic competency and diversity, as well as a cultural and diversity self-assessment and a guide for developing an agency cultural and diversity competency plan. DMHAS also requires all of its grantees to participate in T/TA cultural competence training.

CHALLENGES

DMHAS does not appear to have a process for objectively and formally assessing T/TA needs, or a workforce development plan that addresses the recruitment, T/TA, and retention needs of the prevention workforce.

Despite its significant investment in T/TA, current workforce assessment efforts appear to consist of an annual electronic survey issued by NJPN asking members of the 17 regional coalitions to self-identify their training needs, as well as some anecdotal provider assessments. DMHAS does not appear to have a formal process for assessing the degree to which the prevention workforce possesses the identified core competencies and specialized knowledge, skills, and abilities needed to achieve desired outcomes. DMHAS also does not have a workforce development plan to guide recruitment, retention, or T/TA, although it did provide the CSAP site visit team with a draft plan dated August 2014, which includes a general goal to develop a well-trained, culturally competent, and respectful workforce in collaboration with stakeholders and nine global areas for competency training for prevention, treatment, and mental health professionals.

Potential Enhancements for Workforce Development and Capacity Building

5	**Workforce development assessment and planning** The ability of DMHAS and its T/TA contractors to strategically maximize workforce development resources and T/TA to strengthen the prevention workforce across the state could benefit from the following actions: 1. Conduct a formal assessment of prevention workforce needs, based on identified core

competencies, to inform the scope and intensity of T/TA services needed to help funding recipients fully use the SPF, and select and implement the evidence-based strategies most likely to be effective in addressing substance abuse priorities. As a starting point, DMHAS might benefit from reviewing workforce assessment tools and plans developed by other states to determine the most relevant components for New Jersey.

2. Use workforce assessment data to create a strategic workforce development plan that ensures T/TA services are targeting the most pressing workforce needs. Optimally, this plan would identify desired workforce outcomes that are measurable and time limited, as well as associated strategies for recruitment, T/TA, retention, and providing and coordinating T/TA across organizations at the state and substate levels.

During the onsite discussions, DMHAS staff expressed interest in learning more about a current SAMHSA-supported TA effort that is being collaboratively funded by CSAP, the Center for Substance Abuse Treatment, and the Center for Mental Health Services to help another state develop and implement a workforce assessment and T/TA plan aimed at building workforce competencies across primary, secondary, and tertiary prevention.

State Strategic Plan

STRENGTHS

DMHAS has used data to identify priorities for substance abuse prevention.

DMHAS used data during its last planning process in 2012 to identify priorities to reduce underage drinking, binge drinking, use of illegal substances, medication misuse, and use of new and emerging drugs of abuse. DMHAS staff noted that GCADA has adopted these priorities to guide its work.

CHALLENGES

DMHAS does not have a strategic plan for prevention that is based on current data.

DMHAS's 2012 Substance Abuse Prevention Strategic Plan continues to serve as the Single State Authority's plan for prevention. While the plan focuses on the reduction of substance abuse and includes logic models that identify the consequences, consumption, intervening variables, and contributing factors for each priority, the 2016 CSAP site visit team noted that it is not clear how the plan can be used to guide efforts and evaluate progress toward achieving these priorities. First, the plan is based on data from 2009/2010 and does not include current baseline data. In addition, the plan does not identify measurable, time-limited objectives and outcomes that quantify success. Finally, the plan lacks information on how it will be implemented (e.g., roles, responsibilities, and timelines for key strategies and activities needed to address the priorities) or how progress will be continuously evaluated so that corrections can be made, as needed, to ensure that the state's prevention goals are met. In essence, the state's own planning process falls short of the process it requires of subrecipients.

Potential Enhancements for State Strategic Plan

6	**Comprehensive strategic plan** DMHAS's ability to reduce or prevent substance abuse problems, promote mental health, and strengthen its prevention system would be enhanced by a comprehensive strategic prevention plan that can be used to provide guidance and serve as a model for planning for the entire state prevention system. Optimally, the plan should be based on a formal assessment and include the

following components:

- A clear problem statement or statements describing what currently exists that compromises health and/or organizational effectiveness and needs to be changed
- Clear goals describing desired changes in substance abuse behaviors, related problems and consequences, and state and substate prevention system behavior
- Clear objectives describing the changes in intervening variables that are needed in order to achieve the goals for substance abuse prevention and prevention system development
- Careful identification of the target populations that are involved in and/or impacted by the issue or issues identified in the problem statement
- Targeted and measurable outcomes that specify the degree of change sought and the timeframe in which it is to be achieved for each goal (long-term outcome) and objective (intermediate outcome), as well as changes in knowledge, skills, and abilities (immediate outcomes) needed to achieve the goals and objectives
- State-level strategies and activities that are logically linked to the achievement of desired goals, objectives, and outcomes
- An implementation component with clearly defined roles, responsibilities, and timelines
- An evaluation component sufficient to monitor progress toward outcomes and provide information for midcourse adjustments as needed
- A strategic financing component that analyzes all existing resources and infrastructure and aligns resources to support desired outcomes.

Primary Prevention Set-Aside

New Jersey was found to be in compliance with all requirements of the primary prevention set-aside of the SABG.

STRENGTHS

New Jersey exceeded the 20-percent prevention set-aside requirement of the SABG in federal fiscal year (FFY) 2013. DMHAS reported primary prevention expenditures of $12,011,726 out of a total SABG allocation of $44,113,253, or 27.23 percent.

Required Followup Action

None noted.

Potential Enhancements for Primary Prevention Set-Aside

None noted.

Implementation

Prevention Budget and Funding

STRENGTHS

The State of New Jersey invests a significant amount of funding in substance abuse prevention.

The State of New Jersey provides an estimated $15 million in prevention funding annually through

allocations to DMHAS ($3.9 million in FFY 2015), the 21 County Alcohol and Drug Abuse Directors (10 percent of the annual allocation of $15.9 million from the Alcoholism, Education, Rehabilitation, Enforcement Fund), and GCADA to fund the MAs ($10 million per year).

New Jersey has been successful in competing for federal discretionary grants to supplement SABG prevention funding.

DMHAS is currently administering a 5-year, $10 million Partnerships for Success discretionary grant from SAMHSA, and 22 New Jersey coalitions were awarded highly competitive DFC grants in FFY 2015.

Funding Allocation Processes

STRENGTHS

DMHAS allocates SABG funding through a competitive RFP process.

DMHAS awards SABG prevention funds through competitive contracts to nonprofit agencies and municipal or county governments.

DMHAS is using data to allocate SABG funding.

The 17 regional coalitions funded by DMHAS were selected through an RFP process that used archival and social indicator data and composite incidents of risks to estimate the need for prevention services among New Jersey's 21 counties. Criteria included substance abuse treatment admissions and rates within the region and prevalence of alcohol and prescription drug misuse among middle and high school students. Each region had a minimum of one county and, according to the latest available data at the time the RFP was released, must have reported a minimum of 2,000 treatment admissions.

CHALLENGES

Some DMHAS funding allocations are based on the use of data that may be too old to reflect current needs.

During the onsite discussions, DMHAS staff noted that the Relative Needs Assessment Scale (RNAS) findings were used in 2008 and 2014 to allocate state and SABG funding. The CSAP team observed, however, that the current RNAS relies on 2003 substance abuse data collected through the Household Survey, even though 2009 data are available. While DMHAS staff stated that the data are manipulated to account for age, the CSAP team questioned the utility of using 13-year-old data to calculate funding needs, given the escalating trends in illicit drug use in the state.

Prevention Expenditures and Allocations

STRENGTHS

DMHAS reports having increased its financial support for environmental prevention.

In New Jersey's 2016 SABG application, DMHAS reported that it had increased its support for environmental prevention from 8 percent of SABG prevention funds in FFY 2012 to 32 percent in FFY 2016.

DMHAS reported that all prevention strategies funded in FFY 2013 were evidence based.

These strategies consisted of six strategies for universal direct populations, seven strategies for universal indirect populations, seven strategies for selective populations, and eight strategies for indicated populations.

DMHAS's allocation pattern reflects a comprehensive approach to prevention.

Prevention providers are encouraged to use multiple strategies in multiple settings to work toward a common goal. Community-based prevention service grants are intended to coordinate their efforts with regional coalitions and MA prevention priorities. And although community service grants are discouraged from implementing environmental prevention programs, funded regional coalitions are to exclusively implement environmental prevention strategies. Special projects target priority populations (e.g., families of military personnel, persons identifying as lesbian, gay, bisexual, transgender, and queer), and DMHAS has also funded services that target prescription drug misuse among the 60 and older population. According to DMHAS staff, three providers are also focusing on opioid abuse prevention.

CHALLENGES

Historically, DMHAS-funded prevention initiatives have reached a very small percentage of the population, despite widespread prevalence of the use and abuse of multiple substances.

For FFY 2013, DMHAS reported serving 60,767 persons through individual-based strategies and 168,500 persons through population-based strategies. These figures represent only 0.7 and 1.9 percent of the state's population of 8.8 million residents, respectively. The small reach of prevention funds was also noted during the 2012 CSAP site visit. Given the much larger prevalence of reported substance abuse in the state, it could be difficult for DMHAS to achieve significant outcomes in reduced substance abuse problems and consequences if it does not increase the reach of its funded prevention initiatives.

Funding allocations for environmental prevention may be over-reported due to discrepancies between how DMHAS and SAMHSA classify activities for this strategy.

While the increase in environmental strategies is a very positive step in expanding the comprehensiveness of New Jersey's approach to environmental prevention, the CSAP team observed—and DMHAS staff concurred—that the definition of environmental used by DMHAS and providers to classify strategies does not entirely follow the definitions established by SAMHSA. For example, media campaigns are classified as environmental strategies by New Jersey, rather than as information dissemination strategies per federal definitions, and thus the actual percentage of environmental strategies being implemented in the state may be less than what is being reported.

Funding Requirements

STRENGTHS

Regional coalitions funded by DMHAS are required to use SAMHSA's SPF process to guide the development of their workplans.

DMHAS requires these subrecipients to conduct a needs assessment, address capacity development and mobilization, develop a data-driven workplan, select and implement evidence-based strategies, and participate in evaluation. Regional coalitions must also demonstrate a commitment to cultural competence and develop a plan for how they will sustain successful programs/strategies.

CHALLENGES

Requirements for use of the SPF appear less rigorous for grant types funded by DMHAS outside of the regional coalitions.

While Community-Based Prevention Services and Special Projects grantees are required to conduct a

needs assessment to justify their selection of services, identify community resources, and develop workplans with goals and objectives, they are not required to identify targeted and measurable outcomes or engage in evaluation to the degree that regional coalitions must. And while County Alcohol and Drug Directors are required to create a county plan, they appear to be largely exempt from requirements to implement the SPF. While the lack of adherence to performance management processes and expectations for outcomes is not unusual in states that statutorily mandate funding to substate political subdivisions, it can represent a missed opportunity to ensure that public funds are making their greatest impact in improving public health and well-being within the communities served.

Potential Enhancements for Implementation

7	**Needs-based funding allocation** DMHAS is encouraged to consider updating the substance abuse data that is used to calculate the RNAS, to ensure that the funding formula used to allocate resources represents the current needs of New Jersey counties.
8	**Categorization of environmental strategies** Given that the environmental module of the Prevention Outcomes Management System (POMS) has not yet been finalized, this might be an opportune time for DMHAS to review and strengthen its guidance to providers for classifying and reporting environmental strategies. This would help to ensure accurate reporting and enable DMHAS to monitor the degree to which desired increases in the use of environmental strategies are in fact taking place.
9	**Increased requirements for the use of the SPF or a similar performance management process** DMHAS is encouraged to use lessons learned from the regional coalitions to strengthen requirements for the use of the SPF or a similar performance management process in future RFPs for Community-Based Prevention Services and Special Projects, as well as to strengthen requirements for intermediate and long-term outcome evaluation among all grantee types. In addition, DMHAS is encouraged to work with its state and county partners to increase political will and readiness for increased use of the SPF in county-based prevention planning and implementation.

Evaluation

STRENGTHS

DMHAS's long-standing, electronic POMS is able to accurately collect program data, and includes a module to collect data on provider use of the SPF.

DMHAS uses POMS to collect process data for individual and family programs (e.g., gender, age, race/ethnicity, curriculum, dates the service was provided, CSAP strategy, total number of sessions attended). These data are analyzed to ensure that agencies are serving the appropriate population, delivering the correct number of sessions, and enrolling the appropriate number of individuals or families in the program. POMS includes a module on the SPF, as well as a new module on environmental prevention that had not yet been released at the time of the site visit.

CHALLENGES

DMHAS does not require all grantees to monitor progress toward outcomes.

Subrecipient requirements for process monitoring seem only to apply to treatment providers. The site visit team was no clear on what protocols DMHAS has for monitoring prevention provider performance or enforcing the terms of prevention subrecipient or contractor funding.

DMHAS has not yet been successful in its attempts to use POMS to monitor provider outcomes.

DMHAS staff members noted that they would like to develop an outcomes module for POMS, but they have not yet decided what data should be collected.

DMHAS does not have a comprehensive evaluation system capable of measuring the outcomes produced by SABG-funded grantees.

While DMHAS appears to be invested in evaluating and monitoring prevention outcomes, this seems to be an area of continuing development. The 2016 CSAP site visit team noted that DMHAS does not have a comprehensive evaluation system capable of measuring the effectiveness of its portfolio of prevention initiatives and is not currently able to evaluate the actual outcomes produced by SABG-funded grantees in terms of changes in problems and consequences, consumption, or intervening variables. Specifically, the current evaluation system does not include all funded prevention initiatives and does not appear to be sufficient for measuring change at the population level and correlating that change with strategies funded by the state's prevention system. DMHAS staff members noted that they would like to develop an outcomes module for POMS, but they have not yet decided what data should be collected.

Prevention programs and coalitions are not included in DMHAS's Provider- or State-Level Performance Management System.

DMHAS produces state- and provider-level performance reports. DMHAS staff explained during the onsite visit, however, that these reports apply only to treatment providers and are not used to gauge or monitor the performance of prevention providers.

Potential Enhancements for Evaluation

10	**Statewide evaluation system** DMHAS's ability to evaluate the return on investment from its portfolio of preventive initiatives could be enhanced by the development of a comprehensive evaluation system capable of monitoring and documenting intermediate and long-term outcomes in reduced substance abuse–related problems and consequences for all funded prevention grants and contracts. Toward that end, DMHAS is encouraged to: 1. Require all grantees to identify—and monitor progress toward—desired reductions in substance abuse-related problems, consumption and use, and related intervening variables 2. Develop a performance monitoring and feedback system for prevention grantees, similar to the state- and provider-level performance management systems that are used for treatment.

Synar Recommendations

Synar Program Development and Organization

State Synar Program Organization

STRENGTHS

None noted.

CHALLENGES

The MOU between DMHAS and TASE has not been updated since 2004.

The lack of an updated MOU results in unclear roles and responsibilities between DMHAS and TASE preventing optimal program effectiveness and support.

DMHAS and TASE have limited formal partnerships with community level tobacco control agencies and do not utilize the coalitions that are already in place limiting the agencies reach.

TASE does not have a formal working relationship with other tobacco control agencies involved in tobacco prevention control efforts and does not utilize local coalition's expertise in Synar efforts, preventing a widespread reach of tobacco programing potentially limiting prevention and control outcomes.

Potential Enhancements

1	**Revisit the current MOU.** DMHAS and TASE would benefit from revisiting their MOU agreement and updating it to reflect current roles and responsibilities that may have changed due to changes in funding or job roles.
2	**Create formal partnerships with other local organizations and utilize coalitions in place.** The state may benefit from conducting joint planning activities with other local organizations and coalitions in order to better coordinate its tobacco prevention and control resources to positively impact tobacco prevention and control outcomes.

NOMs and RVR Trends

STRENGTHS

None noted.

CHALLENGES

New Jersey's RVR is increasing.

The RVR increased from 8.5 percent in FFY 2015 to 18.6 percent in FFY 2016. This represents a significant increase nearing the 20 percent RVR limit, which puts the state at risk for not being in compliance with the Synar regulation and result in monetary penalties for regulatory noncompliance.

Potential Enhancements

3	**Examine the fluctuations in the retailer violation rate.** The state may benefit from continuing to examine the factors that have attributed to that

	increase including changes in policies, budgets, and enforcement presence to identify contributing factors and develop an action plan to reverse the current upward trend.

State Synar Program Compliance

State Law

Required Followup Action

None noted.

STRENGTHS

New Jersey includes electronic smoking devices in its youth tobacco access law.

The state limits access to more products accessible to youth by including electronic smoking devices in its law limiting youth use of such products.

CHALLENGES

None noted.

Potential Enhancements

	.

Enforcement

Required Followup Action

None noted.

STRENGTHS

None noted.

CHALLENGES

There are many levels of approval required for revoking licenses, preventing regular implementation of this license penalty.

The large amount of time and resources that this process requires creates a difficulty in revoking licenses providing challenges in the state utilizing this penalty effectively.

Enforcement inspections have been reduced due to a decrease in funding that has significantly reduced the level of tobacco enforcement.

There has been a reduction in capacity of TASE to on the implement TASE tobacco enforcement due to budget cuts in prior years. This has been evidenced by the more than 50 percent reduction in retail inspections and increase in retail violations. Research shows effective enforcement to be the biggest driver of RVR.

Potential Enhancements

4	**Examine the system to implement suspension and revocation of licenses and collaborate with program partners.** The state may benefit from collaborating with the Treasury to explore methods to reduce the burden required to implement tobacco retailer license suspension and revocation in order to allow TASE to leverage this penalty as an incentive to merchants.
5	**Reexamine the impact of the reduction to state-level enforcement.**

	The state may benefit from examining the impact of the reduction to state-level enforcement and the impact that the reduction has on merchant compliance and youth tobacco use. Research indicates that enforcement is the largest driver of changes to the retailer violation rate so this examination will support the state's efforts to examine the fluctuations in the retailer violation rate.

Random, Unannounced Inspections and Valid Probability Sample

Required Followup Action

None noted.

STRENGTHS

TASE has worked with DMHAS to improve the accuracy of their Synar list frame.

TASE and DMHAS have worked together to clean the Synar list frame, improving the state's accuracy rate from 86.8 percent FFY 2015 to 95.1 percent in FFY 2016. This resulted in a cost reduction as the inspection teams went to fewer ineligible outlets during their inspections.

CHALLENGES

Despite improvements, there continue to be limitations on completeness and accuracy tobacco outlet listing TASE receives from the Department of Treasury.

DMHAS reports that cleaning the Treasury list is a difficult process that requires a significant amount of time and resources each year.

Potential Enhancements

6	**The state may benefit from exploring additional strategies to improve the accuracy of the license list.** The state may benefit in learning about the methods other states use to work with their partner agencies to update and clean their list frames in order to identify methods that may reduce burden on DMHAS and TASE staff.

Retailer Violation Rate

Required Followup Action

None noted.

STRENGTHS

None noted.

CHALLENGES

The state RVR is increasing.

The RVR increased from 8.5 percent in FFY 2015 to 18.6 percent in FFY 2016, representing a significant increase and putting the state closer to being out of compliance.

Potential Enhancements

7	**New Jersey may benefit from examining contributing factors to their RVR increase.** The state may benefit from examining the factors that have contributed to the RVR increase including changes in policies, budgets, and enforcement presence to identify contributing factors and develop an action plan to reverse the current upward trend. This analysis will

	help the state identify the strategies they will need to implement an action plan to stabilize and reduce the RVR and remain in compliance with Synar requirements.

Annual Synar Report

Required Followup Action

None noted.

STRENGTHS

None noted.

CHALLENGES

None noted.

Potential Enhancements

	None noted.

Synar Program Support

State Synar Program Budget and Funding

STRENGTHS

None noted.

CHALLENGES

State level budget cuts have resulted in reduction of services.

State level deductions have resulted in a reduction of Synar support services such as the elimination of merchant education and targeted enforcement inspections, reducing the ability for New Jersey to implement strategies that effectively impact merchant behavior.

Potential Enhancements

8	**The state may benefit from developing a sustainability plan for Synar implementation.** Once the state examines the factors that are contributing to the rise in the RVR, the state may benefit from developing a plan to determine the strategies that will help them reduce the RVR and sources of funding for those strategies to ensure they can be fully implemented.

State/SSA Strategic Plan for Youth Tobacco Access Prevention

STRENGTHS

None noted.

CHALLENGES

None noted.

Potential Enhancements

	None noted.

State Synar Program Policy Development and Education

STRENGTHS

The state has begun to increase the legal age to purchase tobacco products in some municipalities.

Fifteen municipalities have enacted ordinances increasing the legal age of tobacco and e-cigarettes sales from 19 to 21. The Institute of Medicine report on this practice has indicted that it primarily impacts 15-17 year olds as it reduces both their retail and social access to tobacco products.

CHALLENGES

None noted.

Potential Enhancements

	None noted.

State Youth Tobacco Access Support Strategies

STRENGTHS

None Noted

CHALLENGES

The state has a limited supply of merchant education materials.

State inspectors have a limited supply of previously generated merchant education materials to provide to the merchants. As New Jersey does not have additional materials or funding to develop new materials, only the retailers who receive Synar inspections receive education about youth tobacco access compliance. This limits the state's ability to ensure that all merchants have the information required to stay in compliance with New Jersey state laws. .

Potential Enhancements

9	**The state may benefit from developing a state wide merchant education campaign.** The state would benefit from developing a culturally appropriate statewide merchant education campaign to ensure that tobacco retailers across the state received important information about youth tobacco access laws, penalties, and the importance of reducing youth access to tobacco products.

APPENDIX B

Participant List From the Site Visit

Name	Title	Organization
State Participants		
Rebecca Alfaro, M.S.W.	Deputy Executive Director	Governor's Council on Alcoholism and Drug Abuse
Suzanne Borys	Assistant Director	DMHAS, Office of Planning, Research, Evaluation, and Prevention
Doug Bratton	Executive Director	Partners in Prevention/NCADD HUDSON
Lily Britton, M.A.	Supervising Program Officer	DMHAS, Office of Planning, Research, Evaluation, and Prevention
Becky Carlson	Assistant Director	Center for Prevention and Counseling
Darren Clark	Synar Inspector	Department of Health Division of Family Health
Kim Cremer	Community Service Officer 1	DMHAS, Office of Planning, Research, Evaluation, and Prevention
Tim Coyle	Lieutenant	New Jersey State Police
Jose Cruz	Mental Health Clinician	Rutgers University Robert Wood Johnson Medical School
Lisa Daly	Associate Director	New Jersey Prevention Network
Sherry Dolan, M.P.H.	Research Scientist 1	DMHAS, Office of Planning, Research, Evaluation, and Prevention
Mollie Greene	Director of Clinical Services	Department of Children and Families
Tracy Gross	Director	Barnabas Health Institute for Prevention
Samantha Harries	Director	Center for Alcohol & Drug Resources, a program of Children's Aid & Family Services
Donald Hallcom, Ph.D.	NPN	DMHAS, Office of Planning, Research, Evaluation, and Prevention
Yohannes Hailu	Research Scientist 1	DMHAS, Office of Planning, Research, Evaluation, and Prevention

Adam Polhemus	Sergeant	New Jersey State Police
Kathleen Russo	Program Support Specialist 1	DMHAS, Office of Planning, Research, Evaluation, and Prevention
Janis Mayer	Manager	Office of Tobacco Control, Nutrition, and Fitness Division of Family Health Services Community Health and Wellness Unit
James Mielo	Prescription Monitoring Program Administrator	Prescription Monitoring
Andrew Peterson	Professor	Rutgers University School of Social Work
Kristen Gilmore Powell	Research Associate and Research Project Coordinator	Rutgers University School of Social Work
Matthew Roche		Rutgers University Behavioral Health Care
Helen Staton	Administrative Analyst 3	DMHAS, Office of Planning, Research, Evaluation, and Prevention
Joel Torres	ADAPT Senior Coordinator	ADAPT Coalition Family Connections New Jersey
Helen Varvi	Deputy Director	Wellspring Center for Prevention
Limei Zhu	Research Scientist 1	DMHAS, Office of Planning, Research, Evaluation, and Prevention
Tina Que		Center for Prevention and Counseling
CSAP Team		
Stacy Fenner-Queen	State Project Officer	Division of State Programs, CSAP
Laurie Barger Sutter	Prevention Specialist	JBS International, Inc.

APPENDIX C

Sources of Information Reviewed

The following tables list the sources of information consulted during the site visit process for the New Jersey prevention system and Synar program (e.g., reports, websites, state documents).

Sources of Prevention Information	
2016-17 SABG Behavioral Health Assessment and Plan (submitted) 2015 Combined Behavioral Health Assessment and Plan (approved)	2015SABG Behavioral Health Report (approved)
New Jersey Substance Abuse Prevention and Synar System Review Report Federal Fiscal Year 2012 May 1–3, 2012	New Jersey Substance Abuse Prevention and Synar System Review Report FY August 4–6, 2009 Fiscal Year 2009
New Jersey Prevention System Assessment Report April 4–6, 2006	New Jersey P-11-7-2011 TA Report New Jersey P-04-23-2010 TA Report
New Jersey CAPT TA Plans FY15–FY16	New Jersey SIR 2012-40 Response New Jersey SIR 2012-39 Response New Jersey SIR 2012-42 Response New Jersey SIR-2011-63 Response
New Jersey TTA Tracker TA Reports	New Jersey State Contacts Directory Page
State and County Quick Facts	State Profile of Underage Drinking –Alcohol Policy NIAAA
State of Profile of Drug Indicators ONDCP	Office of Adolescent Health publishes State: Adolescent Mental Health and Substance Abuse Facts (2007–2011)
States In Brief Substance Abuse and Mental Health Issues At-A-Glance samhsa.gov/data/States_In_Brief_Reports.aspx (Link only)	Grant Awards by State Full Detail of Awards FY 2015–2016
New Jersey Behavioral Health Barometer 2014	Understanding the Economy: State-by-State Snapshots: New Jersey
Profile of State Public Health from the Association of State and Territorial Health Officials	Governor Christie Biography
Mental Health National Outcome Measures (NOMs): CMHS Uniform Reporting System	Executive Orders
New Jersey Wikipedia	Governor Christie's Priorities
New Jersey 2008 Epidemiological Profile http://www.nj.gov/humanservices/dmhas/publications/epidemiological/ County Links to Substance Abuse Related Indicators	New Aging Profile
GCADA Master Plan 2010	Map of Federal Lands in New Jersey

About DMHAS	Prevention Strategic Plan—March 2013
DMHAS Mission-Vision-Values	About DHS
DMHAS Prevention Providers Directory	Division of Mental Health and Addiction Services Home
Regional Prevention Coalitions	DMHAS 3Year Strategic Plan
New Jersey FY 2016 Budget Book	Prevention and Early Intervention
Behavioral Council Bylaws October 2014	Evidence Based Prevention Curricula Workforce Development
New Jersey Prevention Network	Citizen Advisory Council
Governor's Council on Alcoholism and Drug Abuse	New Jersey Prevention Network National Prevention Strategy
Health In Focus Key Findings	Intoxicated Drivers Program Statistical Report
Strategic Plan to Address Prescription Drug Abuse	GCDA Membership List
Strategic Plan 2014 Move to Managed Care	Health In Focus
Strategic Plan Stakeholder Communication May 2015	Strategic Plan 2014 Community Integration
Prevention Definitions	Strategic Plan 2014 Workforce Development
Strategic Prevention Framework	Substance Abuse Prevention Hunterdon June2015 Award Summary
New Jersey Adult Suicide Prevention Plan 2014-2017	Prevention Strategies for Special Populations
Contract Policy Information Manual Glossary	Regional Prevention Membership
Directory of Contracted Services 2010	Regional Prevention Coalitions
Tips for Organizations as DHS Providers	DHS Contract Manual Webpage
Municipal Alliance Capacity	Contracting Fundamental Training Modules
Organizational Chart Department of Mental Health and Addiction Services	Principles of Good Governance and Practice
Certified Community Behavioral Health Clinics Planning Grant Evaluation MOA	Prevention RFP 2014
Intoxicated Driver Resource Center Curriculum MOA	Organizational Chart Department of Human Services December 2015
New Jersey Household Survey of Drug Use and Health 2015 MOA	A Prevention Services for Children with Conduct Disorder Final MOA
State Prevention Enhancement (SPE) Evaluation MOA	Certificate of Community Based Planning MOA
TASE DHS DHSS MOU 2004 (Reorganization Plan)	Middle School Survey MOA
Public Behavioral Health System at Local Level	Partnership For Success in Prevention (PFS) Evaluation MOA
2015 New Jersey Strategy for Youth Suicide Prevention	Student Health Survey Department Of Education
2015 DCF Inventory and Need Assessment for New Jersey Behavioral Health	Support of State Partners

POMS Manual Print Screen Updated 2016	County Inter-Agency Coordinating Council (CIACC) Manual
DMHAS Research Plan 2013–2016	FY 2015 Youth Suicide Report
Standard and Ad Hoc Reports	GAS-GPRA User Manual
County Planning	Strategic Prevention Framework Module User Manual
Adult Suicide Prevention Plan Final 2014-17	DMHAS Quality Improvement Plan 2016-2017
Blueprint for Action Cultural Diversity within DMHAS	Strategic Plan 2014, Workforce Development
DMHAS Site Visit Plan Of Correction Template	DMHAS 3-year Strategic Plan
DMHAS Annual Site Visit Cover Letter	Overview of Behavioral Health Homes
ANNEX A Coalition Evaluation	Prevention Contracts Cultural and Linguistic Competence
ANNEX A New Jersey Prevention Coalition Training and TA	Monitoring Process
Laws Policies	DMHAS Annual Site Visit Plan Of Correction Acceptance Letter
SEOW Information	DMHAS Annual Site Visit Confirmation Letter
Training Calendar	ANNEX A New Jersey Prevention Addiction Treatment Workforce Development
Regional Coalition Quarterly Report January-March 2015	State Development Support
Core Competencies for Prevention Professionals	Prevention Coalition Needs Assessment 2015
Prevention RFP 2014	SEOW Minutes
Atlantic County Substance Abuse Overview	Prevention Workforce Licensing Certification
Middle School Survey 2012	Regional Coalition Quarterly Report July - Sept 2015
CAPT Training Request New Jersey Heroin Data Jan-Feb 2013 With Costs	Coalition RFP
State Exhibit F State Prevention and Synar Budgets 2016	Atlantic Chartbook
State Prevention PPT	Intoxicated Driver Program Statistical Report 2013
Acronyms	

Sources of Prevention Information	
New Jersey Annual Synar Report FFY 2016	Synar Survey Sampling Plan and Inspection Protocol Review Form Initial—Final Version
SSES Tables 1-4	Synar Inspection Protocol
New Jersey Substance Abuse Prevention and Synar System Review Report Federal Fiscal Year 2012 May 1–3, 2012	New Jersey Substance Abuse Prevention and Synar System Review Report FY August 4–6, 2009 Fiscal Year 2009
New Jersey Prevention System Assessment Report	New Jersey Synar System Assessment Report

April 4–6, 2006	February 25–27, 2003
New Jersey-S-10-3-2003-1 TA Report	New Jersey SLATI Detail
Tobacco Prevention Coalition List	FDA Relationship
DAS Transfer MOU	2015-16 Federal and State Distribution and Return Form 2
Tobacco Age-of-Sale Enforcement Program (TASE) Parental Consent Letter	TASE Manual Revised 2012
Office of Tobacco Control Nutrition and Fitness Goals Objectives Activities	Employees Brochure Prohibiting Tobacco Sales to Youth
Merchants Brochure—Nothing Proves You're 19 Except Your ID	State Of New Jersey Required Tobacco Retailer Sign
TASE Laws	Community Education and Support
Look See Check ID Webinar	Synar Budget
Compliance Check Inspection Report (CCIR).	Synar Presentation to CSAP PPT Slides
Annex A—Coalition Technical Assistance—RWJ—Tobacco	

APPENDIX D

Summary of New Jersey's Estimated FFY 2015 and Planned FFY 2016 Prevention and Synar Budgets

Estimated FFY 2015 and Planned FFY 2016 Prevention Budgets by Program Area and Revenue Source and Amount

Estimated FFY 2015 Prevention Budget

Department of Human Services—Division of Mental Health and Addiction Services Prevention Expenditures						
Program Area (e.g., statewide prevention contractors, prevention grants for services, SPF-SIG, SPE grant, EUDL discretionary funding, Partnerships for Success grant, Suicide Prevention grants, Drug-Free Schools carryover)	**FTE for Prevention**	**Revenue Source and Amount**				
		SABG Funds	**% of SABG**	**Federal (Other)**	**State**	**Total**
Community grants for individual and family-focused curricular programs		$5,750,000	60			$5,750,000
Grants to fund 17 regional prevention coalitions		$3,300,000	34.4	$1,748,879		$5,048,879
Training and TA to regional coalitions		$350,000	3.6	$80,000		$430,00
Coalition evaluation				$174,888		$174,888
NCADD-New Jersey					$299,180	$299,180
Partnership for a Drug-Free New Jersey					$1,055,905	$1,055,905
Council on Compulsive Gambling of New Jersey					$2,629,910	$2,629,910
Total		$9,400,000	98	$2,003,767	$3,984,995	$15,388,762

Planned FFY 2016 Prevention Budget

Program Area (e.g., statewide prevention contractors, prevention grants for services, SPF-SIG, SPE grant, EUDL discretionary funding, Partnerships for Success grant, Suicide Prevention grants, Drug Free Schools carryover)	FTE for Prevention	Revenue Source and Amount				
		SABG Funds	% of SABG	Federal (Other)	State	Total
Community grants for individual and family-focused curricular programs		$5,750,000	60			$5,750,000
Grants to fund 17 regional prevention coalitions		$3,300,000	34.4	$1,748,879		$5,048.879
Training and TA to regional coalitions		$350,000	3.6	$80,000		$430,000
Coalition evaluation				$174,888		$174,888
NCADD-New Jersey					$299,180	$299,180
Partnership for a Drug-Free New Jersey					$1,055,905	$1,055,905
Council on Compulsive Gambling of New Jersey					$2,069,910	$2,069,910
Total		$9,400,000	98	$2,003,767	$3,424,995	$14,828,762

Estimated FFY 2015 and Planned FFY 2016 Synar Budgets by Synar Category, Responsible Agency, and Revenue Source and Amount

Estimated FFY 2015 Synar Budget[6]

Synar Category	Responsible Agency	FTE for Synar	Revenue Source and Amount								Total
			State Funds	Licensing Fees	Fines	SABG	Foundations	Retailer Associations	Tobacco Industry or MSA Settlement	Other	
Management/ Staffing											
Sample Design											
Coverage Study											
Inspections											
Merchant Education											
Training											
Community Education & Support											
Data Analysis To Determine RVR											
Enforcement											
Other (please describe)											
Total											

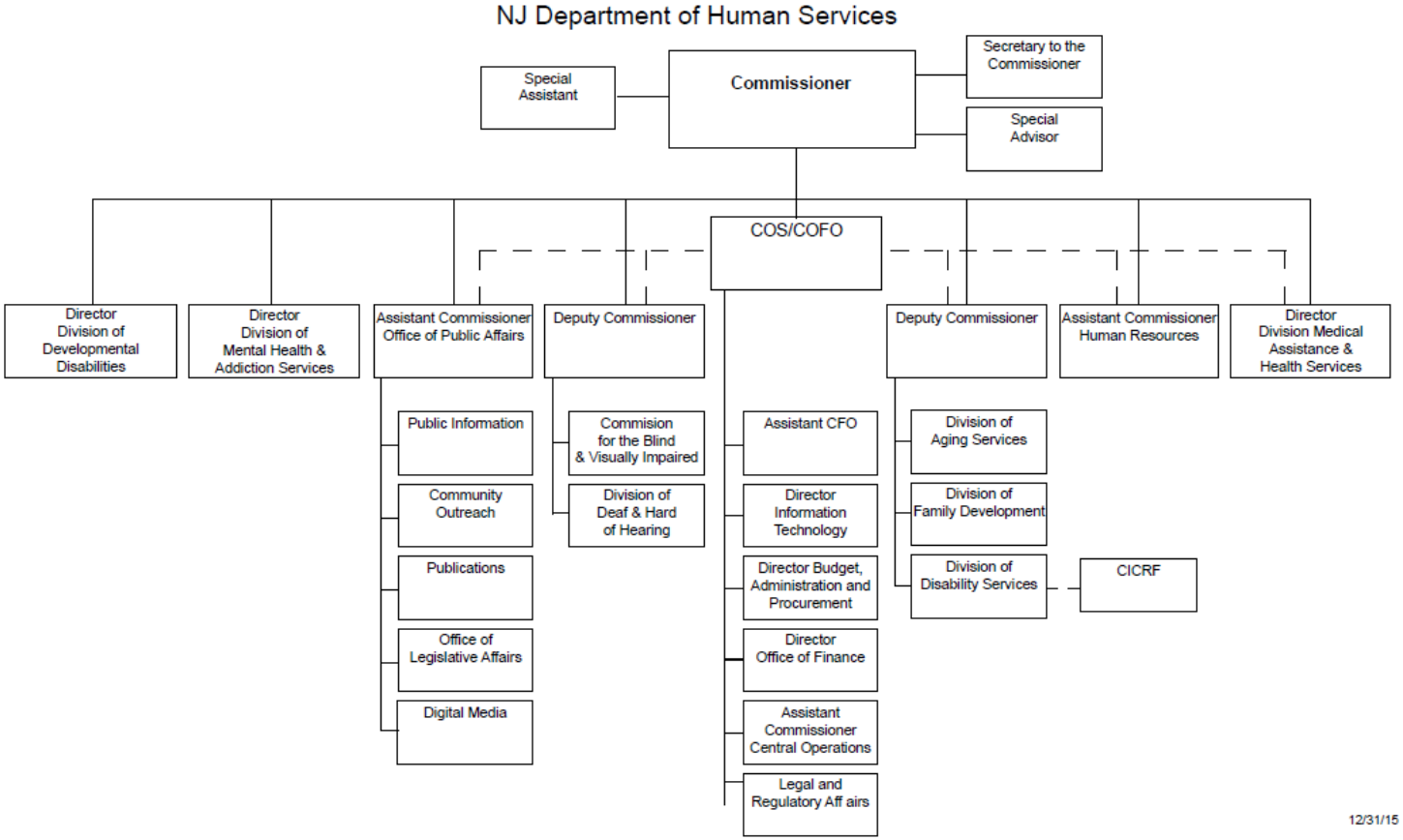
[6] The state did not provide Synar budgets.

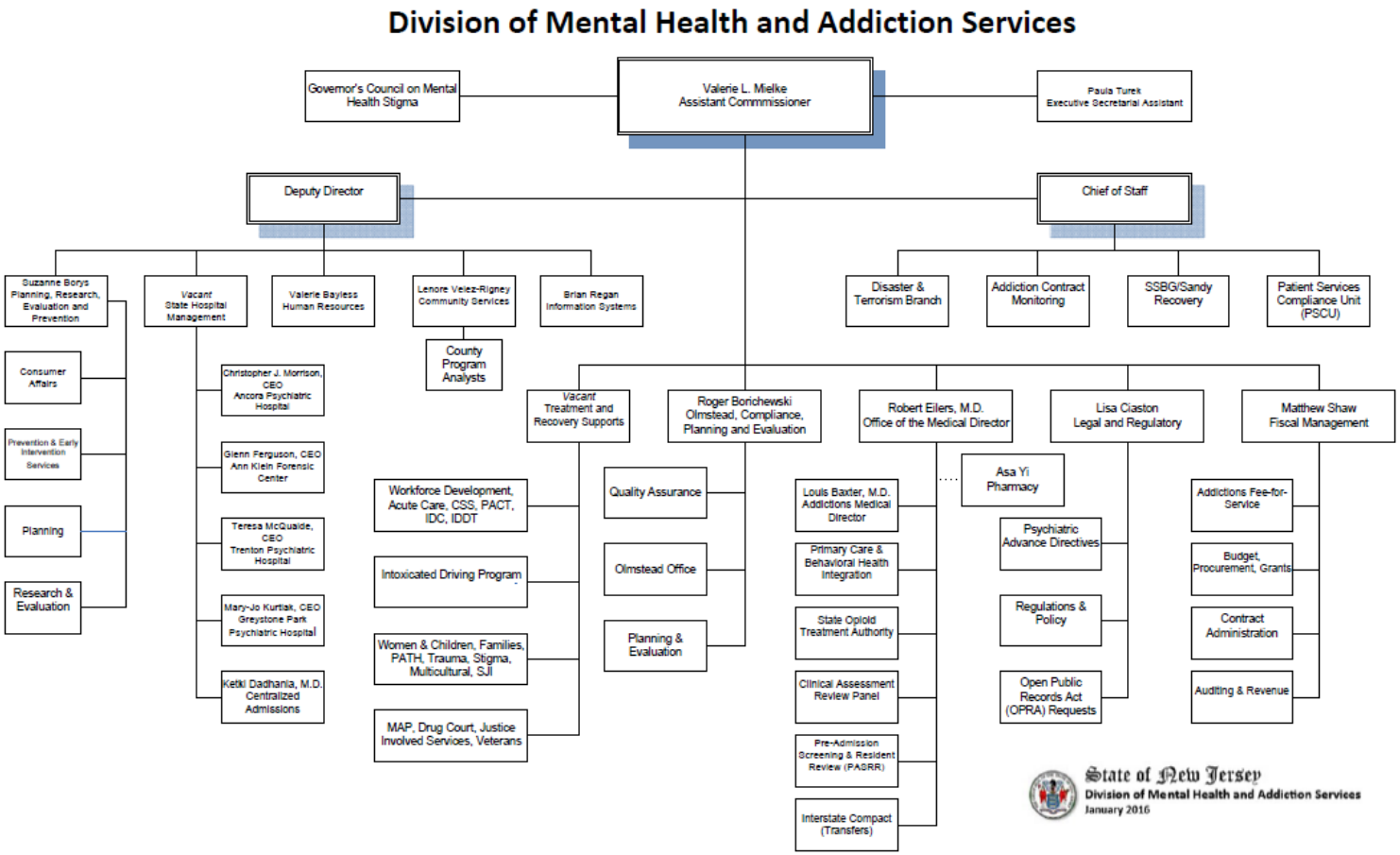
Planned FFY 2016 Synar Budget

Synar Category	Responsible Agency	FTE for Synar	Revenue Source and Amount								Total
			State Funds	Licensing Fees	Fines	SABG	Foundations	Retailer Associations	Tobacco Industry or MSA Settlement	Other	
Management/ Staffing											
Sample Design											
Coverage Study											
Inspections											
Merchant Education											
Training											
Community Education & Support											
Data Analysis To Determine RVR											
Enforcement											
Other (please describe)											
		Total									

APPENDIX E

SSA Organizational Charts, Key Partnerships, and Other Materials




Division of Mental Health and Addiction Services
Governor's Council on Mental Health Stigma
Valerie L. Mielke
Assistant Commissioner
Paula Turek
Executive Secretarial Assistant
Deputy Director
Chief of Staff
Suzanne Borys
Planning, Research, Evaluation and Prevention
Vacant
State Hospital Management
Valerie Bayless
Human Resources
Lenore Velez-Rigney
Community Services
Brian Regan
Information Systems
Disaster & Terrorism Branch
Addiction Contract Monitoring
SSBG/Sandy Recovery
Patient Services Compliance Unit (PSCU)
Consumer Affairs
Prevention & Early Intervention Services
Planning
Research & Evaluation
Christopher J. Morrison, CEO
Ancora Psychiatric Hospital
Glenn Ferguson, CEO
Ann Klein Forensic Center
Teresa McQuaide, CEO
Trenton Psychiatric Hospital
Mary-Jo Kurtiak, CEO
Greystone Park Psychiatric Hospital
Ketki Dadhania, M.D.
Centralized Admissions
County Program Analysts
Vacant
Treatment and Recovery Supports
Roger Borichewski
Olmstead, Compliance, Planning and Evaluation
Robert Eilers, M.D.
Office of the Medical Director
Lisa Ciaston
Legal and Regulatory
Matthew Shaw
Fiscal Management
Workforce Development, Acute Care, CSS, PACT, IDC, IDDT
Intoxicated Driving Program
Women & Children, Families, PATH, Trauma, Stigma, Multicultural, SJI
MAP, Drug Court, Justice Involved Services, Veterans
Quality Assurance
Olmstead Office
Planning & Evaluation
Louis Baxter, M.D.
Addictions Medical Director
Primary Care & Behavioral Health Integration
State Opioid Treatment Authority
Clinical Assessment Review Panel
Pre-Admission Screening & Resident Review (PASRR)
Interstate Compact (Transfers)
Asa Yi
Pharmacy
Psychiatric Advance Directives
Regulations & Policy
Open Public Records Act (OPRA) Requests
Addictions Fee-for-Service
Budget, Procurement, Grants
Contract Administration
Auditing & Revenue
State of New Jersey
Division of Mental Health and Addiction Services
January 2016

APPENDIX F

State Laws and Policies

State Alcohol and Other Drugs Policies Snapshot		
Alcohol	Is state an alcohol control state?	Yes
	What is the minimum age for bartenders to serve alcohol on-premise?	18
	What is the minimum age for servers to serve alcohol on-premise?	18
	What is the minimum age for servers to serve alcohol off-premise?	18
	Does state mandate beverage service training?	Yes
	• If so, what are the requirements? All holders of a plenary retail or limited retail distribution license issued under R.S.33:1-12, or their designees are required to successfully complete the educational program. (33:1-12.42)	
	• Who administers the training? Training is provided by third party contractors (non-profit educational organization) determined by the Division of Alcoholic Beverage Control (13:2-22.5)	
	• Does completion of beverage server training establish an affirmative defense?	No
	What is the minimum age for purchase of alcohol?	21
	What is the minimum age for possession of alcohol?	21
	What is the penalty for selling alcohol to underage persons or to a straw purchaser? • Imprisonment not to exceed 6 months and/or fine up to $1,000.	
	Are retailers required to post signs warning of dangers of alcohol use by pregnant women?	Yes
	Does state law allow municipalities and/or other substate jurisdictions to pass laws that are more stringent than state laws with regard to alcohol?	Yes
	• If so, are there applicable conditions or exceptions? Municipalities may establish the hours during which retail alcohol sales may occur. Otherwise, state statute governs. The municipal fees for retail licenses are fixed by the issuing municipality within broad state statutory limits.	Yes
	Are the following laws/policies in place? • Social host legislation	Yes
	• Dram shop laws (making it possible for bar owners and alcohol servers to be held financially liable if a customer becomes obviously intoxicated on their premises and subsequently injures someone or causes property damage, typically by driving drunk)	Yes
	• Keg registration	No

	• Open container laws	Yes
	• "Use and lose" or other provisions associated with the use of false ID or other aspects of underage drinking	Yes
	• Laws to address alcohol use during pregnancy (e.g., priority treatment, mandatory reporting, warning signs, civil commitments, limitations on criminal prosecution of substance-abusing pregnant women).	Yes
	What is the blood alcohol content that constitutes DUI/DWI? • 21 and over: .08 Under 21: .01 BAC or above	
	Does state law permit the use of sobriety checkpoints?	Yes
	Does state have other key alcohol laws and policies in place (e.g., ignition interlock, "Happy Hour" prohibitions)? If so, what are they?	Yes
Drugs	Do state laws decriminalize, in whole or part, marijuana?	No
	Do state laws legalize medical marijuana?	Yes
	Do state laws decriminalize any illicit drugs other than marijuana?	No
	Do state laws contain provisions intended to prevent the manufacturing and distribution of illicit drugs (e.g., restrictions on over-the-counter sales of precursor drugs used in the manufacture of illicit drugs)?	Yes
	Does state have drugged driving laws?	Yes
	Does state restrict sales of prescription drugs?	No
	Does state have a prescription monitoring program (to prevent "doctor shopping")?	Yes
	Does state have alternative sentencing/Drug Court provisions?	Yes

APPENDIX G

New Jersey Employment Data by County

County	Weekly Wages 4th quarter 2014 ($)*	Unemployment Rate 2014 Annual Wages (%)*
Atlantic	872	10.4
Bergen	1,291	5.4
Burlington	1,060	6.3
Camden	1,017	7.5
Cape May	742	12.0
Cumberland	878	9.9
Essex	1,234	7.9
Gloucester	909	7.1
Hudson	1,335	6.5
Hunterdon	1,187	4.7
Mercer	1,306	5.7
Middlesex	1,217	6.0
Monmouth	1,053	6.0
Morris	1,512	4.9
Ocean	845	7.2
Passaic	1,016	8.1
Salem	1,140	8.2
Somerset	1,543	5.1
Sussex	880	6.2
Union	1,341	6.8
Warren	947	6.1

* U.S. Bureau of Labor Statistics

APPENDIX H

State Substance Abuse Trends and Issues

Alcohol Trends and Issues

According to the 2013–2014 NSDUH, the percentage of 12- to 20-year-olds who reported using alcohol in the past 30 days dropped from 29.2 percent in 2002 to 24.9 percent in 2012. Since 2011, this trend has been somewhat erratic. In the 2012–2013 NSDUH administration this rate dropped dramatically to 15 percent, and then rose to 24.9 in the 2013–2014 administration. In the 2013–2014 administration of the NSDUH, 15.4 percent of New Jersey 12- to 20-year-olds reported binge drinking in the past month. Both past-30-day drinking and binge drinking rates in 2013–2014 were slightly higher than national averages.

According to the 2013 YRBS, past-30-day alcohol use declined from 46.5 percent of New Jersey high schoolers in 2005 to 39.3 percent in 2013. In that same time period, past-30-day binge drinking declined from 27.2 percent to 23 percent. New Jersey teens are more likely than their peers nationally to report current drinking (U.S.=34.9 percent) and binge drinking (U.S.=20.8 percent).

According to the 2011–2012 NSDUH, the percentage of those 21 and over who reported using alcohol in the past 30 days fell moderately from 62.9 percent in 2002 to 60.5 percent in 2012. According to the 2013–2014 NSDUH, the percentage of adults aged 26 and older who reported past-month alcohol use was significantly higher than the national average (61.4 percent vs. 56.2 percent).

The 2013 BFRSS shows that past-30-day alcohol use among New Jersey adults has declined significantly from 61.4 percent in 2011 to 58.6 percent in 2013. The national median is 54.5 percent.

According to the CDC, from 2003 to 2012, New Jersey had an alcohol-involved traffic fatality rate of 1.8 deaths per 100,000 population, which is nearly half the national rate (3.3 per 100,000). In 2012, 1.5 percent of New Jerseyans reported driving after drinking too much compared to 1.9 percent nationally.

Tobacco Trends and Issues

According to the 2013–2014 NSDUH, the percentage of youth who reported smoking cigarettes in the past 30 days fell significantly from 12.2 percent in 2002 to 4.8 percent in 2014. This is slightly lower than the national rate of 5.2 percent. The 2011–2012 NSDUH showed little change over time, with approximately 3.6 percent of youth reporting past-30-day use of tobacco products other than cigarettes. However, this was 31 percent lower than the national median.

The 2013 YRBS showed that reported past-30-day cigarette use has decreased significantly from 19.8 percent in 2005 to 12.9 percent in 2013. New Jersey teens are less likely to report current smoking compared with the U.S. average (15.7 percent).

According to the 2013–2014 NSDUH, the percentage of adults who reported past-30-day cigarette smoking decreased from 25.1 percent in 2002 to 19.1 percent in 2014. This is significantly lower than the national rate of 22.7 percent. The 2011–2012 NSDUH showed that the percentage who reported using tobacco products other than cigarettes fell from 5.7 percent in 2002 to 4.9 percent in 2012, 46 percent lower than the national median.

According to the 2013 BFRSS, New Jersey adults reporting daily smoking has decreased from 11.4 percent in 2011 to 10.6 percent in 2013, while current smoking declined from 16.8 percent to 15.7 percent in the same period. This is lower than national medians for daily and current smoking in 2013 (13.4 percent and 19 percent, respectively). In 2013, 0.5 percent of New Jersey adults reported using smokeless tobacco every day, and 1.2 percent reported use some days. This is lower than the national median of 2.2 percent every day and 2 percent on some days.

Illicit Drug Trends and Issues

According to the 2011–2012 NSDUH, the percentage of New Jersey youth perceiving risk of harm from smoking marijuana weekly fell from 80.3 percent in 2002 to 77.9 percent in 2012. The 2013–2014 NSDUH showed reported past-30-day marijuana use among New Jersey youth has not had a clear trend over time, but has generally fallen from 7.2 percent in 2002 to 6.4 percent in 2014. This is lower than the national average of 7.2 percent. The 2013 YRBS indicates that reported past-30-day use of marijuana among New Jersey high schoolers has been relatively stagnant over time, hovering in the 20–21 percent range. By contrast, 23.4 percent of high schoolers nationally reported using marijuana in the past month.

According to the Trust for America's Health, in 2013 New Jersey had the sixth highest teen drug overdose rate in the country, with 10.7 deaths per 100,000 youth, compared to 7.3 per 100,000 nationally. Among young adult (19–25 years old) males, New Jersey had the fourth highest drug overdose rate in the country.

According to the 2011–2012 NSDUH, the percentage of New Jersey adults perceiving risk of harm from smoking marijuana weekly fell significantly from 81.6 percent in 2002 to 73.2 percent in 2012. The 2013–2014 NSDUH showed that reported past-30-day marijuana use among New Jersey adults has risen from 4.2 percent in 2002 to 6.3 percent in 2014. Despite this uptick, it is still significantly lower than the national average of 8 percent.

According to the CDC, in 2013 New Jersey had a heroin-related overdose death rate of 8.3 deaths per 100,000 people—triple that of the U.S. rate of 2.6 per 100,000. In 2014, there were 781 heroin-related deaths in the state, up from 741 in 2013, with the highest death rates in southern New Jersey (Camden, Atlantic, and Cape May counties). New Jersey law enforcement officials report that heroin can be purchased for as little as $5 per "baggie." The DEA reports that typical purity in the state is 40 percent (much higher than typical purity in New England, which is 15 percent), but can range as high as 80 percent.

According to 2013 TEDS data, heroin is the top reason for admission into state-run treatment programs, representing over 1 in 3 (36.8 percent) admissions.

Nonmedical Use of Prescription and Over-the-Counter Drug Trends and Issues

According to the 2011–2012 NSDUH, the percentage of New Jersey youth reporting *past-month* nonmedical use of prescription painkillers fell from 5.7 percent in 2003 to 5.4 percent in 2012. By the time of the administration of the 2013–2014 NSDUH, only 3.8 percent of New Jersey youth reported illicitly using prescription painkillers in the *past year*, which was also lower than the national average of 4.7 percent. According to the 2013 YRBS, the percentage of New Jersey high schoolers reporting ever using nonmedical prescription painkillers decreased from 15.1 percent in 2011 to 11.8 percent in 2013, significantly lower than the national average of 17.8 percent.

According to the 2011–2012 NSDUH, the percentage of New Jersey adults reporting *past-month* nonmedical use of prescription painkillers rose from 2.7 percent in 2003 to 4.1 percent in 2012. By the time of the administration of the 2013–2014 NSDUH, only 3.5 percent of New Jersey adults reported illicitly using prescription painkillers in the *past year*, which was also lower than the national average of 4 percent.

APPENDIX I

Abbreviations

ABC	Division of Alcoholic Beverage Control
ADA	Alcohol and Drug Abuse
AEREF	Alcoholism, Education, Rehabilitation, Enforcement Fund
AOD	alcohol and other drugs
ASR	Annual Synar Report
ATOD	alcohol, tobacco and other drugs
BRFSS	Behavioral Risk Factor Surveillance System
CDC	Centers for Disease Control and Prevention
CPS	Certified Prevention Specialist
CSAP	Center for Substance Abuse Prevention
DCA	Division of Consumer Affairs
DCF	Department of Children and Families
DFC	Drug Free Communities
DHS	Department of Human Services
DLPS	Department of Law and Public Safety
DMAHS	Division of Medical Assistance and Health Services
DMHAS	Division of Mental Health and Addiction Services
DOE	Department of Education
DOH	Department of Health
DUI	driving under the influence
FDA	Food and Drug Administration
FFY	federal fiscal year
GCADA	Governor's Council on Alcoholism and Drug Abuse
HIDTA	High Intensity Drug Trafficking Area
HTSU	Highway Traffic Safety Unit
IC&RC	International Certification & Reciprocity Consortium
IDP	Intoxicated Driver Program

ILP	Intelligence-Led Policing
LACADA	Local Advisory Committee on Alcoholism and Drug Abuse
LGBTG	lesbian, gay, bisexual, transgender, and questioning
MA	Municipal Alliance
MOA	memorandum of agreement
MOU	memorandum of understanding
MSG	Multicultural Services Group
NJCHS	New Jersey Center for Health Statistics
NJHSDUH	New Jersey Household Survey of Drug Use and Health
NJPMP	New Jersey Prescription Drug Monitoring Program
NJPN	New Jersey Prevention Network
NJSAMS	New Jersey Substance Abuse Monitoring System
NOMs	National Outcome Measures
NPN	National Prevention Network representative
NREPP	National Registry of Evidence-based Programs and Practices
NSDUH	National Survey on Drug Use and Health
OAG	Office of the Attorney General
OPREP	Office of Planning, Research, Evaluation, and Prevention
OTC	Office of Tobacco Control
OTCNF	Office of Tobacco Control Nutrition and Fitness
PDFNJ	Partnership for a Drug-Free New Jersey
PEIS	Prevention and Early Intervention Services
PFS	Partnerships for Success
POMS	Prevention Outcomes Management System
PPC	Policy and Planning Committee
RFP	request for proposals
RNAS	Relative Needs Assessment Scale
ROIC	Regional Operations Intelligence Center
RVR	retailer violation rate
RWJ	Robert Wood Johnson

SABG	Substance Abuse Prevention and Treatment Block Grant
SAG	New Jersey Strategic Advisory Group
SAMHSA	Substance Abuse and Mental Health Services Administration
SEOW	State Epidemiological Outcomes Workgroup
SPE	State Prevention Enhancement
SPF	Strategic Prevention Framework
SSA	Single State Authority
SSES	Synar Survey Estimation System
T/TA	Training and technical Assistance
TA	technical assistance
TASE	Tobacco Age of Sale Enforcement
YRBS	Youth Risk Behavior Survey