Inventory and Need Assessment for New Jersey Behavioral Health

Pursuant to *New Jersey Statute 30:4-177.63*, this is a report to the Governor, the Senate Health, Human Services and Senior Citizens Committee, and the Assembly Human Services Committee concerning activities of the Departments of Human Services (DHS) and Children and Families (DCF) with respect to available mental health services in New Jersey.

The following are some of the statute's key provisions applicable to the Commissioners of Human Services and Children and Families:

A. Establish a mechanism through which an inventory of all county-based public and private inpatient, outpatient, and residential behavioral health services is made available to the public;

B. Establish and implement a methodology, based on nationally recognized criteria, to quantify the usage of and need for inpatient, outpatient, and residential behavioral health services throughout the State, taking into account projected patient care level needs;

C. Annually assess whether sufficient inpatient, outpatient, and residential behavioral health services are available in each service area of the State in order to ensure timely access to appropriate behavioral health services for people who are voluntarily admitted or involuntarily committed to inpatient facilities for individuals with mental illness in the State, and for people who need behavioral health services provided by outpatient and community-based programs that support the wellness and recovery for these persons;

D. Annually identify the funding for existing mental health programs;

E. Consult with the Community Mental Health Citizens Advisory Board and the Mental Health Planning Council, the Division of Developmental Disabilities of the DHS, the Department of Corrections, the Department of Health, and family consumer and other mental health constituent groups, to review the inventories and make

recommendations to the DHS and DCF regarding overall mental health services development and resource needs;

F. Consult with the New Jersey Hospital Association, the Hospital Alliance of New Jersey, and the New Jersey Council of Teaching Hospitals in carrying out the purposes of this act. The commissioners also shall seek input from Statewide organizations that advocate for persons with mental illness and their families; and

G. Annually report on departmental activities in accordance with this act to the Governor and to the Senate Health, Human Services and Senior Citizens Committee and the Assembly Human Services Committee, or their successor committees. The first report shall be provided no later than 18 months after the effective date of this act.

A. Inventory of Behavioral Health Services

A mechanism has been developed to inventory all public and private behavioral health services in New Jersey. Several approaches are utilized which are described below.

Mental Health.

An inventory of all New Jersey licensed mental health treatment providers has been prepared which lists every agency with all its sites, license numbers, address, type of service (e.g., inpatient, outpatient, residential, etc.) by county and bed capacity for residential programs. This information was derived from several sources in order to ensure the completeness of this inventory. The DHS Licensing Information System (LIS) was utilized. In addition, the Division of Mental Health and Addiction Services (DMHAS) Contracts Database was useful, especially for programs not licensed by DHS. It is noteworthy that information from the contracts database is available in the form of a Mental Health Services Treatment Directory. This is available on the DMHAS website at http://www.state.nj.us/humanservices/dmhs/news/publications/mhs/index.html. DMHAS also utilized the Quarterly Contracts Monitoring Report (QCMR) as a resource in pulling together the data for this inventory.

The Substance Abuse and Mental Health Services Administration (SAMHSA) hosts a Mental Health Treatment Facility Locator on its website at http://findtreatment.samhsa.gov/ for all mental health programs nationally which can be searched by state.

In addition, the listing of Short Term Care Facilities (STCFs) may be found at http://www.state.nj.us/humanservices/dmhs/news/publications/mhs/directory_by_program.html#19, on the DMHAS website. STCFs are acute care adult psychiatric units. They are located in a general hospital for the short term admission of individuals who meet the legal standards for commitment and require intensive treatment. All admissions to STCF's must be referred through an emergency or designated screening center. STCF's are designated by DMHAS to serve a specific geographic area, usually a county.

Substance Abuse.

An inventory of all New Jersey licensed substance abuse treatment providers has been prepared; which lists every agency with all its sites, license numbers, address, type of service (e.g., inpatient, outpatient, residential, etc.) by county and bed capacity for residential programs. This information is derived from the DHS LIS. In addition, a searchable Substance Abuse Treatment Directory is available on the DMHAS website at https://njsams.rutgers.edu/dastxdirectory/txdirmain.htm.

SAMHSA hosts a Substance Abuse Treatment Facility Locator on its website at http://findtreatment.samhsa.gov/ for all substance abuse programs nationally which can be searched by state.

The DMHAS also participates in an annual survey, conducted by Mathematica, known as the National Survey of Substance Abuse Treatment Services (N-SSATS), and a Directory of Drug and Alcohol Abuse Treatment Programs is published annually using information from the survey.

An inventory of all funded substance abuse prevention programs also has been prepared by DMHAS and is available on the internet at http://www.state.nj.us/humanservices/das/prevention/provider/Prevention_Dir_2013.pdf.

Children's System of Care.

DCF's Children's System of Care, or DCF CSOC (formerly the Division of Child Behavioral Health Services), serves children and adolescents with emotional and behavioral health care challenges and their families; and children with developmental and intellectual disabilities and their families. CSOC is committed to providing services based on the needs of the child and family in a family-centered, community-based environment. The DCF CSOC offers a statewide continuum of care, which includes case management, a mobile response service, community-based services (e.g. outpatient and in home therapy), as well as a range of residential services of varying intensities. Effective July 1, 2013, the DCF CSOC also assumed oversight from the DHS' DMHAS of 15 substance abuse treatment programs for adolescents ages 13 to 18.

Services available through the DCF CSOC are authorized without regard to income, private health insurance or eligibility for Medicaid/NJ FamilyCare or other health benefits programs. Families with private insurance, or other means, may choose to access services outside of the public system. For more information about the DCF CSOC, visit http://www.state.nj.us/dcf/about/divisions/dcsc/.

The single portal for access to all services available through the DCF CSOC is PerformCare, the Administrative Service Organization (ASO) for the children's system. For more information about the services available through the DCF CSOC, please contact PerformCare at 877-652-7624 or visit http://www.performcarenj.org/.

Child Substance Abuse.

The array of substance abuse services available through the DCF CSOC includes outpatient, intensive outpatient, partial care, short-term residential, and long-term residential. The list of the 15 programs available through the DCF CSOC may be found on the website of the ASO for the children's system, at http://www.performcarenj.org/pdf/provider/substance/substance-use-provider-list.pdf.

The number of substance abuse treatment programs available through the DCF CSOC is expected to increase in 2014 with the transition of the South Jersey Initiative (SJI) from the DHS' DMHAS to the DCF's CSOC. The SJI is a treatment funding stream available for adolescents with substance abuse addictions from Atlantic, Burlington, Camden, Cumberland, Gloucester, Cape May, Ocean, and Salem counties. The SJI provides a continuum of care that includes methadone maintenance, detoxification, residential, halfway house, and outpatient treatment services.

Child Behavioral Health.

Information on children's mental health services can be obtained through the New Jersey DCF website at http://www.state.nj.us/dcf/families/csc/. An inventory of the DCF CSOC in-state Out-of-Home Behavioral Health Programs can be found at http://www.performcarenj.org/families/find-prov.aspx. The types of Out-of-Home or residential programs includes Treatment Homes (TH), Group Homes (GH), Residential Treatment Centers (RTC), Specialty Programs (SPEC), Psychiatric Community Homes (PCH), Detention Alternative Programs (DAP), and Medical Needs Programs (Pregnancy/Diabetes). The programs listed only are accessible through the DCF CSOC. The inventory includes the address, gender, age range and capacity for each program.

PerformCare, the ASO for the children's system, also maintains a listing of children's Medicaid enrolled outpatient providers by county at the following website: http://www.performcarenj.org/families/find-prov.aspx. Currently, these programs are accessed by directly contacting individual providers.

B. Methodology to Estimate Behavioral Health Services Need

Substance Abuse.

As a participant in the SAMHSA, CSAT-sponsored "State Treatment Needs Assessment Program" from 1993 through 2006, the former Division of Addiction Services (DAS) developed its capacity to employ a variety of scientifically-valid methods for estimating substance abuse treatment needs. Primary among these are 1) surveys, 2) social indicator analysis, and 3) "synthetic" statistical estimation techniques, called modeling.

In 1993, DAS established a periodic telephone household survey of drug use and health and a periodic survey of middle school students. Originally, the household survey supported statewide needs assessments with a sample of 3,336 completed interviews of residents 18

years of age or older. By 2003, DAS expanded the household survey sample size to its current standard sampling plan of 700 household interviews per county. The latest survey was conducted in 2009 and plans are underway for a 2014-2015 survey. The household survey yields sample proportions that are applied to the New Jersey or county adult population to obtain estimates of alcohol treatment need and illicit drug use at both the state and county levels. In addition, every three years since 1999, DMHAS conducts a statewide survey of middle school students that measures prevalence of student use of alcohol and illicit drugs as well as student perceptions of risk and protective factors for substance abuse operative in their lives.

Since the household survey underestimates drug treatment need, a statistical technique known as the two-sample capture-recapture model, is applied to treatment admissions data to estimate drug treatment need at both the state and county levels. The admissions data for the model are obtained from the web-based New Jersey Substance Abuse Monitoring System (NJ-SAMS), DMHAS' real-time, administrative, client information system for substance abuse treatment. Together with the estimated alcohol treatment need obtained from the household survey, DMHAS produces an annual estimate of treatment need that is used in the distribution of all alcohol and drug abuse treatment funds. Table 1 below presents the 2010 estimates of substance abuse treatment need for the state and each county.

Table 1

Estimated Statewide Alcohol and Drug Treatment Need by County, 2010					
New Jersey Counties	Treatment Need in 2010				
	Adult Population 2010 [1]	Alcohol Treatment [2]	Drug Treatment [3]	Total	Percent [4]
Atlantic	206,375	23,279	19,482	42,761	20.7
Bergen	698,967	62,907	25,542	88,449	12.7
Burlington	343,687	23,646	15,840	39,486	11.5
Camden	389,697	30,396	29,339	59,735	15.3
Cape May	76,794	6,666	8,157	14,823	19.3
Cumberland	118,529	10,561	10,909	21,470	18.1
Essex	575,083	44,741	36,587	81,328	14.1
Gloucester	221,381	20,522	15,600	36,122	16.3
Hudson	465,081	29,207	22,451	51,658	11.1
Hunterdon	99,682	9,679	9,372	19,051	19.1
Mercer	281,197	37,174	14,158	51,332	18.3
Middlesex	606,778	40,593	26,018	66,611	11
Monmouth	490,431	60,470	37,138	97,608	19.9
Morris	372,340	43,824	14,352	58,176	15.6
Ocean	437,322	38,266	28,175	66,441	15.2
Passaic	364,055	20,860	17,501	38,361	10.5
Salem	51,155	4,036	4,161	8,197	16
Somerset	244,029	20,620	10,791	31,411	12.9
Sussex	115,167	12,933	8,931	21,864	19
Union	393,528	29,515	19,260	48,775	12.4
Warren	83,801	6,922	6,672	13,594	16.2
Total	**6,635,079**	**576,819**	**380,436**	**957,255**	**14.4**

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

Prepared: May, 2011

[1] Source: Source: U.S. Census Bureau, American Fact Finder (2005-2009 American Community Survey 4/14/2011

[2] Alcohol treatment need is derived from The 2009 New Jersey Household Survey on Drug Use and Health.

[3] Drug treatment need is estimated by applying a two-sample capture-recapture statistical model using the 2008 & 2010 NJSAMS data.

[4] Percent of the adult population in need of treatment in each county is calculated by dividing the total treatment need in each county by the total adult population of each county and multiplied by 100.

In addition to survey data, the DAS research team developed methods for using social indicators to supplement estimates of need obtained through other methods. Because social indicator data are compiled by their primary users and archived for use by others, indicator data are somewhat convenient to obtain, especially when random samples surveys are not feasible to undertake.

One such method of social indicator analysis, the Relative Needs Assessment Scale (RNAS), which was developed by DAS researchers, Mammo & French (1996), using social indicators with known correlations to the incidence and prevalence of substance abuse. The scale calculates an index of risk for each jurisdiction of the same size (county, municipal, zip code, etc.) for which the indicators can be obtained. Because the scale is an interval level of measurement that sums to one, scores are comparable and easily interpreted across jurisdictions.

The RNAS methodology has been used since 2003 to estimate the need for the prevention of alcohol and other drug abuse. It was updated in 2008 and utilized to facilitate the evaluation of proposals submitted to DAS as part of the state's Substance Abuse Prevention and Treatment Block Grant (SAPT BG) funded prevention RFP. In the current county comprehensive planning process for 2014 to 2017, the RNAS model, updated to include data from the 2010 U.S. Census, will be used to identify areas within counties with potentially high concentrations of people with substance abuse prevention, treatment and recovery support service needs.

Mental Health.

The aforementioned planned 2014-2015 New Jersey Household Survey of Drug Use and Health will include a new section of validated questions from the federal behavioral risk factor surveys with which to estimate mental health treatment needs throughout the New Jersey and county adult populations. In its place, meanwhile, a mental health version of the RNAS has been developed using correlates of mental health disorders with known predictive power to estimate state and county mental health treatment needs.

A key assumption in the use of the RNAS to estimate the prevalence of mental health treatment need is that the population at risk of mental illness can be estimated by using demographic data from the U.S. Census and other data like rates of suicides, divorce, or crime, found in other publically provided data bases. This assumption was evaluated by Cagle in 1984 who suggested that a small set of carefully chosen indicators can serve the purpose of estimating mental health treatment need. Cagle's purpose was to assess need for acute psychiatric services in New York State. The epidemiological evidence was grouped into three categories: socioeconomic status, marital status and other social factors.

DMHAS conducted its own review of recent epidemiological literature to determine the strongest social correlates of mental illness while retaining Cagle's original classifications. The social indicators and their definitions that were used to produce a mental health treatment needs assessment in New Jersey are presented in Table 2 and are partially based on Cagle's work. Table 3 presents the mental health treatment need by county. DMHAS seeks to refine

the RNAS model for both substance abuse and mental health so that indices may be calculated by level of care, e.g., inpatient, outpatient and residential services. However, this would require validated social correlates of the full range of levels of care in each system and these have not yet been identified.

Table 2

Definition of Social Indicators Used in the RNAS Model to Calculate

Mental Health Risk Index for New Jersey Counties

Low socioeconomic status	
• Poverty [A]	Poor families below the poverty level
• No high school education [B]	Number of people age 25 years & over, with no high school diploma, 2010
Marital status	
• Divorced families [B]	Adults 15 and over in 2010 who were separated or divorced.
• Female householder [B]	Female householder, no husband present with own children less than 18 years, 2010.
• Living alone, 2010 [B]	Nonfamily householder living alone, 2010.
Environmental and Other Social Factors	
• Unemployment [B]	Population 16 and over unemployed in 2010
• Housing tenure [B]	Ratio of occupied housing which are renter occupied, 2010
• Population density [A]	County population per square mile, 2010
• Suicide [C]	Death with suicide as underlying cause. Suicide is defined as death resulting from the intentional use of force against oneself.

Source:
A U.S. Census Bureau, Quick Facts, 2006-2011.
B U.S. Census Bureau, 2010 Census
C New Jersey Death Certificate Database, Bureau Vital Statistics and Registration, NJ-DHSS, (http://nj.gov/health/shad)

The DMHAS will explore further needs assessment methodology that will enable the DMHAS to refine our mental health need assessment by level of care, e.g., inpatient, outpatient and residential services. The Publicly funded behavioral health system in New Jersey currently is undergoing a significant change, specifically due to the Center for Medicaid and Medicare's October 1, 2013 approval of the 1115 Comprehensive Medicaid Waiver application submitted by the State. As a result the State will be able to braid non-Medicaid funding streams with Medicaid funds to develop a more integrated system of care. Introducing managed care

technologies through contracting with an administrative services organization (ASO) has been associated with improved access, better monitoring of quality outcomes, and enhanced distribution of services across the entire care continuum[1]" based on utilization and demonstrated need. The DHS will be securing a contract with an ASO to manage the continuum of behavioral health services in fiscal year 2015.

Also, Cagle's review of the research suggested that there may not be much difference in correlations between social indicators and the need for long term- vs. acute-care services. Cagle pointed out that the New York Office of Mental Health policy is that patients should be treated in the least restrictive setting and that focus on acute psychiatric beds could be shortsighted.

Table 3
Relative Need Assessment Scale By County

County	Index	Percent
Atlantic	0.031	3.1
Bergen	0.103	10.3
Burlington	0.051	5.1
Camden	0.058	5.8
Cape May	0.011	1.1
Cumberland	0.018	1.8
Essex	0.089	8.9
Gloucester	0.033	3.3
Hudson	0.072	7.2
Hunterdon	0.015	1.5
Mercer	0.042	4.2
Middlesex	0.092	9.2
Monmouth	0.072	7.2
Morris	0.056	5.6
Ocean	0.066	6.6
Passaic	0.057	5.7
Salem	0.008	0.8
Somerset	0.037	3.7
Sussex	0.017	1.7
Union	0.061	6.1
Warren	0.012	1.2
TOTAL OF INDEX =	**1.0**	**100.0**

Child Behavioral Health.

[1] http://www.state.nj.us/humanservices/dmahs/home/NJ_1115_Demonstration_Comprehensive_Waiver_9-9-11.pdf

DCF and its system partners employ several methodologies to quantify the usage of and need for inpatient, outpatient, and residential behavioral health services throughout the State, including 1) needs assessments and 2) analysis of utilization management data.

The County Interagency Coordinating Councils (CIACCs) are key components of the needs assessment process. Established by statute[2], CIACCs are county-based planning and advisory groups composed of individuals from government and private agencies that advise counties and DCF regarding children, youth and young adults with serious emotional and behavioral health challenges. The mission of the CIACCs includes working in collaboration with DCF to create a seamless array of services. CIACCs also serve as the counties' mechanism to advise DCF on the development and maintenance of a responsive, accessible, and integrated system of care for youth and their families, through the involvement of parents, children, youth and young adults, child-serving agencies, and community representatives. Through enhanced coordination of system partners, CIACCs also identify service and resource gaps, and priorities for resource development.

In order to fulfill these duties, CIACCs are charged with conducting an annual County Needs Assessment (CNA). The CNA process, which is prescribed by DCF policy, involves a variety of activities including interviews with community leaders and others affiliated with organizations or agencies, public forums, focus groups, surveys, data analysis, and asset mapping. The results of the needs assessments are provided to the DCF CSOC to help inform resource decision-making and allocation at both the state and county level. Using the needs assessments as a guide, the DCF CSOC may allocate funds to establish a statewide service or services targeted to specific counties. Each year, DCF also makes community development funds available to the CIACCs in order to assist counties with procuring outpatient or other services designed to meet mental health needs within a particular county[3].

Since the DCF, the CIACCs, and other partners within the children's system still are in the adjustment period regarding the transition of services for youth with developmental disabilities and services for youth with substance addictions from DHS, DCF did not require CIACCs to conduct needs assessments in 2013. However, DCF still receives input from counties concerning their needs. Separate from the needs assessments conducted by the CIACCs, each year DCF is provided Needs Assessments conducted by the County Human Services Advisory Councils in several counties. They are so comprehensive, that these needs assessments often are conducted in lieu of a separate CIACC Needs Assessment. As with the CIACC needs assessments, the statutorily mandated needs assessments conducted by the County Human Services Advisory Councils are used by DCF for planning purposes. Moving forward, it is hoped that DCF and DHS can work even more closely in the needs assessment process in order to

[2] N.J.S.A. 30:4C-66 et seq.

[3] CIACCs are required to follow the Request for Proposal (RFP) procedure utilized by county government in order to receive Community Development funds.

make the process more standardized and more efficient for both the departments and the counties.

As noted in last year's report, the Comprehensive Medicaid Waiver calls for the ASO contracted with the children's system to assume responsibility for utilization management of inpatient and outpatient programs. It is expected that it will begin providing utilization management of inpatient and outpatient programs in 2014. Once that occurs, it will be possible to quantify the usage of and the need for inpatient and outpatient services using the CSOC's comprehensive management information system, thereby enabling the DCF CSOC to plan accordingly.

To quantify the usage of and the need for residential services in the children's system, the DCF CSOC utilizes an electronic bed-tracking system jointly developed with the ASO for the children's system. The electronic bed-tracking system, which is part of the DCF CSOC's comprehensive management information system, allows DCF CSOC staff to monitor utilization of DCF-contracted residential programs in real-time. The data generated by the bed-tracking system (utilization rates and admission wait times) enables the DCF CSOC to identify where there is unmet need for specific types of residential services. When the need for a particular type of service is identified, that information is communicated to senior DCF staff with authority to authorize the issuance of a Request for Proposals (RFP) to meet the need. This process enables the DCF CSOC to stand up new residential programs at any time throughout the year, depending upon the availability of resources.

C. Annual Assessment

With the establishment of a needs assessment methodology for mental health and the development of the inventories, it will be possible to annually assess the need for and availability of mental health services.

Two critical areas of need identified within the children's system in 2013 include services to combat Human Trafficking and services to counter the trauma related to Superstorm Sandy.

D. Annual Funding for Existing Mental Health Programs

DMHAS

The appropriations that the DMHAS received for fiscal year 2014 are reflected in Table 4 below.

Table 4

DMHAS FISCAL SUMMARY FY 2014
(State, Fed & Other $)
(Amounts in Thousands - $000's)

Category	FY 2014
Direct State Services:	
State Psychiatric Hospitals	$ 320,088
DMHAS Admin. (Includes Fed. Grants)	$ 17,251
Total Direct State Services	$ 337,339
Grants-In-Aid:	
MH Community Care	$ 264,975
MH Olmstead	$ 88,817
MH Block and PATH Grant & Other	$ 15,008
SA Community Services	$ 34,861
SA Block Grant & Other Federal	$ 42,361
SA Dedicated Funds & Other	$ 12,994
MH Dedicated Fund	$ 400
	$ 459,416
Rutgers / UBHC Line-Items:	
Rutgers, UBHC- CMHC Newark	$ 6,165
Rutgers, UBHC-CMHC Piscataway	$ 11,780
Subtotal Rutgers, UBHC	$ 17,945
Total Grants-In-Aid	$ 477,361
State Aid - County Psychiatric Hospitals	$ 130,165
Federal DSH (Disproportionate Share Hospital) to Supplement Hospitals	$ 53,000
GRAND TOTAL DMHAS *(State, Fed & Other)*	$ 944,865

Children's System of Care

For State Fiscal Year 2014, funding directly appropriated to the DCF CSOC from State and Federal sources, and the funds contributed by Juvenile Justice Commission for the provision of behavioral services across all service lines totaled $ 417,827,000. See Table 5.

Table 5

Sources of Funding for Children's Behavioral Health Services[4]

Grants in Aid	$239,017,000
Title XIX (Federal)	$140,431,000
Title XXI (State and Federal)	$ 29,904,000
Juvenile Justice Commission	$ 573,000
Substance Abuse Block Grant (Federal)	$ 7,902,000
	$417,827,000

Table 6 lists the allocation of funds for children's behavioral health services by type for State Fiscal Year 2013. Residential programs range from high-intensity hospital-based psychiatric services to low-intensity services like Treatment Homes[5]. Behavioral Assistance and Intensive In-Community therapy are short-term, home-based intensive treatments. Youth Incentive Programs represent CIACC community development funds.

Table 6

Allocation of funds for Children's Behavioral Health Services by Service Type

Residential	$223,537,000
Care Management Organizations	$ 69,278,000
Family Support Organizations	$ 10,864,000
Mobile Response & Stabilization Services	$ 23,330,000
Behavioral Assistance/Intensive In-Community therapy	$49,553,000
Youth Incentive Programs	$ 3,709,000
Outpatient	$11,842,000

[4] Funds appropriated for developmental disability services are not included. Funds for the administrative funding for Family Support Organizations and the Contracted Systems Administrator are included as they support the system of care.

[5] Please see the attached document entitled, *Descriptions of CSOC Residential Programs by Intensity of Service (IOS)* for more information on residential services available through the DCF CSOC.

Substance Abuse	$12,162,000
Contracted System Administrator (ASO)	$13,552,000
	$417,827,000

E. Consultation with Community Mental Health Citizens Advisory Board and the Mental Health Planning Council

The Community Mental Health Citizens Advisory Board (Board) and the Mental Health Planning Council (Planning Council) meet monthly as a joint advisory body with the DMHAS and DCF. Members of the Board are appointed by the Governor of New Jersey and Planning Council members are appointed by the Assistant Commissioner of DMHAS. The Advisory Board and the Planning Council function together as the New Jersey Mental Health Planning Council. A federally mandated minimum of 50% of the members of the Planning Council are mental health consumers, family members of adults with serious mental illnesses (SMI), or family members of children with severe emotional disturbances (SED).

The role of the Board is to serve as advocate and advisor to the DHS for the development of effective mental health services in the community. The Board consists of: eight citizens of the State who, as consumers, have demonstrated an interest in the delivery of mental health services; one person recommended by the Board of Chosen Freeholders, one person recommended by the League of Municipalities; two from providers of mental health services and one person recommended by the chairpersons of the standing Assembly and Senate committees on Human Services, and two persons recommended by the State Board of Human Services from among persons currently serving as members of the Board of Trustees of the State psychiatric hospitals. Membership on the Planning Council includes citizens of the State who, as consumers, have demonstrated an interest in the delivery of mental health services, providers of children's and adult mental health services, advocacy organizations and New Jersey State Agencies. The entities identified in N.J.S.A. 30:4-177.63 (e) required to "review the inventory and make recommendations to the Departments of Human Services and Children and Families" are members of the Board and Planning Council.

In response to the merger of the State Mental Health Authority (SMHA) and the Single State Authority on substance abuse (SSA), as well as recommendations from the Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Mental Health Services and Center for Substance Abuse Treatment, the Planning Council has worked to broaden the membership to include more individuals in addiction recovery and with co-occurring disorders. The membership includes individuals in recovery from co-occurring disorders, providers that offer mental health and addiction services, a substance abuse prevention and intervention, tobacco treatment and training and wellness program provider, and a representative from the County Drug and Alcohol Association. In addition, a member of the SSA's Citizen's Advisory Council (CAC), which consists of consumers of addiction services as well as individuals in substance abuse recovery and family members, is an active member of the Planning Council. A

notice of the call for new members in addiction recovery is available online (http://www.state.nj.us/humanservices/dmhs/boards/planning_council.html) and continues to be circulated among addiction providers and consumer agencies to generate additional members.

The Planning Council serves in an advisory capacity to the DMHAS and is charged with the responsibility of advocating for adults with serious mental illness and children with severe emotional disturbances for community mental health services throughout the State. The role of the Planning Council is to fulfill a federal mandate to review State plans and submit any recommended modifications to the Community Mental Health Block Grant and participate in the planning for this application. Planning Council members monitor, review, and evaluate periodically the allocation and adequacy of mental health services through presentations of various State agencies and consumer groups. In addition, the Planning Council also has been reviewing the Substance Abuse Prevention and Treatment Block Grant since the applications have been merged.

Some highlights of the work of the Planning Council in SFY 2013 include: participation in the CMHS Mental Health System Review, the ASO/MBHO Stakeholder Steering Committee meetings and rate setting process; providing feedback to DMHAS on a draft SMI (Serious Mental Illness) definition; reviewing and providing feedback on the combined Block Grant applications and usage of the additional Mental Health Block Grant funding received for SFY 2013. Additionally, the Planning Council heard presentations on: the status of the Wellness and Recovery Transformation Action Plan implemented from 2008-2010; the Crisis Intervention Team (CIT) program; State Family Support Plan services; Olmstead activities; final report on the closure of Hagedorn State Psychiatric Hospital; rollout and implementation of S-COPE (Statewide Clinical Outreach Program for the Elderly); services of the Traumatic Loss Coalition; DMHAS workforce development initiatives and an overview from CSOC concerning youth behavioral health services and the transition of adolescents with substance use disorders into its system.

Additionally, the DHS and/or DMHAS convene ongoing stakeholder meetings with constituency and advocacy groups such as the Mental Health Association of New Jersey, New Jersey Association of Mental Health and Addiction Agencies, New Jersey Psychiatric Rehabilitation Association, Coalition of Mental Health Consumer Organizations, County Mental Health Administrators, County Drug and Alcohol Abuse Directors, National Alliance on Mental Illness – New Jersey, Disability Rights New Jersey, New Jersey Hospital Association, County Hospital Chief Executive Officers and Supportive Housing Association. Further, the DMHAS participates in regular, ongoing meetings with the New Jersey Department of Health, Administrative Office of the Courts, New Jersey Division of Medical Assistance and Health Services and the Division of Developmental Disabilities. The DMHAS is committed to consulting with these constituency and advocacy groups to discuss outcomes of needs assessment and plan development. This is

in addition to the DMHAS' active, monthly participation in county-based system's review meetings, county advisory board meetings and county professional advisory committee meetings. It is in these meetings that local needs and plans are discussed.

DCF is committed to maintaining close, interactive relationships with its system partners. Therefore, DCF staff meets regularly with families, CIACCs, the New Jersey Alliance for Children, New Jersey Association of Mental Health and Addiction Agencies, New Jersey Youth Suicide Prevention Advisory Council, and other advocates and stakeholders. Further, as noted in last year's report, DCF continues to work closely with both DDD and DMHAS since assuming responsibility for providing the services that were formerly provided by the DHS - Division of Developmental Disabilities (DDD) to youth under the age of 21 with developmental disabilities and addiction services formerly provided by DMHAS.

F. Consult with the New Jersey Hospital Association, the Hospital Alliance of New Jersey, the New Jersey Council of Teaching Hospitals, and Statewide organizations that advocate for persons with mental illness and their families

Senior management of the DCF, including the Director of the DCF CSOC, participates in regular meetings with the New Jersey Hospital Association, the Hospital Alliance of New Jersey, and other advocates for persons with mental illness and their families. The Commissioner of the DHS and the Assistant Commissioner of DMHAS, along with senior staff, conduct ongoing meetings with stakeholder leadership groups, trade organizations and consumer/family advocacy groups, inclusive of the New Jersey Hospital Association, to discuss services currently available, service gaps, feedback on services working well and where services can improve to better meet the needs of individuals served.

G. Looking Ahead

The landscape of mental health services for children and adults in New Jersey continues to change and to improve as components of both the Comprehensive Medicaid Waiver and the restructuring of State government move forward.

As noted in last year's report, the Comprehensive Medicaid Waiver will enable the DHS to contract with an ASO to manage behavioral health services for adults across the continuum. The ASO for the adult system will facilitate the integration of behavioral health and primary care services, support community alternatives to institutional placement through the management of service utilization, improve access to appropriate physical and behavioral health care services, provide opportunities to rebalance rates and braid various funding streams to maximize access and improved monitoring of quality outcomes. The ASO will be

able to provide utilization data and information regarding service needs to the DMHAS, supporting improved data-driven decision-making regarding funding and resource needs.

Likewise, as a result of the Governor's transition of primary responsibility for serving children with developmental and intellectual disabilities and substance abuse challenges to the DCF CSOC, DCF continues to make improvements to the children's system. In 2013, based on the identified demand, the DCF CSOC brought online 5 new psychiatric community home programs for girls and young women and 1 new psychiatric community home that serves boys and girls. As of October 2013, DCF has several pending RFPs including one for a 10 bed residential program for youth rescued from Human Trafficking; and one for up to six, five bed Residential Treatment Centers.

In addition, in conjunction with the CIACCs in the 10 counties (Atlantic, Bergen, Cape May, Cumberland, Essex, Hudson, Middlesex, Ocean, Monmouth, and Union Counties) identified as most impacted by Superstorm Sandy, DCF CSOC is embarking on an initiative to prevent the onset and reduce the progression of substance abuse, including underage drinking. The initiative will enable CIACCs to employ one or a combination of the following strategies, 1) an evidenced based practice model for substance abuse prevention; 2) build upon existing capacity and infrastructure for substance abuse prevention related activities; and/or 3) provide substance abuse prevention education to schools, mental health professionals and community members. DCF has two other pending RFPs related to Superstorm Sandy. More will be issued in the coming months.

Similarly, behavioral health services for adults will be expanded for individuals who were impacted by Sandy and who resided in one of the following 10 counties (Atlantic, Bergen, Cape May, Essex, Hudson, Middlesex, Ocean, Monmouth and Union). These services are being made available through funding from the US Department of Health and Human Services, Administration for Children and Families. The specific funding mechanism is the Social Services Block Grant (SSBG). This funding stream is time limited to support the disaster recovery efforts related to Superstorm Sandy. The DHS' DMHAS will administer the following programs/services: detoxification and short term residential treatment services for individuals with a substance use disorder, outpatient services (for individuals with a substance use disorder and/or mental illness), supportive housing with support services (for individuals with a substance use disorder and/or mental illness), career services (supportive employment and supported education for individuals in supportive housing through this initiative), Early Intervention Support Services (for individuals with a mental illness and/or co-occurring mental illness and substance use disorder) and a media campaign, which will inform the public of the services available.

Another important item that is moving forward is the CIACC Education Partnership Initiative. As noted in last year's report, the partnership initiative is a cross-systems training and network-

building program designed to bring together individuals representing education, behavioral health, and other child-serving systems to enhance access to children's behavioral health services and other services including substance abuse treatment and developmental disability services. In the fall of 2013, the program lead for the CIACC Education Partnership Initiative began providing technical assistance to counties looking to establish or strengthen CIACC Education Partnerships.

DHS and DCF will continue to assess the needs of New Jersey families on a regular basis in order to improve the behavioral health system in New Jersey.

Descriptions of CSOC Residential Treatment Programs by Intensity of Service (IOS)

Children's Crisis Intervention Services (CCIS): Psychiatric inpatient hospital services located in community hospitals that provide acute inpatient treatment, stabilization, assessment and short-term intensive treatment.

Intermediate Inpatient Psychiatric Units: Inpatient secure sub-acute psychiatric units located in community hospitals that provide Children's Crisis Intervention Services (CCIS). These units serve youth who require additional inpatient treatment following stabilization in a CCIS.

Intensive Residential Treatment Services (IRTS): Inpatient secure treatment services provided to youth with a wide range of serious emotional and behavioral needs who require 24 hour per day care in a safe, secure environment with constant line-of-sight supervision.

Psychiatric Community Homes (PCH): A community residential facility that provides intensive therapeutic services for youth who have had inpatient psychiatric care and/or children who may be at risk of hospitalization or re-hospitalization.

Specialty Bed Programs (SPEC): Programs that provide intensive residential services for children who are presenting with very specific high risk behaviors including fire setting, assaultive behavior, sex offending behavior predatory or non-predatory, and children who have experienced significant trauma from physical, sexual, or emotional abuse.

Residential Treatment Center (RTC): Programs that provide 24 hour per day care and treatment for youth unable to function appropriately in their own homes, schools and communities, and who are also unable to be served appropriately in smaller, less restrictive community-based settings.

Group Home (GH): Group home services provide up to 24 hour per day care and treatment to youth whose needs cannot be met appropriately in their own homes or in foster care, but who do not need the structure and intensiveness of a more restrictive setting.

Treatment Homes (TH): Programs that provide care and supervision by specially trained parent/caregivers in a family-like setting for typically one or two children with behavioral health needs who require a moderately high level of therapeutic intervention.