New Jersey

UNIFORM APPLICATION
FY 2024/2025 Combined MHBGSUPTRS BG
ApplicationBehavioral Health Assessment and Plan

SUBSTANCE ABUSE PREVENTION AND TREATMENT
and
COMMUNITY MENTAL HEALTH SERVICES
BLOCK GRANT

OMB - Approved 04/19/2021 - Expires 04/30/2024
(generated on 01/30/2024 3.24.32 PM)

Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

and

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

State Information

State Information

Plan Year

Start Year	2024
End Year	2025

State SAPT Unique Entity Identification

Unique Entity ID	MLGMLZ76EMC3

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

Agency Name	Division of Mental Health and Addiction Services
Organizational Unit	Office of Planning, Research, Evaluation, Prevention and Olmstead
Mailing Address	PO Box 362
City	Trenton
Zip Code	08625-0362

II. Contact Person for the SAPT Grantee of the Block Grant

First Name	Valerie
Last Name	Mielke
Agency Name	Division of Mental Health and Addiction Services
Mailing Address	PO Box 362
City	Trenton
Zip Code	08625-0362
Telephone	(609) 438-4352
Fax	(609) 341-2302
Email Address	Valerie.Mielke@dhs.nj.gov

State CMHS Unique Entity Identification

Unique Entity ID	MLGMLZ76EMC3

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

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

II. Contact Person for the CMHS Grantee of the Block Grant

First Name	Valerie
Last Name	Mielke
Agency Name	New Jersey Division of Mental Health and Addiction Services
Mailing Address	5 Commerce Way PO Box 362
City	Hamilton Township

Zip Code 08691-0362

Telephone (609) 438-4352

Fax 609-341-2302

Email Address Valerie.Mielke@dhs.nj.gov

III. Third Party Administrator of Mental Health Services

Do you have a third party administrator? ○ Yes ◉ No

First Name

Last Name

Agency Name

Mailing Address

City

Zip Code

Telephone

Fax

Email Address

IV. State Expenditure Period (Most recent State expenditure period that is closed out)

From

To

V. Date Submitted

Submission Date 9/1/2023 7:28:28 PM

Revision Date 10/31/2023 1:41:58 PM

VI. Contact Person Responsible for Application Submission

First Name Valerie

Last Name Mielke

Telephone (609) 438-4352

Fax

Email Address Valerie.Mielke@dhs.nj.gov

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Substance Use Block Grant Planner: Suzanne Borys, Ed.D., Suzanne.Borys@dhs.nj.gov

National Prevention Network Representative: Donald Hallcom, Ph.D., Donald.Hallcom@dhs.nj.gov

Mental Health Planner: Donna Migliorino, Donna.Migliorino@dhs.nj.gov

Children's Mental Health Planner: Nicholas Pecht, Nicholas.Pecht@dcf.nj.gov

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [SUPTRS]

Fiscal Year 2024

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Substance Abuse Prevention and Treatment Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1921	Formula Grants to States	**42 USC § 300x-21**
Section 1922	Certain Allocations	**42 USC § 300x-22**
Section 1923	Intravenous Substance Abuse	**42 USC § 300x-23**
Section 1924	Requirements Regarding Tuberculosis and Human Immunodeficiency Virus	**42 USC § 300x-24**
Section 1925	Group Homes for Recovering Substance Abusers	**42 USC § 300x-25**
Section 1926	State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18	**42 USC § 300x-26**
Section 1927	Treatment Services for Pregnant Women	**42 USC § 300x-27**
Section 1928	Additional Agreements	**42 USC § 300x-28**
Section 1929	Submission to Secretary of Statewide Assessment of Needs	**42 USC § 300x-29**
Section 1930	Maintenance of Effort Regarding State Expenditures	**42 USC § 300x-30**
Section 1931	Restrictions on Expenditure of Grant	**42 USC § 300x-31**
Section 1932	Application for Grant; Approval of State Plan	**42 USC § 300x-32**
Section 1935	Core Data Set	**42 USC § 300x-35**
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	**42 USC § 300x-51**
Section 1942	Requirement of Reports and Audits by States	**42 USC § 300x-52**

Section 1943	Additional Requirements	**42 USC § 300x-53**
Section 1946	Prohibition Regarding Receipt of Funds	**42 USC § 300x-56**
Section 1947	Nondiscrimination	**42 USC § 300x-57**
Section 1953	Continuation of Certain Programs	**42 USC § 300x-63**
Section 1955	Services Provided by Nongovernmental Organizations	**42 USC § 300x-65**
Section 1956	Services for Individuals with Co-Occurring Disorders	**42 USC § 300x-66**

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions

to State (Clear Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
    a. Checking the Exclusion Extract located on the System for Award Management (SAM) at **http://sam.gov [sam.gov]**
    b. Collecting a certification statement similar to paragraph (a)
    c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work place in accordance with 2 CFR Part 182 by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
    1. The dangers of drug abuse in the workplace;
    2. The grantee's policy of maintaining a drug-free workplace;
    3. Any available drug counseling, rehabilitation, and employee assistance programs; and
    4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
    1. Abide by the terms of the statement; and
    2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
    1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
    2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-construction Programs and other Certifications summarized above.

State: ______________________________

Name of Chief Executive Officer (CEO) or Designee: Valerie L. Mielke, MSW

Signature of CEO or Designee[1]: ______________________________

Title: Assistant Commissioner

Date Signed: ______________________________

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [SUPTRS]

Fiscal Year 2024

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Substance Abuse Prevention and Treatment Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1921	Formula Grants to States	42 USC § 300x-21
Section 1922	Certain Allocations	42 USC § 300x-22
Section 1923	Intravenous Substance Abuse	42 USC § 300x-23
Section 1924	Requirements Regarding Tuberculosis and Human Immunodeficiency Virus	42 USC § 300x-24
Section 1925	Group Homes for Recovering Substance Abusers	42 USC § 300x-25
Section 1926	State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18	42 USC § 300x-26
Section 1927	Treatment Services for Pregnant Women	42 USC § 300x-27
Section 1928	Additional Agreements	42 USC § 300x-28
Section 1929	Submission to Secretary of Statewide Assessment of Needs	42 USC § 300x-29
Section 1930	Maintenance of Effort Regarding State Expenditures	42 USC § 300x-30
Section 1931	Restrictions on Expenditure of Grant	42 USC § 300x-31
Section 1932	Application for Grant; Approval of State Plan	42 USC § 300x-32
Section 1935	Core Data Set	42 USC § 300x-35
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52

Section 1943	Additional Requirements	42 USC § 300x-53
Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions

to State (Clear Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
   a. Checking the Exclusion Extract located on the System for Award Management (SAM) at **http://sam.gov [sam.gov]**
   b. Collecting a certification statement similar to paragraph (a)
   c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work place in accordance with 2 CFR Part 182 by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-construction Programs and other Certifications summarized above.

State: New Jersey

Name of Chief Executive Officer (CEO) or Designee. Valerie L. Mielke, MSW

Signature of CEO or Designee[1].

Title: Assistant Commissioner

Date Signed: 7/11/23

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved. 04/19/2021 Expires: 04/30/2024

Footnotes:

State of New Jersey
OFFICE OF THE GOVERNOR
P.O. BOX 001
TRENTON, NJ 08625-0001

PHILIP D. MURPHY
Governor

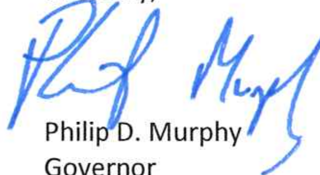
December 19, 2018

Elinore F. McCance-Katz, M.D., Ph.D.
Assistant Secretary for Mental Health and Substance Use
Substance Abuse and Mental Health Services Administration
5600 Fishers Lane, Suite 18E41
Rockville, MD 20857

Dear Dr. McCance-Katz:

As the Governor of the State of New Jersey, for the duration of my tenure, I delegate signatory authority to the Assistant Commissioner for the Division of Mental Health and Addiction Services (DMHAS) within the New Jersey Department of Human Services (DHS), for all the transactions required to administer the Substance Abuse and Mental Health Services Administration (SAMHSA) Substance Abuse Prevention and Treatment (SAPT) Block Grant, Mental Health Block Grant (MHBG) and Projects for Assistance in Transition from Homelessness (PATH) grant.

Sincerely,



Philip D. Murphy
Governor

c: Deepa Avula, SAMHSA
Carole Johnson, Commissioner, DHS
Valerie Mielke, Assistant Commissioner, DMHAS

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [MH]

Fiscal Year 2024

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Community Mental Health Services Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1911	Formula Grants to States	**42 USC § 300x**
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	**42 USC § 300x-1**
Section 1913	Certain Agreements	**42 USC § 300x-2**
Section 1914	State Mental Health Planning Council	**42 USC § 300x-3**
Section 1915	Additional Provisions	**42 USC § 300x-4**
Section 1916	Restrictions on Use of Payments	**42 USC § 300x-5**
Section 1917	Application for Grant	**42 USC § 300x-6**
Section 1920	Early Serious Mental Illness	**42 USC § 300x-9**
Section 1920	Crisis Services	**42 USC § 300x-9**
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	**42 USC § 300x-51**
Section 1942	Requirement of Reports and Audits by States	**42 USC § 300x-52**
Section 1943	Additional Requirements	**42 USC § 300x-53**
Section 1946	Prohibition Regarding Receipt of Funds	**42 USC § 300x-56**
Section 1947	Nondiscrimination	**42 USC § 300x-57**
Section 1953	Continuation of Certain Programs	**42 USC § 300x-63**

Section 1955	Services Provided by Nongovernmental Organizations	**42 USC § 300x-65**
Section 1956	Services for Individuals with Co-Occurring Disorders	**42 USC § 300x-66**

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to

State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
    a. Checking the Exclusion Extract located on the System for Award Management (SAM) at **http://sam.gov [sam.gov]**
    b. Collecting a certification statement similar to paragraph (a)
    c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 2 CFR Part 182by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
    1. The dangers of drug abuse in the workplace;
    2. The grantee's policy of maintaining a drug-free workplace;
    3. Any available drug counseling, rehabilitation, and employee assistance programs; and
    4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
    1. Abide by the terms of the statement; and
    2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
    1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
    2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Valerie L. Mielke, MSW

Signature of CEO or Designee[1]: ______________________

Title: Assistant Commissioner

Date Signed: ______________________

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Please upload your state's Bipartisan Safer Communities Act (BSCA) – 2nd allotment proposal to here in addition to other documents. You may also upload it in the attachments section of this application.

Based on the guidance issued on October 11th, 2022, please submit a proposal that includes a narrative describing how the funds will be used to help individuals with SMI/SED, along with a budget for the total amount of the second allotment. The proposal should also explain any new projects planned with the second allotment and describe ongoing projects that will continue with the second allotment. The performance period for the second allotment is from September 30th, 2023, to September 29th, 2025, and the proposal should be titled "BSCA Funding Plan 2024. The proposed plans are due to SAMHSA by September 1, 2023.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [MH]

Fiscal Year 2024

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Community Mental Health Services Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1911	Formula Grants to States	42 USC § 300x
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	42 USC § 300x-1
Section 1913	Certain Agreements	42 USC § 300x-2
Section 1914	State Mental Health Planning Council	42 USC § 300x-3
Section 1915	Additional Provisions	42 USC § 300x-4
Section 1916	Restrictions on Use of Payments	42 USC § 300x-5
Section 1917	Application for Grant	42 USC § 300x-6
Section 1920	Early Serious Mental Illness	42 USC § 300x-9
Section 1920	Crisis Services	42 USC § 300x-9
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53
Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63

Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3 Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to

State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
    a. Checking the Exclusion Extract located on the System for Award Management (SAM) at **http://sam.gov [sam.gov]**
    b. Collecting a certification statement similar to paragraph (a)
    c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 2 CFR Part 182by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
    1. The dangers of drug abuse in the workplace;
    2. The grantee's policy of maintaining a drug-free workplace;
    3. Any available drug counseling, rehabilitation, and employee assistance programs; and
    4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
    1. Abide by the terms of the statement; and
    2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
    1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
    2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Valerie L. Mielke, MSW

Signature of CEO or Designee[1]:

Title: Assistant Commissioner

Date Signed: 7/11/23

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Please upload your state's Bipartisan Safer Communities Act (BSCA) – 2nd allotment proposal to here in addition to other documents. You may also upload it in the attachments section of this application.

Based on the guidance issued on October 11th, 2022, please submit a proposal that includes a narrative describing how the funds will be used to help individuals with SMI/SED, along with a budget for the total amount of the second allotment. The proposal should also explain any new projects planned with the second allotment and describe ongoing projects that will continue with the second allotment. The performance period for the second allotment is from September 30th, 2023, to September 29th, 2025, and the proposal should be titled "BSCA Funding Plan 2024. The proposed plans are due to SAMHSA by September 1, 2023.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

State of New Jersey

OFFICE OF THE GOVERNOR
P.O. BOX 001
TRENTON, NJ 08625-0001

PHILIP D. MURPHY
Governor

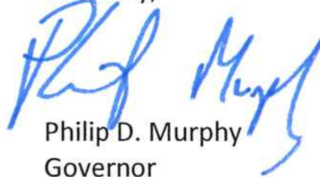
December 19, 2018

Elinore F. McCance-Katz, M.D., Ph.D.
Assistant Secretary for Mental Health and Substance Use
Substance Abuse and Mental Health Services Administration
5600 Fishers Lane, Suite 18E41
Rockville, MD 20857

Dear Dr. McCance-Katz:

As the Governor of the State of New Jersey, for the duration of my tenure, I delegate signatory authority to the Assistant Commissioner for the Division of Mental Health and Addiction Services (DMHAS) within the New Jersey Department of Human Services (DHS), for all the transactions required to administer the Substance Abuse and Mental Health Services Administration (SAMHSA) Substance Abuse Prevention and Treatment (SAPT) Block Grant, Mental Health Block Grant (MHBG) and Projects for Assistance in Transition from Homelessness (PATH) grant.

Sincerely,



Philip D. Murphy
Governor

c: Deepa Avula, SAMHSA
Carole Johnson, Commissioner, DHS
Valerie Mielke, Assistant Commissioner, DMHAS

New Jersey Division of Mental Health and Addiction Services
Mental Health Block Grant Supplemental Funding
Bipartisan Safer Communities Act (BSCA) Narrative and Budget
Budget Period II: 9/30/2023-9/29/2025

Revised & Submitted August 30, 2023

New Jersey's Department of Human Services (NJ DHS) houses the Division of Mental Health and Addiction Services (DMHAS). Located within DMHAS is a specialized behavioral health-focused unit referred to as the Disaster and Terrorism Branch (DTB), which is responsible for activating the State's behavioral health disaster response plan in coordination with the NJ Office of Emergency Management and the NJ Emergency Social Services Coordinators, during declared disasters. Each county (21 in total) in the State also maintains a county-specific all-hazards behavioral health disaster plan. During times of disaster, the county's plan may also be activated by the County Mental Health Administrator and County Alcoholism and Drug Abuse Directors in coordination with the County Office of Emergency Management and in collaboration with State partners. The DMHAS partners with over 120 contracted community behavioral health provider agencies to provide services to New Jersey residents. Over the past several years and especially since September 11th, training for these behavioral health providers as well as private practitioners, has been consistently provided through federal grant programs. In the past year more than 1,000 people received training through DMHAS-sponsored training programs. The DTB consists of a multi-disciplinary Training and Technical Assistance Group (TTAG), which has the capacity to provide on-demand training for behavioral health professionals in the wake of disaster to further increase the State's capacity to address the psychosocial needs of the community. The services available through the Disaster and Terrorism Branch include but are not limited to:

› Individual crisis counseling
› Psychological First Aid
› Disaster-specific psycho-educational information
› Group crisis counseling
› Consultation and training
› Information and referral services
› Toll-free warm line services

The DTB will use the Bipartisan Safer Communities Act (BSCA) funding to expand its existing behavioral health services continuum in the aftermath of traumatic events that impact the psychological health of New Jersey residents. Outlined below are multiple initiatives that help support this work.

Disaster Response Crisis Counselor

In 2007, DTB began the Disaster Response Crisis Counselor (DRCC) Certification Program. DRCC's are trained and background-checked volunteers who are deployed in a county or Statewide in the immediate aftermath of a community crisis. With the help of BSCA funding,

DTB will increase the numbers and scope of the DRCC program in order to have a more specialized crisis taskforce for specific response types such as mass casualty events, impacting target populations such as rural communities, those with severe mental illness, and those who are deaf and hard of hearing, etc. In order to best communicate with individuals who, have access and functional needs, the support of technology is vital and is an included budget line item. The development of such unique task force teams to deploy to incidents of mass casualties will require coordination with law enforcement, medical examiner offices and healthcare systems. The preparation of DRCC teams to respond to more complex anticipated and no-notice events is a vital part of response efforts.

Disaster response is always local and the DTB has cultivated successful working partnerships with the County Mental Health Administrators and the County Alcoholism and Drug Abuse Directors; they are responsible for planning behavioral health services in their counties. A stipend will be given to each county to fund recruitment, completion of exercise drills, training activities as well as engagement efforts for Disaster Response Crisis Counselors; each county will be awarded up to $15,000 per year. DTB will assist counties with DRCC recruitment efforts and provide deployment kits, and deployment vest and fleece.

The DTB will promote the DRCC program throughout New Jersey through the dissemination of printed materials, electronic newsletter, and podcast or recorded informational pieces of current responses, lessons learned, and emerging trends in the field.

Learning Management System

With BSCA funds, DTB would like to secure a robust learning management system (LMS) in order to ensure consistency and quality of training and messaging. The learning management system would consist of informative video clips, interactive quizzes, pre and post knowledge test that engage and enhance the learning of participants. The target audiences for the LMS are Disaster Response Crisis Counselors, first responders, behavioral health providers, county behavioral health coordinators, emergency managers, non-profit organizations, and the disability, access and functional needs community; trainings will be ADA (Americans with Disabilities Act) compliant. Specifically, funds for training content creation and technical assistance are line items in the budget.

Critical Incident Stress Management

Critical Incident Stress Management (CISM) is a comprehensive, integrative, multicomponent crisis intervention system. CISM is considered comprehensive because it consists of multiple crisis intervention components, which functionally span the entire temporal spectrum of a crisis. CISM interventions range from the pre-crisis phase through the acute crisis phase to the post-crisis phase. CISM is also considered comprehensive in that it consists of interventions which may be applied to individuals, small functional groups, large groups, families, organizations, and even communities. CISM teams have been an important part of the behavioral response for first responders in New Jersey for the past two decades, but attrition has led the teams to fold or be chronically understaffed. DTB proposes coordinating with the remaining CISM teams in New

Jersey to increase training for law enforcement, fire, dispatchers, and EMS to rebuild the CISM Infrastructure.

Traumatic Loss Coalition

The DTB deploys DRCC's to work with all residents of New Jersey. However, when there is an incident primarily impacting youth and young adults, DTB works closely with New Jersey's Traumatic Loss Coalition (TLC). DTB proposes strengthening this partnership through cross-training. For this effort, the plan is to train 250 lead responders in the "Managing Sudden Traumatic Loss" (MSTL) response model. Specifically, the goal is to:

- Build Statewide capacity to respond to youth and young adult-related incidents such as significant incidents of school violence, with 10-15 responders per county
- Offer 5-6 training with an audience of 40-50 people
- Conduct staff training with two co-facilitators/trainers for each offering
- Provide in person or virtual or hybrid training
- Provide manuals to participants

Approximately $5,000 per training (Trainer's fee, manuals, and fees for a venue when required; cost range $25,000 to $30,000 per year). Sustainability would be possible as teams will be located in each county; and can cross-train as DRCC's to also work with the adult population. Volunteers have no ongoing costs for deployment.

BTAM Team Initiative

The NJ BTAM (Behavioral Threat Assessment and Management) Team is a centralized resource focused on the sharing of information and knowledge, and leveraging support of law enforcement and behavioral health professionals for the purpose of threat management. When law enforcement identifies a community threat, the team convenes to provide consultation in reviewing individuals at risk for engaging in violence or other harmful activities, and recommending intervention strategies to manage the risk of harm for individuals who pose a potential safety risk. The team includes representatives from several agencies and organizations including law enforcement, intelligence, education and behavioral health sectors. Each member of the team has advanced training in behavioral threat assessment, and works collaboratively to prevent targeted acts of violence through early identification, consultation, and management of individuals displaying concerning or threatening behavioral indicators. The team's goal is to reduce the number of incidents that occur by creating diversion pathways for at-risk individuals into programs for behavioral health or other services. DTB will play an integral role in the BTAM, a DTB staff person will lead DTB efforts and engagement with the team. The DTB Trainer will engage with the New Jersey Behavioral Health Provider network for a series of trainings to recognize the signs of radicalization, pathways to violence, and how to engage with law enforcement to prevent future episodes of mass violence.

Vulnerable Populations

New Jersey has incredible diversity and DTB will connect with faith-based, LGBTQ+, and other culturally and racially vulnerable populations. DTB will partner with these organizations to

prepare for incidents of mass violence. Areas of training will be recognizing the pathways to violence, responding to active shooters, and Stop the Bleed training. DTB wants to set aside funding for community provider engagement and training; hosting specialized trainings to prepare community behavioral health providers with tools to address the needs of the community and first responders after incidences of mass violence.

FAC's and Reunification Exercises

The DTB works in coordination with the NJ Department of Human Services' Office of Emergency Management (OEM) in planning for the aftermath of a mass casualty event. We propose using this grant to conduct regional exercises for Reunification and Family Assistance Centers. The increase in mass fatality incidents in the past decade – natural, man-made, and intentional – underscores the need for communities to be able to provide specialized behavioral health support to the families directly affected by these tragic incidents. In the aftermath of a mass casualty event, a Family Reunification Center (FRC) will be operational to facilitate the reunification of those affected by the event with their family members. Reunification is the process of reuniting friends and family members who have been physically separated as a result of an incident. After a crisis event, such as an active shooter, the FRC is the gathering place where family reunification can occur.

The FRC may run in concert with Family Assistance Centers (FAC). The FAC is established to provide an array of support services to those impacted by the event. There are many services provided at a FAC. Some require or benefit from behavioral health support. Here is a list of some services provided at a FAC:

- Family Briefings
- Antemortem Data Collection (to assist in identifying victims)
- Death Notifications
- Call Center/Hotline
- Reception and Information Desk
- Spiritual Care Services
- Behavioral Health Services
- Medical/First Aid Services
- Translation/Interpreter Services
- Child Care

DRCC's and DTB specialized behavioral health crisis response teams are an integral part of assisting the families at these centers to aid survivors and their families with their immediate crisis mental health needs while they are at the FAC. By conducting disaster behavioral health exercises, DTB will prepare members of the DRCC's and other specialized crisis teams for their role in Reunification and Family Assistance Center operations. At the completion of the Reunification and FAC Training Exercise, DRCC's and other specialized disaster behavioral health teams will be prepared to assist with Reunification and FAC's, and provide behavioral health support to individuals affected by a mass casualty incident.

County and State Emergency Partners Workshops

The facilitation of local, county, and State workshops with all emergency management partners will ensure coordination and collaboration ahead of a community crisis or mass causality incident. The goal is to break down existing silos to prevent duplication of services and to educate partners about the importance of and improved behavioral health outcomes when behavioral health issues are addressed in the immediate aftermath of a community crisis. The workshops will include education and planning for all partners on the specific needs of individuals with serious mental illness and those living with substance use disorders, specifically those in need of medication-assisted treatment. County Alcoholism and Drug Abuse Directors and Mental Health Administrators are a vital part of increasing communication and planning to ensure better behavioral health outcomes for NJ residents after an event.

Set Aside Funds

The 10% ESMI/FEP set aside funds will be leveraged with the COVID Supplemental, ARPA, and MHBG 10% set aside to fund Coordinated Specialty Care (CSC) services, an evidence-based practices for serving the ESMI population. DMHAS will be funding up to six CSC and CSC CI programs to increase access to services. Currently the programs serve individuals with first episode psychosis. The expansion will include individuals with affective psychosis. Additionally, the expansion will include CSC step down programs called CSC community integration programs or CSC CI programs. Each of the six CSC programs will have a CSC CI program which will allow for individuals to be able to step down to CSC CI or go back up to CSC if more intensive services are needed. The transition between levels of care will be virtually seamless to the individual as the treatment team will remain the same for continuity of services.

The 5% Crisis Services set aside funds will be leveraged with the COVID Supplemental, ARPA, and MHBG 5% set aside to fund the implementation of Crisis Receiving Stabilization Centers (CRSCs). DMHAS will be funding up to five new CRSCs throughout the state as part of the crisis continuum in NJ. The individuals served by the centers will receive community-based treatment and supportive services 24 hours per day, 7 days per week, 365 days per year. CRSCs will offer a no-wrong-door access to services, accepting all walk-ins and drop-offs.

The BSCA Budget is outlined in the table below:

BSCA Budget Proposal	
Project & Budget Period II 9/30/2023-9/29/2025	
Set Aside Funds	**Cost**
ESMI/FEP10% Set Aside	$183,589
Crisis Services 5% Set Aside	$91,794
Subtotal	**$275,383**

Disaster Response Crisis Counselor	Cost
Statewide/Regional Meetings	$24,000
Update Printed Materials	$40,000
Deployment Vest/Fleece	$20,000
DRCC Recruitment	$30,000
Podcast/Electronic Communications	$20,000
Inclusive Language Services	$25,000
Database & Website Improvements, ID Equipment, Conferences	$100,000
Specialized Training for DTB State Coordinators/DRCC	$56,000
DRCC County Engagement Activities (30k each, 21 Counties total)	$630,000
Subtotal	**$945,000**
Learning Management System	**Cost**
Subscription/Content Creation	$119,000
Technical Assistance	$10,000
Subtotal	**$129,000**
Critical Incident Stress Management	**Cost**
Regional Trainings x6 (3 per yr.)	$60,000
Part-time CISM Coordinator	$40,000
Subtotal	**$100,000**
Traumatic Loss Coalition	**Cost**
TLC Trainings	$60,000
Subtotal	**$60,000**
Family Assistance Center	**Cost**
Regional Exercises	$9,000
Space/Venue	$4,000
After Action	$4,000
Medical Examiner Office Exercises	$10,000
Subtotal	**$27,000**
Behavioral Threat Assessment & Management	**Cost**
Staff Time	$87,360
Training	$44,142
Subtotal	**$131,502**
Vulnerable Populations	**Cost**
VP Special Initiatives	$60,000
Statewide Community Provider Engagement	$60,000
Subtotal	**$120,000**
State/County Emergency Partners Workshops	**Cost**
Staff Time	$30,000
Travel	$10,000
Printed Materials	$8,000

Subtotal	$48,000
GRAND TOTAL	**$1,835,885**

State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL).
Standard Form LLL (click here)

Name

Title

Organization

Signature: Date:

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

This form is not applicable to the NJ Division of Mental Health and Addiction Services.

Planning Steps

Step 1: Assess the strengths and organizational capacity of the service system to address the specific populations.

Narrative Question:

Provide an overview of the state's M/SUD prevention (description of the current prevention system's attention to individuals in need of substance use primary prevention), early identification, treatment, and recovery support systems, including the statutory criteria that must be addressed in the state's Application. Describe how the public M/SUD system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD services or contribute resources that assist in providing the services. In general, the overview should reflect the MHBG and SUPTRS BG criteria detailed in "Environmental Factors and Plan" section.

Further, in support of the **Executive Order On Advancing Racial Equity and Support for Underserved Communities Through the Federal Government**, SAMHSA is committed to advancing equity for all, including people of color and others who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality. Therefore, the description should also include how these systems address the needs of underserved communities. Examples of system strengths might include long-standing interagency relationships, coordinated planning, training systems, and an active network of prevention coalitions. The lack of such strengths might be considered needs of the system, which should be discussed under Step 2. This narrative must include a discussion of the current service system's attention to the MHBG and SUPTRS BG priority populations listed above under "Populations Served."

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

CSOC Planning Step 1

History / Background

The Children's System of Care (CSOC) was first implemented with a single county-based initiative in 2001[1] when New Jersey began to implement the service components outlined in *The Children's System of Care Initiative Concept Paper* released by the New Jersey Department of Human Services in January 2000. The concept paper detailed key elements for system reform to better serve children with emotional and behavioral health care challenges and their families. The reform was ambitious and virtually unprecedented in its scope and commitment to individualized, integrated, culturally competent, and family centered service design and delivery.

When the Department of Children and Families (DCF), the state's first Cabinet-level department focused solely on child and family well-being, was created in July 2006, the Children's System of Care (CSOC) was established as one of the four main Divisions of the new Department. DCF is the single state agency providing services to children, youth, and young adults with emotional and behavioral health needs, substance use needs, and intellectual and developmental disabilities, and their families through CSOC.

On June 29, 2012, Governor Chris Christie signed a bill that reorganized CSOC into a single point of entry for all families with children, youth and young adults with intellectual/developmental disabilities and substance use challenges. This realignment of services removes barriers to accessibility, provides more comprehensive care through all service offerings, and improves efficiency for those families served by DCF throughout the state. The transition of these services to DCF from the Department of Human Services (DHS) began July 1, 2012.

On January 1, 2013, CSOC began coordinating services for youth with developmental disabilities and their families. Coordination of services for youth with substance use challenges and their families began on July 1, 2013.

The goal of DCF's CSOC is to enable youth to remain at home, in school, and within their community. CSOC is committed to providing services that are:

1. Clinically appropriate and accessible
2. Individualized and delivered through a continuum of services and/or supports, both formal and informal, based on the unique strengths and needs of each youth and his or her family/ caregivers
3. Provided in the least restrictive, most natural setting appropriate to meet the needs of the youth and his or her family/caregivers
4. Family-guided, with families engaged as active participants at all levels of planning, organization, and service delivery

---

[1] Prior to 2001, children's behavioral health services were provided under the auspices of the New Jersey Department of Human Services (DHS) through multiple Divisions and initiatives, including the Division of Mental Health Services (DMHS) and the Division of Youth and Family Services (DYFS). As DYFS was responsible for residential programs for all New Jersey youth, families were obliged to "open a case" with DYFS in order to secure out-of-home treatment for their youth in need, even in the absence of abuse and neglect concerns. DMHS maintained responsibility for community-based programs, including outpatient facilities, as well as acute settings such as hospital units.

5. Community-based, coordinated, and integrated with the focus of having services, decision-making responsibility, and management operational at a community level
6. Culturally competent, with agencies, programs, services, and supports that are reflective of and responsive to the cultural, racial, and ethnic differences of the populations they serve
7. Protective of the rights of youth and their family/caregivers and
8. Collaborative across child-serving systems, including child protection, juvenile justice, and other system partners who are responsible for providing services and supports to the target populations.

CSOC served **over 74,000** youth in CY 2022 through a complement of needs-driven supports and services within a system of care approach: family driven, youth-guided, strengths-based, individualized care. The primary goals of CSOC are to ensure youth receive quality care in the most appropriate, community-based setting whenever possible to maintain connections to family and communities for sustainable relationships and planning. CSOC also has a continuum of out-of-home treatment settings of varying degrees of intensity of service accessible based on youths' individual needs.

CSOC Strategic Planning

Stakeholder Task Force

The Children's System of Care (CSOC) has previously reported on the collaboration with the Center for Health Care Strategies (CHCS) and Casey Family Programs through which a Task Force of sixteen stakeholders was convened to participate in building a behavioral and physical health integration model. Release of the report and recommendation from this task force was delayed due to the onset of the public health emergency. In August of 2021, a final stakeholder advisory group was held where CSOC presented on all of the progress made toward the previously identified priorities, as well as provided an outline for initiatives for fiscal year 2022. Shortly thereafter, CHCS convened an internal meeting with CSOC leadership with the focus of reviewing and committing to identified program initiatives organized under the three main priorities:

1. Build capacity for integrated health
2. Increase the availability of evidence-based and best practice interventions and services
3. Improve access to CSOC services and supports

CSOC also maintains a priority of Service Excellence. Some highlights of these initiatives include the Infant and Early Childhood Mental Health Initiative, the Garrett Lee Smith Suicide Prevention Grant, and the Developing Resiliency with Engaging Approaches to Maximize Success (DREAMS) Initiative to implement the Nurtured Heart Approach into 50 school districts a year over three years. DREAMS is supported with American Rescue Plan Act (ARPA) funding.

Outcomes and Successes

1. Reducing the length of stay in residential treatment centers
    - In FY 2003, average length of stay was 407 days
    - In FY 2020 average length of stay was 252 days
    - In FY 2021 average length of stay was 276 days
    - In FY 2022 average length of stay was 290 days

A 36% reduction in length of stay in residential treatment was achieved between FY 2003 and FY 2020. Lengths of stay increased in FY 2021 and FY 2022 due to operational challenges resulting from the COVID pandemic. Length of stay increased by 15% from FY 2020 to FY 2022.

2. Expanding community-based care management, in-home, and day treatment programs for children
   - In 2000, NJ served approximately 7,000 children, youth and young adults in community-based care management, in-home services and supports and day treatment programs
   - In 2022, NJ served approximately 74,000 children, youth and young adults in community-based care management, in-home services and supports, and day treatment programs, a 950% increase over 22 years
   - As of January 2023, 16% of the youth receiving care management were Developmental Disability (DD) eligible
   - As of January 2023, 16% of the youth receiving care management were involved with child welfare

4. Reducing the number of juvenile justice commitments:
   - The system of care is fully accessible to youth involved with the juvenile justice system and helps keep youth out of detention centers. Over the past few years, there has been a significant increase in the number of youth who utilize CSOC services leading to a substantial decrease in the number of youth entering Detention Centers.
   - Today, youth are released to alternatives while actively utilizing CSOC services as they await disposition[2] and/or residential treatment programs.

5. Creating a proactive safety net for youth:
   - In 2003, 40% of newly enrolled children were under 14 years of age. In 2022, 34,319 youth were newly enrolled. 69% were under 14 years of age. This change in age distribution among youth served indicates that the system of care is effectively reaching youth at a younger age to offer earlier intervention to address the youth and family's needs.

6. Reducing the number of children in out-of-home (OOH) treatment settings:
   - In FY 2007, approximately 4,000 children served in behavioral health OOH treatment settings. Between FY 2012 and FY 2022, the number of youth served in all OOH placement settings (behavioral health (BH), substance use (SU) and Intellectual and Developmental Disability (IDD) decreases steadily to 1,932 in FY 22.

7. Providing immediate services to youth in crisis:
   - Mobile Response maintains youth in crisis in their homes or current living situation, reducing disruptions for youth and their families and providing them with support and access to services during times of behavioral health instability.

[2] 'The term "disposition" is utilized in Juvenile Court versus the term "sentence" when the outcome of charges yields the Court determination that a youth needs out-of-home treatment through CSOC not incarceration; and the youth remain in Detention while waiting for admission to a treatment bed.

- As of December 2022, over 96% of youth receiving Mobile Response services remained in the home or current living situation during the Mobile Response intervention.

8. The Children's System of Care continues to improve and to be the national leader and model for systems of care. NJ CSOC is frequently called upon by other states and jurisdictions to offer strengths, lessons learned and insights on how best to develop a system of care in communities and serve youth and families. NJ CSOC has been of particular interest to other states seeking to implement FFA (Family First Act) strategies related to prevention of child welfare involvement through development of community-based treatment, including mobile crisis response services, as well as decreased use of congregate care, and creation of a structure that supports clinically appropriate out-of-home treatment.

DCF Children's System of Care Funding

The DCF-CSOC provides behavioral health care to youth and families every day in a broad continuum of services with total budget authority of state and federal resources consisting of Grants in Aid, Medicaid (Title XIX), the State Children's Health Insurance Plan (S-CHIP) (Title XXI), and, for some youth (18-20 yr. old), through an Alternative Benefit Plan (ABP).

Description of the current Children's System of Care and Program Summaries

The primary goals of CSOC are to ensure youth receive quality care in the most appropriate, community-based setting whenever possible to maintain connections to family and communities for sustainable relationships and planning. CSOC also has a continuum of out-of-home treatment settings of varying degrees of intensity of service accessible based on youths' individual needs.

1. CSOC employs the use of the system of care approach and collaborates with many system partners throughout the State to leverage expertise of the local communities. There are state administrative and management staff, and services are provided by private agencies – primarily not-for-profit agencies.

2. CSOC staff members are assigned to manage the key services available through CSOC (i.e. CMO, MRSS, IIC/BA, FSO) in a collaborative, regional model.

3. Services are primarily funded through Medicaid state plan amendments (Title XIX and Title XXI).

4. CSOC also receives funding through the NJ FamilyCare Comprehensive Demonstration (1115 Waiver). The most recent Waiver renewal was approved by the Centers for Medicare and Medicaid Services (CMS) on April 1, 2023. More information about the Children's Support Services Program is available at Department of Human Services | 1115 NJ FamilyCare Demonstration Renewal Request.

5. Services are provided based on medical necessity.

6. Medical necessity is authorized by PerformCare, the Contracted System Administrator (CSA)/Administrative Services Organization (ASO), which provides the administrative services to the system of care.

Care Management Organization (CMO)

CMOs are nonprofit organizations responsible for care management, assessment, and comprehensive service planning for youth and their families with intense and/or complex needs related to behavioral health, substance use, and/or intellectual or developmental disability. Youth are enrolled with a CMO when independent CSOC CSA review of clinical and need-based information about the youth meets the threshold of clinical criteria, and the youth and family can benefit from services. CMOs engage families and youth, coordinate Child/Family Team (CFT) meetings, and implement Individual Service Plans (ISP) for each youth and their family. The CMO provides a single point of accountability for the organization, coordination, and delivery of services and supports needed to maintain stability for each youth.

Child Family Team (CFT)-Wraparound Approach

The Wraparound approach depends on collaboration among a team of family members, professionals, and significant community residents identified by the family and organized by the care manager to design and oversee implementation of the Individual Service Plan (ISP). The ISP connects the assessed strengths and needs of the youth with plan elements including family vision, goals, strategies, supports, and services. The CFT is an ongoing coordinated process that includes participation from the youth, the youth's family, the CMO care manager, and any other individual identified by the youth and family to help support the family towards a sustainable plan of care. The CFT meets, at minimum, every 90 days or as needed. Through the CFT process strengths and needs, progress and barriers to care, and services to be implemented are identified. Once identified, a request is added to the youth's treatment (care) plan, which is reviewed by CSA's licensed clinical staff (Care Coordinators) against established clinical criteria and in the context of the youth's assessment and comprehensive plan. Clinical criteria for services are located at: http://www.performcarenj.org/provider/clinical-criteria.aspx. The Care Coordination staff requests additional information from the CMO when there is a question about the youth meeting the clinical criteria. Clinically appropriate services are authorized by the CSA.

Behavioral Health Homes

In five counties, CMOs serve as the designated Behavioral Health Home (BHH) entities for youth in New Jersey, serving as a "bridge" that connects prevention, primary care, and specialty care. Each Behavioral Health Home (BHH) is a designated Care Management Organization (CMO) with enhanced care management teams that include medical expertise and health/wellness education for purposes of providing fully integrated and coordinated care for youth remaining in their home and who have chronic medical conditions. Medical and wellness staff are integrated into the existing CMO CFT structure responsible for care coordination and comprehensive treatment planning for youth and their families, which includes planning for the holistic needs of the youth.

Family Support Organizations (FSOs)

FSOs are nonprofit organizations run by family members of youth with emotional, behavioral, developmental, and/or substance use challenges that have lived experience in supporting youth in addressing their needs. FSOs provide advocacy, education, and support through an array of supports and services including individual family-to-family peer support for youth with moderate and high needs, support groups and workshops, community outreach and education, telephonic support, and local level advocacy to help them navigate the System of Care, school system, CP&P, and the legal system, and to listen and provide moral support. In addition to caregiver supports, FSO Youth Partnerships (YPs), led by a young-adult Youth Coach, help youth to engage with other youth with mental, emotional, and

behavioral health needs. Through support groups, social activities, and leadership development, youth and young adults ages 13-21 find their voice to affect change in their own lives and the lives of others. Each YP participates in monthly community activities to challenge stigma and strengthen other youth in their communities, and each year, youth leaders across the state develop and facilitate an annual youth conference.

Mobile Response and Stabilization Services (MRSS)

MRSS is the CSOC's urgent response service designed to help families stabilize youth in home and community settings. MRSS are available 24 hours per day, 7 days a week, year-round. MRSS provides immediate (within one hour) intervention designed to minimize risk, maintain the youth in his/her current living arrangement, prevent repeated hospitalizations, stabilize behavioral health needs, and improve functioning in life domains such as school and home routines. Mobile Response and Stabilization Services (MRSS) deliver services to youth vulnerable to or experiencing stressors, coping challenges, emotional or behavioral symptoms, difficulties with substance use as a coping strategy, or traumatic circumstances that may compromise the youth's ability to function optimally and thrive within their family/living situation, school, and/or community environments. MRSS is designed as an upstream intervention available to support families and youth when they first identify they need assistance based on their definition of need. Care is individualized, strengths-based, youth-centered, family-driven, community-based, trauma-informed, and culturally and linguistically mindful. MRSS provides engagement, crisis intervention, assessment, and planning designed to stabilize presenting stressors, behaviors and/or emotional challenges, maintain youth in their home environment and community, build formal and informal supports, and prevent unnecessary psychiatric hospitalization, out of home care, and legal involvement.

Intensive In-Community/Behavioral Assistance (IIC/BA) services

Intensive In-Community/Behavioral Assistance (IIC/BA) services are short term, intensive, community-based therapeutic interventions, rather than clinic or office-based, that are needs-driven, youth and family guided, and accessible. IIC/BA are aimed at engaging youth and families in a therapeutic process to reduce and stabilize challenging behavioral and emotional patterns and symptoms, introducing "replacement" skills, and developing parent skills for sustaining positive change and connecting to continued therapeutic supports when the need presents.

IIC services have two components:

- **IIC Bio-Psychosocial and Strengths and Needs Assessments** are conducted and submitted to the CSA for review by licensed behavioral health clinicians within 10 days of request. The assessment describes present challenges, strengths, identified goals, youth and family perspective and recommended intervention strategies. Assessments are provided in a youth's current living situation, including resource homes and detention centers. Assessments provide necessary information for a level of care determination.
- **IIC Treatment Services** are clinical interventions provided by licensed or licensed-supervised master's level clinicians working within the scope of their licensing board in the youth and families' natural environment. Time limited and goal-oriented, these services aim to reduce acute symptomatology, enhance strengths, and transition youth and families to more traditional, i.e. clinic/office-based services, as soon as possible.

BA services are adjunctive to IIC services. They are never stand-alone. BA services are delivered by a license-supervised individual who holds a bachelor's degree at minimum and has at least one-year

experience working with the population served. The BA is the agent of the IIC plan of care. The BA service provides direct youth and parent training, support, and intervention to maximize the potential of positive and sustainable change.

Evidence-Based Practices

The Children's System of Care has a focused strategic priority to ensure capacity to provide behavioral health services that are based on the best evidence available with a goal of improving outcomes and the quality of life for children, youth, and young adults receiving services through the Division. The following are examples of EBPs available through CSOC: Multisystemic Therapy (MST), Functional Family Therapy (FFT), Wraparound approach, Trauma Focused Cognitive Behavioral Therapy (TF CBT), Six Core Strategies and Nurtured Heart Approach, and the ARC framework and ARC Grow Model. Additional information on EBPs available through CSOC is located in another document (C12 – Trauma).

Youth Outpatient Services

Outpatient mental health treatment services offer community based behavioral health care to youth and families. These services frequently exist within a licensed community mental healthcare agency. Outpatient services are designed to support, enhance, and encourage the emotional development of life skills to preserve or improve individuals' functioning, strengths, and resources. Interventions may include individual, group, and family therapy, as well as medication evaluation and monitoring, and referral. Interventions are provided based on the need of the youth and family. CSOC does not manage outpatient services but does coordinate and collaborate with these providers at the local system and individual planning levels to support meeting youth and family needs.

Partial Care/Partial Hospitalization

Partial Care/Partial Hospitalization programs are highly structured, intensive (minimum 2 hours, 3 to 6 times per week) behavioral health services for youth with serious behavioral health needs. Multi-disciplinary behavioral health interventions include rehabilitation programming such as activities to support daily living, recreation, socialization, and community reintegration. Programs are typically located in a community-based mental health or hospital setting (N.J.A.C. 10:37-12). These services assist in stabilizing youth with acute needs, either following, or for prevention of, hospitalization or other out-of-home treatment.

Children's InterAgency Coordinating Council (CIACC)

The CIACC serves as the county mechanism to advise DCF/CSOC on the development and maintenance of a responsive, accessible, and integrated system of care for youth with behavioral and emotional health needs, substance use, and/or intellectual or developmental disabilities and their families. Through enhanced coordination of systems partners, the CIACC also identifies service and resource gaps and priorities for resource development. Functions of the CIACCs include:

- Evaluating the local county policies to understand and minimize the impact of local barriers to serving youth with behavioral and emotional health needs, substance use, and/or intellectual and developmental disabilities in their community.
- Identifying local strategies and mechanisms to promote the integration and coordination of county, State, or other resources serving youth with behavioral and emotional health needs, substance use, and/or intellectual or development disabilities.

- Assessing local systems needs using information received from DCF, the Contracted System Administrator (CSA), any child-serving agency identified by DCF, and other bodies to make recommendations regarding service and resource development priorities.
- Identifying and informing DCF/CSOC regarding gaps and barriers to local service effectiveness.
- Providing input to State, regional, and county entities regarding system performance and service need.

In collaboration with the Department of Education, DCF recommended the creation of an **"Educational Partnership"** in every county in NJ. These partnerships use the County Inter-Agency Coordinating Councils to build a better working partnership between the DCF system of care and the local education system. This initiative has many goals, but one simple goal is to have at least one person in every school in NJ formally trained on the DCF service delivery system. This will help to facilitate a more preventative response to behavioral health challenges. Efforts to achieve this goal continue. DCF believes bringing systems together through the Educational Partnership will improve coordination in the service delivery process.

Out-of-Home (OOH) Treatment Services

Funding for CSOC OOH care encompasses a full continuum of services for behavioral health, intellectual or developmental disabilities, substance use, and co-occurring treatment needs. OOH treatment intervention must be directly related to the goals and objectives established by the Child/Family Team (CFT) process in coordination with the multidisciplinary Joint Care Review (JCR)/treatment plan. The OOH provider submits the JCR to the CSA for utilization review and for clinical determination of continued stay in out-of-home treatment. Family/guardian/caregiver involvement is essential, and, unless contraindicated, should occur consistently and on a regular basis (or as determined in the JCR/treatment plan). The recommended length of stay for OOH intervention is typically nine to twelve months. One single episode of OOH care is optimal. Clinical criteria for the OOH continuum of services are available at http://www.performcarenj.org/provider/clinical-criteria.aspx.

CSOC data have demonstrated a gradual decline in OOH utilization over the past several years, which is attributed to the success of maintaining more youth at home with community supports. Based on the analysis of utilization data, while most youth are served in the community, some with high needs require OOH intervention.

Behavioral Health Out of Home Treatment Services

- IRTS (Intensive Residential Treatment Services) - Non-hospital treatment services provided to youth with a wide range of serious emotional and behavioral needs who require 24 hours per day care in a safe, structured environment with constant line-of-sight supervision.
- PCH (Psychiatric Community Home) - 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.
- SPEC (Specialty Bed Program) - Programs that provide intensive residential services for children who are presenting with 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.
- RTC (Residential Treatment Center) - Programs that provide 24 hours 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.

- GH (Group Home) - Group home services provide up to 24 hours per day care and treatment to youth whose needs cannot be met appropriately in their own homes or in resource care, but who do not need the structure and intensiveness of a more restrictive setting.
- TH (Treatment Homes) - 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.
- STAS (Stabilization and Assessment Services for Child Welfare) - Short-term, highly structured, and nurturing environments with professional competencies to stabilize children engaged with, or at risk of, involvement with child welfare, who are homeless, and/or present with complex behavioral health challenges on an emergent basis, and who do not meet the need for an acute hospital setting. The intent is to stabilize crises in a soothing and trauma aware milieu while diagnostic assessments, services, and supports that meet the children's needs are conducted. The goal of this intervention is to identify and secure an appropriate living situation for youth (in home/out-of-home). In 2019, CSOC issued an RFP for up to two five-bed STAS programs for females and males, ages 13 – 18, but ultimately awarded three STAS programs due to the recent unexpected closure of a residential program serving human trafficking involved youth in need of stabilization and assessment services. These additional 15 beds complement the STAS beds developed in 2017-2018 to serve young children, ages 5-12.

Intellectual/Developmental Disability Out-of-Home Treatment Services

- SSH IDD (Special Skills Home) - Designed for youth who present with challenges in adjusting within their primary home setting or in a less intensive treatment setting. These homes are in private single-family homes. Youth are under the supervision of an agency trained mentor parent. There is no awake, overnight staff monitoring or supervision.
- GH-1 IDD (Group Home-Level 1) - Designed for youth who present with periodic behavioral difficulties that cannot be consistently managed in their primary home environment or in a less intensive treatment setting.
- GH-2 IDD (Group Home-Level 2) - Designed for youth who present with persistent challenging behaviors that cannot be safely and consistently managed in their primary home environment or in a less intensive treatment setting.
- RTC BH/DD (Residential Treatment Center for Intellectual/Developmental Disabilities) - Provides all-inclusive integrated programming with comprehensive therapeutic and clinical services in a 24-hour staff supervised, community-based setting for youth who present severe and persistent challenges in social, emotional, behavioral, and/or psychiatric functioning with a co-occurring intellectual/developmental disability.
- SPEC-IDD (Specialty IDD) - Designed for youth who present with challenges related to sexually reactive behavior. These specialty homes are in private single-family homes. Youth are under the supervision of an agency trained mentor parent. There is no awake, overnight staff monitoring or supervision.
- PCH-IDD (Psychiatric Community Home-IDD) - Provides supervised 24-hour care within an intensive treatment program for youth with intellectual/developmental disabilities who present with severe behavioral health challenges. PCH-IDD programs are designed for youth who have received inpatient services for behavioral health needs and who cannot be supported in their current living arrangement with a reasonable degree of safety.

- Intensive-IDD (Intensive Psychiatric Community Home -IDD) - Youth who are considered for admission present with complex, challenging behavior(s) of such intensity, frequency, and duration that it prevents the youth's personal development and inclusion in family life and community. Challenging behaviors may be unusual responses to sensory experiences and recurring trauma, thus manifesting challenging behaviors that include, but are not limited to, inappropriate/rule violations, noncompliance, self-injurious behaviors, and destructive, aggressive, and/or assaultive behaviors that require medical attention.
- RESP IDD (Respite for Intellectual/Developmental Disabilities) - Short term out-of-home respite services for youth and young adults with limited behavioral challenges.
- Crisis Stabilization and Assessment Program **-** CSAP IDD provides 24-hour care in a highly structured, community-based treatment setting with professional competencies and capabilities to stabilize youth with I/DD ages 6 to 20 years old (males/females) that are in crisis and unable to be safely supported in their current living situation. The primary goal upon stabilization is transitioning the youth to the community with wraparound services and supports, whenever possible. CSAP provides comprehensive diagnostic assessments that result in the identification of proper in-home services and supports that can meet the youth's habilitative and behavioral health needs upon transition.

Substance Use (SU) Treatment

The Children's System of Care offers an array of substance use treatment services for youth and young adults, including four withdrawal management beds, contracted outpatient/intensive outpatient services through 9 providers statewide, partial care services through one provider, and short term out-of-home treatment through one provider with 19 beds. In addition, residential treatment services for youth with co-occurring substance use needs and significant behavioral health needs can be accessed through the CMO from five providers with a total of 54 beds.

The South Jersey Initiative provides fee for service funding to 10 providers for outpatient and intensive outpatient substance use services for the eight southern counties. One agency, with a capacity of three beds, provides short term out-of-home treatment.

Outpatient and Intensive Outpatient services are authorized based on individual clinical need and are not monitored on a slot-based method. This allows the providers to serve more youth and avoid waiting lists. The contracted providers manage their annual funding for these services.

A parent/legal guardian may contact the CSA to access CSOC contracted services. If the parent/legal guardian is requesting substance use treatment services, the CSA licensed clinicians complete the CSOC standardized substance use assessment via phone, determine appropriate levels of care, provide referrals, and authorize services. If a youth meets clinical criteria for out of home co-occurring services, he/she will be opened with a CMO from their service area. The CMO Care Manager will assist in coordinating treatment services for youth and families, including meet and greets with treatment providers, educating families about services for their youth during and after treatment process, as well as providing support and encouraging family involvement throughout this process.

Families may also access services directly through one of the CSOC contracted substance use treatment providers. The provider will complete a substance use assessment and submit it to the CSA for review by licensed clinicians for intensity of service determination and authorization for treatment.

The ASAM Criteria (developed by the American Society of Addiction Medicine (ASAM)) are used to determine admission to level of care and readiness for discharge/transfer to another level of care. These decisions are made by Licensed Clinical Alcohol and Drug Counselors (LCADCs) with appropriate specialized training employed by the CSA.

Substance use treatment services are authorized without regard to income, private health insurance, or eligibility for FamilyCare.

Types of substance use treatment services offered through CSOC

- Outpatient (Level I) – consists of less than 6 hours of service per week for adolescents including individual, family, and group therapy/counseling, including co-occurring services.
- Intensive Outpatient (Level 2.1) – consists of more than 6 hours per week of day treatment for adolescents including individual, family, and group therapy/counseling, including co-occurring services.
- Partial Care (Level 2.5) – consists of 20 hours per week for adolescents including educational programming, individual, family, and group therapy/counseling, including co-occurring services.
- Co-Occurring OOH Treatment (Level 3.5 and Level 3.7) – consists of residential services for adolescents/young adults providing 24-hour care with dually licensed clinicians including individual, family, and group therapy/counseling, including co-occurring services. Level 3.7 also provides 24-hour nursing care and a more intense clinical program, offering more hours of clinical services including individual, family, and group therapies by a dually licensed clinician, as well as an increased ratio of direct care staff to youth.
- Medically Monitored High Intensity Inpatient-Withdrawal Management (Level 3.7WM) - Medically monitored withdrawal management, providing medical and nursing 24-hour care, evaluation, and withdrawal management in an agency with inpatient beds.
- Co-Occurring Behavioral Health/Substance Use Treatment Program – provides 24 hours supervised, all inclusive, co-occurring clinical services in a community-based setting for adolescents ages 13-18 who present with challenges in social, emotional, behavioral and/or psychiatric functioning as well as co-occurring substance use treatment needs.
- South Jersey Initiative (SJI) **-** The South Jersey Initiative is a historical funding stream that was designated as a result of advocacy to increase substance use treatment resources for youth and young adults in Southern NJ. To receive SJI funding, the youth must meet ASAM criteria for services and must be from one of the following eight counties: Atlantic, Burlington, Camden, Cumberland, Gloucester, Cape May, Ocean, and Salem. SJI funding is the payer of last resort. Authorization for outpatient/intensive outpatient substance use treatment services, under the SJI funding, is the same process for accessing contracted funding. Intensity of service determination is based on ASAM criteria.

Supports and Services for Youth with Developmental Disabilities

DD Eligibility

CSOC is responsibility for determining eligibility for developmental disability services for children under age 18. Families apply for DD eligibility through the CSOC established process. The CMOs and MRSS work with family members enrolled with them to make application for eligibility determinations. The Division of Developmental Disabilities (DDD) continues to determine eligibility for individuals aged 18 and over,

and the Children's System of Care provides services to those youth. DDD and CSOC collaborate through an established protocol to provide a seamless transition to adult services.

Intensive In-Home: IIH Supports

While traditional therapies are typically provided at the health care provider's office location, Intensive In-Home (IIH) services are provided in the youth's home or at another location in the community, which makes sense to both the family needs and the goals of the service. IIH covers a variety of services geared to assist youth with challenging behaviors that may impact their ability to remain at home.

- **Clinical and therapeutic interventions**- These services are rehabilitative, focused on the restoration of a youth's functional level after an acute episode or decline in functioning related to mental illness or a significant life stressor.
- **Applied Behavior Analysis (ABA)**- ABA is a set of habilitation services, designed for decreasing dangerous behaviors while assisting youth in acquiring and retaining self-help, communication, and adaptive skills. Services focus on helping youth learn these skills while working with and training the youth's parent or caregiver to implement a behavior plan.
- **Individual Support Services (ISS)**- ISS is skill development for activities of daily living. Including self-care tasks and the enabling of an individual to live independently in the community.

Family Support Services for Children with Intellectual/Developmental Disabilities

Family Support Services (FSS) are available for youth who are determined eligible for developmental disability services and meet the criteria for FSS. The services described below may be provided based on availability and appropriateness to the needs of the youth and their family.

- **Respite** means "break" or "relief." Respite services are intended to provide temporary relief for the primary caregiver from the demands of caring for an individual with disabilities during the times when the caregiver would normally be available to provide care. The service relieves family members from care on a temporary basis for short periods of time. There are several different settings for respite, including home-based, agency after-school, overnight stays, and weekend recreation. Please note that respite services are dependent upon funding availability.
- **Assistive Technology** is designed to increase the functional skills of a youth with a developmental disability and enhance their ability to live successfully in the community. An assistive device is an item to increase, maintain, or improve functional capabilities of the youth, and is not solely therapeutic. **Vehicle** and **home** (environmental) **modifications** are also included in this category. It must be an item not covered by medical insurance and cannot be used to restrain the youth.
- **Educational Advocacy** is a service provided to youth and their families when the youth needs in-depth help with education-related needs.
- **Summer Camp** offers limited financial support for eligible youth to attend summer camp. Youth can attend either a specialized camp or a mainstream camp, as long as the camp becomes qualified as a camp provider through CSOC. One-to-One Aide services may also be available for youth deemed eligible.

<u>Juvenile Justice</u>

Reducing the Number of Juvenile Justice Commitments

The Children's System of Care (CSOC) is fully accessible to youth involved with the juvenile justice system and the services coordinated by care managers help to keep youth out of detention centers. There has been a significant decrease in the number of detention center admissions resulting in the reduction of the number of county detention centers from seventeen to six in the past few years (Burlington County Detention Center closed in 2020).

Detention Alternative Program/Youth Advocate Program (DAP/YAP)

CSOC funds Community Re-Integration Services through YAP (Youth Advocate Program) to maintain youth in their community who, without this program, would enter out-of-home treatment due to juvenile justice involvement. The program provides services both individually and in groups, along with a mentor, life skills groups, and employment skills. The program is located in the three counties (Middlesex, Camden, and Essex) with the highest rate of court ordered out-of-home referrals. Additionally, this program has enabled the Division of Child Protection and Permanency to successfully maintain youth in resource homes after their arrest.

Medicaid

Currently, youth in juvenile detention facilities are eligible for Medicaid or New Jersey FamilyCare (S-CHIP) only after adjudication and referral to a non-secure setting.

CSOC Representation on the New Jersey Council for Juvenile Justice Improvement

Diversion and the reentry processes are discussed by the Access to Treatment and Racial Disparities sub-committees of the Council. Formal recommendations are presented to the full Council by the individual sub-committees.

DCF Cooperative Relationships with the Juvenile Justice Commission (JJC)

Since December 2004, the Department has maintained a Memorandum of Understanding with the JJC that outlines a distinct process by which youth in the JJC can be referred directly to what is now known as the Children's System of Care for services that will be implemented upon the youth's release from a JJC facility. Representation from both CP&P and CSOC participate in the JJC and Annie E. Casey Foundation driven Juvenile Detention Alternative Initiative (JDAI) in order to collaborate on developing alternatives to detention and to reduce the number of youth going into detention. Both systems participate in each other's planning and case review processes.

The Juvenile Justice Commission is responsible for operating state services and sanctions for juveniles and for developing a statewide plan for the effective provision of juvenile justice services and sanctions at the state, county, and local levels. To emphasize New Jersey's commitment to provide coordinated quality services and appropriate sanctions for youthful offenders while ensuring the public's safety, the JJC established the State/Community Partnership Grant Program. These Partnership Grants provide funding to each county for services to reduce detention overcrowding, to provide treatment for sex offenders, to increase disposition options, and to provide aftercare to youth and their families.

Special Case Review Committee

The Special Case Review Committee (SCRC) reviews those youth, both male and female, who present multi-system needs/issues and the need for special attention or advocacy. Included are those who appear to have developmental disabilities, those who need placement by DCF/CP&P due to court orders for diversion or aftercare, and/or those who have special presenting problems, including homelessness, and those who are being referred, or are accepted by, DCF/CSOC.

The Office of Special Needs oversees the SCRC in terms of intra- and inter-agency planning. It is chaired by the Special Needs Assistant. Members include representatives from CP&P, Office of Adolescent Services, Children's System of Care, the JJC Juvenile Parole and Transitional Services (JP&TS), Pre-Release Teams, Regional Court Liaisons/designees, the JJC Child Study Teams, JJC community residential homes, and representatives from the New Jersey Training School at Jamesburg (NJTS), Juvenile Medium Security Facility (JMSF), and the Juvenile Female Secure Care and Intake Facility (Hayes Unit) Social Services Departments.

Meetings are held twice a month, for northern and southern regional cases, respectively. Referrals are primarily made from the Reception and Program Review committees, the Reception and Assessment Center (RAC), the New Jersey Training School (NJTS), and Juvenile Female Secure Care and Intake Facility. However, youth may be referred by any source identifying a special need for advocacy and planning, including the Institutional Classification Committees, JP&TS staff, court liaisons, supervisors, and program staff.

When youth in a JJC facility have permanency and treatment needs that require the intervention of DCF, the JJC Special Needs Review Committee will work with CSOC and CP&P to make appropriate referrals prior to time of discharge. In circumstances where CSOC is unable to access a timely treatment plan in accordance with mandatory release dates, CP&P will be expected to effectuate the most appropriate contingency plan until such time that a more feasible plan is developed. Care Management Organization (CMO) involvement is inclusive in this agreement, when appropriate.

CSOC maintains a "Protocol for Supervision of Juvenile Probationers Court-ordered to Attend and Complete a DCSOC Specialty Services Program." This protocol was approved in 2012 by NJ Juvenile Probation Managers, NJ Conference of Chief Probation Officers, CSOC Representative for Specialty Programs, NJ Juvenile Committee of Family Presiding Judges, and the NJ Conference of Family Presiding Judges. Subsequent protocols were developed that address communication and collaboration for youth in either a residential treatment program or a substance use treatment program.

CSOC Training and Technical Assistance

CSOC offers a broad array of training and technical assistance to system partners through contracts with several entities including Rutgers University Behavioral HealthCare, the Boggs Center, and Autism New Jersey.
DCF/CSOC funds the Technical Assistance Center through University Behavioral Health Care - Rutgers, the State University, to provide training statewide. CSOC, through the UMDNJ Training contract, offers training to all children's system of care providers free of charge.

In addition, CSOC staff provides training on working with individuals with behavioral health challenges to staff of the Juvenile Justice Commission.

The Contracted System Administrator (CSA)

The Contracted System Administrator (CSA) was designed to provide the State with overall healthcare system management to assure 24-hour access to appropriate and coordinated services and provide child-specific and systemic data analysis on all children under the jurisdiction of CSOC.

The CSA creates a common single point of entry for youth and families. The CSA functions as, and is inclusive of the activities of, a non-risk Administrative Services Organization (ASO). The CSA registers all youth requesting services, authorizes services in a single electronic record, and tracks and coordinates care for all New Jersey youth enrolled in CSOC.

CSOC retains all regulatory and policy-making authority. As such, there are key functions that remain the responsibility of CSOC, including, but not limited to, network development, provider contracting, and provider outcome standards. As a partner to CSOC, the CSA provides administrative support and is encouraged to offer recommendations for improvements to the delivery of services which may be implemented with the approval of CSOC.

The CSA performs a broad range of administrative service functions including, but not limited to, the following:

- Providing a Call Center with 24-hour/7-day intake and customer service capability.
- Providing a web-based application/interface with the CSA's Management Information System (MIS).
- Managing care, including utilization management, outlier management (including authorization of services), and care coordination; if youth are involved with a Care Management Organization, the CSA reviews service requests based on the youth's comprehensive plan of care which is developed by the Child/Family Team (CFT).
- Coordinating access to services for all youth, including facilitating access to specialized services for youth involved with the Division of Child Protection and Permanency (CP&P).
- Coordinating Third Party Liability and medical coverages.
- Intellectual/Developmental Disability (IDD) eligibility determinations for youth up to age 18.
- Coordinating a transition to adult services for youth.
- Providing quality and outcomes management, and system measurement that supports CSOC's goal to promote best practices and aiding the State in assuring compliance with State and federal guidelines.
- Providing training and training materials.
- Providing support for provider network development.
- Completing annual audit reviews.

To support these administrative services, the CSA created and routinely maintains an MIS called CYBER (**C**hild and **Y**outh **B**ehavioral **E**lectronic **R**ecord) that is backed by strong, clinical guidance and fosters flexibility, system integration, comprehensive information management, and production of management reports that support business decisions.

<u>Youth Suicide Prevention Resources</u>

Every life lost to suicide is a tragedy and the New Jersey Department of Children and Families is committed to decreasing youth suicide and supporting youth who have attempted suicide. Suicide is the third leading cause of death for New Jersey youth between 10 and 24 years of age.

Traumatic Loss Coalitions for Youth (TLC) – UBHC Suicide Prevention

The Traumatic Loss Coalitions for Youth Program (TLC) at Rutgers-University Behavioral HealthCare is an interactive, statewide network that seeks to reduce suicide attempts, deaths by suicide, and to promote recovery of persons affected by suicide by offering collaboration and support to professionals working with school-age youth and direct crisis response services to staff and youth at youth-serving organizations following a traumatic event. The TLC offers county, regional, and statewide conferences, training, consultation, on-site traumatic loss response, and technical assistance. Since its inception, the TLC has trained thousands of individuals throughout the state with the purpose of saving lives and promoting post trauma healing and resiliency for the youth of New Jersey. The TLC website can be accessed at http://ubhc.rutgers.edu/tlc/

Project Connect

In November 2020, the Garrett Lee Smith Youth Suicide Prevention Grant was awarded to the New Jersey Department of Health (NJDOH) from the Substance Abuse and Mental Health Services Administration (SAMHSA). This federal grant was awarded to implement NJDOH's Readiness to Stand United Against Youth Suicide (R2S Challenge). The Department of Children and Families (DCF) is collaborating with the DOH on a portion of the grant. This collaboration is to assist New Jersey hospitals to effectively connect youth to services following suicide attempts. DCF is developing Project Connect to increase engagement in community mental health services after hospital discharge, reduce unnecessary Emergency Department utilization through connection to appropriate community services, and improve safety and well-being for youth and families. Through the innovative role of the Regional Care Coordinator (RCC), Project Connect works in partnership with identified hospitals to enhance discharge planning for youth with suicide ideation and/or attempts. After youth are medically stabilized, screened, and determined to be safe for discharge, hospital staff will engage in a warm transfer process to connect families to PerformCare and community resources. Hospital staff will also be coached on how to obtain consent to connect the family to the RCC who will make contact with the caregiver post-discharge to provide the youth and family with follow up support and ensure linkage and engagement with community behavioral health services.

2NDFLOOR Youth Helpline

Accredited by the American Association of Suicidology, 2NDFLOOR is a confidential call/text helpline and message board platform serving youth and young adults. Youth who contact the 2NDFLOOR are assisted with their daily life challenges by professional staff and trained volunteers. The 2nd Floor website can be accessed at http://www.2ndfloor.org/

Crisis Text Line

The Children's System of Care has partnered with Crisis Text Line in New Jersey to provide another tool for constituents. Crisis Text Line is a free 24/7 support that connects anyone experiencing a self-defined crisis with a trained counselor. It can be accessed from anywhere in the United States. When texts are received, they are screened by an algorithm for severity, and texts that indicate imminent risk are placed

at the top of the queue for faster response. Crisis counselors are trained to bring texters from "a hot moment to a cool calm," using empathic listening techniques. They collaboratively problem-solve to help the texter come up with a plan to stay safe. Calls are anonymous and confidential, unless referral to emergency services is necessary. For cell phone plans with AT&T, T-Mobile, Sprint, or Verizon, texts are completely free and will not show up on the phone bill. For plans with another carrier, normal text rates will apply and will appear on the phone bill as 741741. Additional information about Crisis Text Line can be found at http://www.crisistextline.org

Additional Suicide Prevention/Crisis Resources

Staffed by mental health professionals and peer support specialists 24 hours a day, seven days a week, the **New Jersey Suicide Prevention Hopeline** is available to all ages for confidential telephone support (except when a suicide attempt is in progress), assessment, and referral. The NJ Hopeline offers call, text, chat, and email options. General information is available at: **www.njhopeline.com**

New Jersey Youth Suicide Prevention Advisory Council

Established in, but not of, the Department of Children and Families, the New Jersey Youth Suicide Prevention Advisory Council is comprised of appointed New Jersey citizens and state government representatives. The New Jersey Youth Suicide Prevention Advisory Council examines existing needs and services and makes recommendations for youth suicide reporting, prevention, and intervention. It advises the development of regulations pursuant to N.J.S.A. § 30:9A-25 et seq.

Community Programs for Outreach and Intervention with Youth and Young Adults at Clinical High Risk for Psychosis (CHR-P) – A SAMHSA Grant Program

On September 30, 2018, SAMHSA awarded a 4-year grant to the Children’s System of Care to address youth and young adults at clinical high risk for psychosis. CSOC worked in partnership with DMHAS to develop the program, which provides outreach and intervention for youth and young adults up to age 25, who may be experiencing prodromal symptoms of psychosis.

The program utilizes established behavioral health agencies who are currently providing treatment services for persons experiencing first episode psychosis (FEP). NJ PROMISE provides intervention to approximately 60 youth and young adults across three regions annually. Through extensive outreach, coordinated care, the use of evidence-based, evidence-informed, best, and promising practices, as well as the expertise of a team of professionals, participants and their families will have the tools necessary to lead productive lives in their homes and communities.
The project’s measurable goals are to:

- Reduce the percentage of youth/young adults at clinical high risk for psychosis who become hospitalized.
- Reduce the prevalence of psychiatric symptoms that youth/young adults at clinical high risk for psychosis experience.
- Increase the percentage of youth and young adults at clinical high risk for psychosis who adopt their collaboratively developed treatment plan, including all recommended medication.
- Increase the overall functioning of youth and young adults at clinical high risk for psychosis, as evidenced by increased participation at school, employment, and in their communities.

Planning Step 1: Assess the Strengths and Needs of the Service System to Address the Specific Populations

I. Overview of the State's Behavioral Health Prevention, Early Identification, Treatment, and Recovery Support Systems

Department of Human Services

New Jersey manages the public behavioral health system separately for adult and children services. The adult behavioral health system falls within the Department of Human Services (DHS) Division of Mental Health and Addiction Services (DMHAS) while the children's system is within the Department of Children and Families (DCF) Children's System of Care (CSOC). Although both the DMHAS and the CSOC operate in two different departments, both Divisions work collaboratively to serve adults with serious mental illness (SMI) and children with serious emotional disturbance (SED).

The DHS serves more than 2.1 million of New Jersey's most vulnerable citizens, or about one of every five New Jersey residents: DHS serves individuals and families with low income, people with mental illnesses and/or substance use disorders; developmental disabilities; late-onset disabilities; the blind and/or visually impaired; deaf or hard of hearing; and older adults. In addition, the Department serves parents needing child care services, child support and/or healthcare for their children, as well as families facing catastrophic medical expenses for their children.

DHS has the following Divisions: Commission for the Blind and Visually Impaired; Division of the Deaf and Hard of Hearing; Division of Developmental Disabilities; Division of Disability Services; Division of Family Development, Division of Medical Assistance and Health Services (Medicaid); Division of Aging Services; and DMHAS. DHS also provides many support systems for the families of children served by DCF.

In 2011, DHS merged its Division of Mental Health Services and the Division of Addiction Services into DMHAS. The merger provided an opportunity to integrate adult mental health, substance use and co-occurring disorders treatment at all levels of service in an efficient and coordinated manner from the statewide and regional level to the local levels, thus enhancing access and coordination of services, alignment of policies and contracts, and workforce development efforts.

Between 2017-2018, DMHAS went through two major reorganization processes. On June 29, 2017, former Governor Christie filed an executive reorganization plan with the State Legislature transferring the institutions and programs under DMHAS and its staff that support the provision of mental health and addiction services from the Department of Human Services (DHS) to the Department of Health (DOH). The plan stated that "transferring the provision of mental health and addiction services to DOH is necessary to improve health care, remove bureaucratic obstacles to the integration of physical and behavioral health care and effectively address substance abuse disorder as the public health crisis it is." On August 28, 2017, DMHAS became part of DOH.

On June 21, 2018, Governor Murphy announced plans to return the DMHAS back to the DHS, reversing a decision made by Governor Christie in 2017. By restoring DMHAS at the DHS where Medicaid and social services are housed, Governor Murphy's plan would ensure that mental health programs and substance use disorder services are delivered to New Jersey residents in the most effective and efficient manner possible. The four state psychiatric hospitals would remain in the DOH. DOH would create an integrated licensing system for mental health, substance use, and primary care and continue to improve the quality of care in the state psychiatric hospitals. Governor Murphy's plan took effect on August 20, 2018.

Mental Health Services

DMHAS is the state mental health authority (SMHA) that oversees the state's public system of adult mental health services. The SMHA works closely with three regionally-based, adult psychiatric hospitals, and one adult forensic psychiatric hospital. The SMHA contracts with a total of 111 not-for-profit community provider agencies. Of these agencies, SMHA awarded 99 cost-based contracts and 65 fee-for-service contracts. In addition, the SMHA provides 85% of the cost for individuals with a designated county of residence who are uninsured and a 100% of the cost for individuals who do not have a county of residence and are uninsured for the four county-operated psychiatric facilities (New Bridge Medical Center, Essex County Hospital Center, Meadowview Hospital, Cornestone Behavioral Health Hospital of Union County, and the three regional state hospitals and forensic center. The state psychiatric hospitals, county hospitals, and community provider agencies all function as part of the continuum of mental health services in New Jersey.

New Jersey's has 21 counties each county has a Mental Health Board that is staffed by a Mental Health Administrator. The Boards advise the SMHA and the New Jersey Behavioral Health Planning Council (BHPC) of issues and programs that are of significance to their locale and residents. In each county, a System's Review Committee (SRC) is convened monthly in accordance with state regulation (NJAC10:31-5.3(a)). The SRC is comprised of representatives from the acute care community and include staff from: state and county hospitals, short-term care facilities (inpatient units serving individuals on commitment status), voluntary psychiatric inpatient units, the county Mental Health Board, community provider representation (including the county's Designated Screening Center (DSC), Program for Assertive Community Treatment (PACT) and county's Integrated Case Management Services (ICMS) program), family and consumer organizations, and the SMHA. The SRC is charged with the collection and review of service data as well as monitoring the provision of acute care services statewide. Each county has at least one Designated Screening Center with mobile outreach and 24-hour access. The county-based Designated Screening Centers generally determine who meets the commitment standard and requires inpatient treatment.

The community mental health system of services provides for eight levels of care: (1) prevention and early intervention; (2) crisis stabilization services <24 hours; (3) crisis stabilization and diversionary services > 24 hours; (4) acute care services; (5) peer recovery support; (6) family support; (7) treatment and rehabilitative services; (8) county and state psychiatric hospitals. The SMHA contracts for statewide, regional and county/local behavioral health services. Statewide

contracted services include services for specialty populations such as: Crisis Assessment Response & Enhanced Services (CARES) program which provides consultation and training to our hospital and community providers regarding individuals dually diagnosed with a mental illness and developmental disability; Statewide Clinical Outreach Program for the Elderly (S-COPE) which provides consultation and training to nursing facilities and DMHAS residential providers who serve older adults (55 years of age and older) who are at risk of psychiatric hospitalization; and *ACCESS* which provides consultation, residential, outpatient and case management services to individuals who are deaf or hard of hearing and diagnosed with a mental illness. Additional statewide contract services include contracts to provide training and technical assistance to specialized segments of the provider workforce and statewide depositories of behavioral health resource information and self-help information. The SMHA contracts for regional services including: Behavioral Health Cultural Competence Training Centers to provide training and information to providers regarding cultural competence, co-occurring services for individuals with a mental illness and substance use disorder and housing with enhanced supports for individuals with co-occurring medical needs, development disorders, substance use disorders, or criminal justice involvement.

According to its 2021 URS Data Table 3, & 14a, the SMHA served 365,705 unduplicated adult (age 18+ years) persons receiving services SFY 2021. There were a total of 365,705 individuals served in all settings in SFY 2021. Of the total number of unduplicated adult persons receiving services in SFY 2021, there were 346,940 (94.9%) served in community settings; 1,990 (0.54%) were served in State Psychiatric Hospitals, 15,928 (4.36%) were served in other psychiatric inpatient settings, and 847 (.23%) were served in the institutions under the Justice System. Of the total number of unduplicated adults (365,705) served in *all* settings by the SMHA in SFY 2021, 134,470 (36.8%) were reported to have SMI.

Persons diagnosed with a SMI are the primary target population for SMHA funded services. However, the SMHA also provides specialized services to other high risk target populations including persons with first episode psychosis, individuals in need of crisis services, special access needs, older adults, ethnic and linguistic minorities, individuals with co-occurring mental health and substance use disorders, hearing impairment, co-occurring developmental disability, and individuals with criminal justice involvement. Many of the activities of the SMHA focus on inter-organizational coordination and collaboration to improve access for special needs populations. This is achieved through interface with the various Divisions within the DHS including the Division of Developmental Disabilities (DDD), Division of Aging Services, Division of Deaf and Hard of Hearing, Division of Family Development (Welfare), and Division of Medical Assistance and Health Services (Medicaid). In addition, there is coordination with the DCF's Children's System of Care (CSOC) and Division of Child Protection and Permanency (DCP&P), Department of Health, Department of Community Affairs (housing/homeless) and the New Jersey Housing and Mortgage Financing Agency (NJMHFA). There is also coordination with the Division of Vocational Rehabilitation Services (DVRS) within the Department of Labor and Workforce Development, the Department of Corrections, the Administrative Office of the Courts (AOC), the Department of Military and Veterans Affairs (DMAVA), and the Department of Education (DOC).

The Five Criteria in State Mental Health Plan
Section 1912(b) of the Public Health Act (42 USC § 300x-1) establishes five criteria that must be addressed in MHBG plans. The criteria are defined below:

Criterion 1: Comprehensive Community-Based Mental Health Service Systems: **Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring M/SUD. States must have available services and resources within a comprehensive system of care, inclusive of the crisis services, provided with federal, state, and other public and private resources, in order to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities.**

SMHA funds eight levels of service along the mental health continuum of care Mental Health Block Grant, and other federal or state funds. They are: Prevention and Early Intervention Services, Crisis Stabilization Services < 24 hours, Crisis Stabilization and Diversionary Services > 24 hours, Acute Care Services, Peer Recovery Support, Family Support, Treatment and Rehabilitative Supports, and County and State Psychiatric Hospitals. NJ funds four State Psychiatric Hospitals, operated by the Department of Health and partially funds four County Psychiatric Hospitals, operated independently of the state. The SMHA Office of Olmstead, works collaboratively with the state and county hospitals to help integrate patients back into the community.

1. Prevention and Early Intervention Services.

Coordinated Specialty Care (CSC)

The SMHA has utilized the CMHBG 10% set-aside funds for providing services to individuals with first episode psychosis (FEP) since FY 2017. A Request for Proposal was issued in June 2016 for three agencies to provide Coordinated Specialty Care (CSC) services for individuals with FEP. Three agencies: Oaks Integrated Care, Rutgers University Behavioral Health Care (RUBHC), and Careplus Inc NJ, became operational on November 1, 2016. NJ teams implemented the National Institute of Mental Health's (NIMH) Recovery after an Initial Schizophrenia Episode (RAISE) model, which is detailed in the Coordinated Specialty Care for First Episode Psychosis Manuals I: Outreach and Recruitment, and II: Implementation.

The New Jersey's CSC programs emphasize a team approach with the following components: outreach, low-dosage medications, cognitive and behavioral skills training, supported employment and supported education, case management, and family psycho-education. Each CSC team is comprised of, at minimum, six team members of mostly masters' level trained clinicians. They include a team leader, a recovery coach, a supported employment and education specialist, a pharmacotherapist, an outreach and referral specialist, and a certified peer support specialist. Clinicians receive training in the RAISE Manual and the Coordinated Specialty Care model.

New Jersey's CSC services are provided for youth and adults ages 15 to 35 years who have experienced psychotic symptoms for less than 2 years with or without treatment. New Jersey

CSC programs cover 21 counties using extensive outreach efforts. By the end of the fiscal year 2020, the CSC program had received approximately 974 referrals and treated over 477 clients. New Jersey utilized the 10% set-aside funding in the FY 2020-21 to support these three CSC teams in providing evidence-based services for individual with FEP. With increased demand for FEP services, the CSC programs expanded from serving a caseload of 35 clients in FY 2017 to 70 clients per agency in FY 2022 and increased clinical staff from 5.2 FTE to 6.6 FTE levels.

A data evaluation specialist assists in data collection and evaluation. The agencies have been required to submit: Quarterly Contract Monitoring Reports (QCMR); Quarterly Client Clinical Evaluation Data Tables; Quarterly Programmatic Progress Reports, and Quarterly Report of Expenditures (ROE) reports that tracks federal fiscal spending for each agency. The data evaluation specialist reviews quarterly data to monitor the progress of all clients, to evaluate the CSC programs, and also to address all federal data evaluation and reporting requirements.

The New Jersey CSC programs have implemented and collected data from the Mental Illness Research, Education and Clinical Centers Global Assessment Functioning scale (MIRECC GAF) and the Colombia Suicide Severity Index to get an understanding of clients' diagnostic symptoms during treatment in the CSC program. MIRECC GAF is the primary assessment tool used to determine symptom progress in the CSC client base. Scores are collected on a quarterly basis and compared against previous quarter scores. The Colombia Suicide Severity Index is used at intake, after each hospitalization, and on a discretionary basis to assess client suicidality. These measures have also been used by other RAISE programs outside New Jersey and proven to be sound measures for symptom severity among the FEP population.

Since inception in 2017, CSC programs have effectively improved the quality of care for the FEP population in New Jersey. By the end of the fiscal year 2022, the CSC program has received approximately 1635 referrals and treated 719 clients. The psychotropic medication adherence rate was 91% in FY 2022, compared to the national average for medication adherence in FEP populations that can vary from 40 to 60%[1]. CSC has also provided a stable system for FEP individuals to interact in the community through gainful employment, continuing education and return to school, and improved level of functioning for those who remain in care for a consistent period. New Jersey plans to continue utilizing the 10% set-aside funding in the FY 2024-25 to support the three CSC initaitves in providing evidence-based services to individuals with early psychosis.

---

[1] Rafal A. H. Yeisen, Jone Bjornestad , Inge Joa1, Jan Olav Johannessen, and Stein Opjordsmoen. Experiences of antipsychotic use in patients with early psychosis: a two-year follow-up study, BMC Psychiatry (2017) 17:299

Behavioral Health Prevention Efforts of the New Jersey Governor's Council on Mental Health Stigma

In November of 2004, then Acting Governor Richard J. Codey signed the Executive Order that created the Governor's Task Force on Mental Health. One of the recommendations of the Task Force, as per Executive Order #58, was the establishment of a Governor's Council on Mental Health Stigma. The mission of the Governor's Council on Mental Health Stigma is to combat mental health stigma as a top priority in New Jersey's effort to create a better mental health system. The council delivers a message through outreach and education that mental health stigma must no longer be tolerated.

As a part of its work and effort to eradicate stigma, the Council posts training videos related to stigma awareness and messages of hope and recovery on its website. The council conducts outreach to schools, the media and other organizations. The Council recognizes the importance of cultural competency in all of its efforts and inclusion of all groups in prevention efforts. Community partnerships focus on collaboration with all groups to ensure that input, information and guidance in regarding messaging, content and approach are accurate and culturally competent. Staff from NJAMHAA and NAMI NJ coordinate the implementation of the Stigma Council activities. A NAMI NJ staff member serves as the liaison with the Stigma Council and works with the Council to implement statewide stigma initiatives through ongoing outreach and stigma related work and projects. More recently, outreach activity has been in the form of virtual webinars, conferences, in-person learning forms, and community events.

In 2022, the Council developed a work plan to acknowledge and support the efforts of NJ communities that have established Stigma-free zones and to enhance the capacity of communities interested in developing Stigma-free zones. The plan included establishing and supporting a Learning Collaborative of current Stigma-free zone ambassadors and those seeking resources to develop a Stigma-free zone; acknowledging and showcasing ambassadors and communities that have successfully established Stigma-free zones in their communities; compiling resources to support the development and sustainability of Stigma-free zones; and, dedicating space on the Council's website to link community members to Stigma-free zone ambassadors (websites, social media, etc.).

Suicide Prevention

Compared with the rest of the United States, New Jersey has low rates of deaths by suicide, consistently varying between lowest and second lowest in the nation (CDC, WISQARS). However, suicide rates in NJ are following national trends and have steadily risen over the years. The last confirmed age adjusted rate for 2018 was 8.3 per 100,000 (compared to 14.2 nationally). Known risk factors of suicide, which include mental illness, serious physical illness, chronic pain, addiction, loss, economic concerns, trauma, stress, and loneliness, will be exacerbated by COVID-19. A recent CDC survey conducted in 2020 at the onset of the pandemic found that almost 11% of adults had seriously considered suicide in the last month and that the rates were significantly higher among respondents aged 18-24 years, minority racial/ethnic groups, unpaid caregivers for adults, and essential workers. We expect to see long term effects from the pandemic that will likely impact the rate of suicide attempts in the future.

There were 685 deaths by suicide in New Jersey in 2020, making suicide the 15th leading cause of death that year. In 2021, there was a increase to 704 deaths by suicide. The highest suicide rates, if not counts, in both years were seen among those 85 years and older, with a nearly 10% decline in rate from 2020 to 2021 (14.3 to 12.9 per 100,000). In 2020, the next highest rate was in the 55-64 age group, but the following year the next highest rate was among those 45-54 years, who experienced a nearly 20% increase in rate of suicide. The rate among those 15-24 also increased from 2020 to 2021, rising 18% from 6.6 to 7.8 per 100,000 adolescents and young adults. This highest rate increase from 2020 to 2021, nearly 29%, was among those 35-44 years. The largest decline in suicide death rate was among those 65-74 at 24% (from 10.0 to 7.6 per 100,000).

For every NJ resident who died by suicide in 2021, there were approximately nine inpatient hospitalizations and emergency room treatments for suicide attempts with the cost of care totaling more than $285 million, not to mention the great emotional toll on suicide attempt survivors, their families, friends and co-workers. In 2021 there were 2,935 inpatient hospitalization to treat suicide attempts and 3,340 Emergency Department visits to treat self-inflicted injuries that did not require further inpatient care.

The SMHA now funds five (5) centers providing response to calls, chats and texts through the 988 Suicide and Crisis Lifeline, a national response system for suicide prevention, mental health and/or substance use crisis. The New Jersey 988 Lifeline centers together accept calls 24 hours a day, every day of the year from individuals who are seeking assistance or information for themselves, friends or relatives that may be at risk of suicide and in need of services. The Crisis Lifeline is a national response system for suicide prevention, mental health and/or substance use crisis. The SMHA continues to fund the NJ Hopeline, a suicide prevention call line operated by Rutgers University Behavioral Health Care which has been operational since 2013. In calendar year 2019, the Hopeline received a total of 47,162 incoming calls. This is an average of 3,930 calls per month. In the year 2020, the Hopeline received a total of 57,059 inbound calls, with a monthly average number of 4,755. The significant increase in call volume in 2020 was resulted from the effects of the COVID pandemic and was consistent with national trends. To publicize this valuable, local helpline, the SMHA created and distributed posters for display at many gatherings and conferences to providers, agencies and other public places. Given the diverse population of NJ, the SMHA made the Hopeline brochures and posters available in Spanish.

In addition to the Suicide Prevention Hopeline, NJ has several other helplines available for individuals in need:

- Veterans and their families can call a crisis helpline at:
  1-866-838-7654 1-866-VETS-NJ 4 U
- Anonymous and confidential resource for youth
  2nd Floor Youth Helpline: 1-888-222-2228
- Peer Recovery Warm Line: 1-877-292-5588
- NJ Mental Health Cares: 1-866-202-HELP (4357)
- Crisis Text Line: Text “Start” to 741-741
- Cop-2-Cop: 1-866-COP-2COP or 1-866-267-2267

- Mom-2-Mom Help line program: 1-877-914-Mom2 or 1-877-914-6662
  (Peer support for Mothers of Special Needs Children and Adults)

In fiscal years 2019 and 2020 the DHS/DOH Adult Suicide Prevention Committee continued their work of information sharing, collaboration and advising to the governing authority based on identified practice gaps as per survey results. The focus shifted to increasing Community Collaboration and Integration and will be pursued on a regular basis. The membership of the Committee consists mostly of DHS and DOH employees, but includes members from State Universities and Persons with Lived Experience. For 2019 and 2020, the SMHA had requested and received Proclamations from the Governor's Office declaring Suicide Prevention Month and/or a Suicide Prevention Week in September for Suicide Prevention efforts. In 2019, the Committee hosted their annual Suicide Prevention Conference. More than 600 people registered for the 2019 Conference, with close to 500 attending. Attendees included people with lived experience, person receiving services, medical professionals, social workers and community social service providers, educators, community health providers, hospital-based providers, community agencies, administrators, state representatives, and executive leadership. There has been a steady increase of attendance of these annual conferences over the last four years; however, due to COVID-19, the conference was cancelled in 2020.

In 2019, DMHAS hired a staff member for the Medical Director's Office to be tasked with spear-heading the implementation of the state-wide Zero Suicide approach in NJ and consolidate suicide-related activities under her purview. Such an important initiative for NJ is based in the belief that suicide deaths for individuals under care within health care systems are preventable**.** The Zero Suicide Institute under the Education Development Center (EDC) is recognized as the leading proponent and training entity of this model. DMHAS offered 3 virtual Zero Suicide Academies in September and October 2020. This is a signature training for health and behavioral health organizations seeking to dramatically reduce suicides among those in their care. Across 3 separate 3 half-day virtual trainings, DMHAS accepted 30 agencies to commit to the academies consisting mostly of behavioral health agencies. Using the Zero Suicide Framework, participants of the health care system learn how to incorporate best and promising practices into their organizations and processes to improve care and safety for individuals at risk under their care. Funding for this project was included in the 2020 budget.

Besides SMHA, New Jersey Department of Military and Veterans Affairs is participating in the 2021 Governor's Challenge to Prevent Suicide Among Service Members, Veterans and Their Families (SMVF). The United States Department of Veterans Affairs (VA) has partnered with the Substance Abuse and Mental Health Services Administration (SAMHSA) to continue the Governor's Challenges. A total of 35 states are taking part in the challenge and are working to develop and implement state-wide suicide prevention best practices for SMVF, using a public health approach. With the support of the governor, each state formed an interagency military and civilian team to develop a strategic action plan to advance the National Strategy for Preventing Veteran Suicide. Teams are encouraged to include suicide prevention coordinators representing the state public/behavioral health agency, VA, and National Guard.

In response to firearms in a home increasing the risk for suicide among all household members by 300%, DMHAS has partnered with the Rutgers University School of Public Health's Gun

Violence Research Center (GVRC) to address suicide by firearms and safe storage. The GVRC has developed 2 webinars for DMHAS to be posted publically: one on firearms and suicide for the community, and the second for healthcare providers.

Community Behavioral Health Programs contracted by the Department of Human Services and/or licensed by the Department of Health are required to report Unusual Incidents regarding individuals they serve. According to the UIRMS data that DMHAS received, there were 262 suicide attempts and 57 deaths by suicide reported in 2019 and 276 suicide attempts and 53 deaths by suicide reported in 2020. DMHAS requires providers to intensely analyze each of these events to assess opportunities for improvement in their systems and processes. All reports of the providers are reviewed by the DMHAS Mortality Review Committee for patterns and trends among agencies. Many of DMHAS person receiving services, who have died by suicide**,** did not have an evidence-based suicide risk screening or assessment completed, person receiving services were often not appropriately linked to treatment, and oftentimes clear risk factors were overlooked. Members of the Mortality Review Committee review the reports they receive from agencies, make recommendations for improvement, and follow-up on actions taken, if indicated.

DMHAS also continues to receive and analyze data from the NJ Violent Death Reporting System (VDRS)–New Jersey's detailed and timely surveillance system of all violent fatalities—as well as existing NJ data from other systems that capture non-fatal suicide attempts of individuals who received treatment through emergency room visits and inpatient hospitalizations.

2. Crisis Stabilization Services < 24 hours

Call Centers

988 Implentation is funding by both the COVID Supplemental Plan and ARPA plan. New Jersey has five (5) locally based crisis call centers that provide services for the 988 Suicide and Crisis Lifeline. The centers are certified by Vibrant Emotional Health (Vibrant) for meeting the minimum clinical, operational and performance standards. In April 2022, DMHAS was awarded approximately $2.5 million from the SAMHSA 988 Capacity Building Grant to prepare Lifeline centers for the increase in call, chat, and text volume in preparation for the transition to 988. Following the State's procurement process, funding from a combination of federal grants totaling $3.7 million was awarded to the five (5) NJ Lifeline centers. These funds were from the SAMHSA Capacity Building Base Grant, Mental Health/Substance Abuse Block Grants and American Rescue Plan Act.

On July 16, 2022, New Jersey successfully transitioned from the ten-digit National Suicide Prevention Lifeline number to the 988 Suicide and Crisis Lifeline. In June 2022, New Jersey received 4,278 crisis line calls, answering 70% of those calls with an average speed to answer of 37 seconds. The following June (2023) saw an increase of 6.8% in total crisis line call volume and an improved answer rate of 83%. These calls were also answered an average of 8 seconds faster than in 2022. Calls not answered in NJ were handled by Vibrant's national backup centers.

In December 2022, NJ DMHAS was awarded an additional $1 million through the SAMHSA 988 Capacity Building Supplemental Grant. Of this award, approximately $340,000 has been

awarded to four (4) of the five (5) 988 Lifeline centers in New Jersey. (One center declined additional funding.) These awards continue to support centers as they onboard additional staff to increase their capacity to respond to 988 Lifeline contacts.

Additional funding of $12.8 million was allocated in the State Fiscal Year 2023 (SFY23) budget toward the expansion of the 988 Lifeline network to handle the increased volume of 988 calls, chats and texts.

In January 2023, NJ DMHAS published a Request for Proposals (RFP) soliciting applications to establish a Managing Entity (ME) for the New Jersey 988 Suicide and Crisis Lifeline system. Carelon Behavioral Health was awarded this contract and was awarded $1.9 million from the SFY23 state appropriations allocated to the 988 Lifeline network.

Among the NJ 988 ME's responsibilities will be:

- To collect and report 988 Lifeline center data to NJ DMHAS, Vibrant and SAMHSA.
- Dispatch Mobile Crisis Outreach Response Teams (MCORTs) throughout the state once they are operational.
- Establish and maintain a comprehensive resource and referral database for use by all NJ 988 Lifeline centers.
- Establish and help administer a standardized training curriculum to ensure greater consistency of service across all NJ Lifeline centers.
- Monitor call line performance and implement performance improvement activities as deemed necessary.

Through a competitive procurement process, the remaining $10 million in the SFY23 budget for the 988 Lifeline network will go toward the expansion of 988 Lifeline center operations (for current and/or additional centers). This expansion will add capacity to the NJ 988 system and allow a higher rate of response to calls, chats and texts 24 hours a day, every day of the year.

The goal is to reach a minimum of 90% in-state answer rate with no more than 10% of calls being routed to the national backup system. Data provided by Vibrant for the month of June 2023 shows that NJ had an in-state answer rate of 83%. NJ 988 Lifeline centers continue to recruit and onboard staff to expand the capacity for responding to calls, chats and texts. Future funding opportunities and ongoing funding streams are vital to reaching and maintaining this goal.

To establish a "no wrong door" philosophy for 988, NJ DMHAS has been working closely with multiple agencies including the Department of Children and Families' (DCF) Children's System of Care (CSOC)/PerformCare (serving children and adolescents), ReachNJ (substance use treatment resources and referrals), 911, the Department of Human Services' Division of Developmental Disabilities (DDD), and NJ211.

This collaborative work has included other state agencies in New Jersey's system of acute care and crisis response. DMHAS is developing warm transfer protocols for the 988 network. Plans include CSOC/PerformCare, NJ211, ReachNJ and DDD. These transfers will be used after an initial assessment determines specialists on other call lines could be helpful to the individual in crisis.

Mobile Crisis Outreach Response Teams (MCORTS)

Mobile Crisis Outreach Response Teams (MCORTs) will be established as the "Someone to Come/Respond" for the NJ 988 system. The SFY23 budget includes $16 million for the establishment of statewide MCORTs. These teams are designed to respond 24 hours a day, every day of the year to non-life-threatening mental health, substance use or suicidal crises in the community. MCORTs will be comprised of a two-person unit in the field under remote supervision by a third professional from a centralized location. The professionals include: trained peer support specialists, bachelor's level staff with related educational and professional experience (in the field), and master's level supervisors providing clinical consultation.

MCORTs will be dispatched by the NJ 988 Managing Entity after a 988 Lifeline Center determines a community-based response, without emergency responders, is necessary and appropriate.

The goals of the Mobile Crisis Outreach Response system are:

1. Provide timely access to crisis intervention services;
2. Stabilize person receiving services in their community;
3. Prevent hospitalization, re-hospitalization, incarceration and intervention by law enforcement whenever it is safe to do so;
4. Deliver equitable behavioral healthcare to all New Jersey residents.

DMHAS will be procuring for MCORTs and anticipates making up to nine (9) regional awards with multiple counties served in each region.

NJ DHS has contracted with Mercer to provide insight and guidance for development of the MCORT program to ensure the state is leveraging full Medicaid federal participation. Mercer has provided consultation to several other states on 988-related matters and will assist the DHS/DMHAS 988 team in refining procurement documents, drafting a Medicaid State Plan Amendment (SPA) or Waiver for services, and review of MCORT coverage plans and system design.

Crisis Receiving Stabilization Centers

With the mental health block grant 5% crisis set-aside, Covid and funding from the Covid Supplemental Plan and ARPA Plan, the DMHAS will develop crisis receiving stabilization centers (CRSCs) which will advance the development of the crisis continuum in NJ based on the

National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit. The objective is to develop an appropriate alternative to the use of local hospital emergency services and in-patient psychiatric hospitalization, by providing crisis services and placement support for those in need of permanent housing. The goal of this program is to decrease the utilization of local hospital emergency services, designated screening centers, and in-patient psychiatric hospitalization while maintaining crisis stabilization treatment. DMHAS is planning to develop up to five centers.

The target population are individuals 18 years of age and older with a primary SMI and/or SUD experiencing acute symptoms that could interfere with community tenure. DMHAS will be using the "no wrong door" concept and partnering with community crisis responders. Services will be available 24 hours per day, 7 days per week, every day of the year and include access to trained staff who can provide assessment, crisis stabilization, intensive supports, engagement, psycho-education, identification of strengths, collaborative problem solving, and individualized crisis planning. Services will be offered in a safe, clean, home-like environment conducive to the recovery process. Medication management, administration, and education will also be offered. Medication-Assisted Treatment will also be available at the CRSCs. Clinical staff in the program will strive to stabilize individuals and address mental health needs. The program will offer continuity of care promoting continued stability and ensuring linkages are arranged that meet the needs of the individual.

3. Crisis Stabilization and Diversionary Services > 24 hours

Crisis Diversion Homes

Crisis Diversion Housing is funded by the ARPA plan. In order to bridge the gap between homelessness and permanent housing, DMHAS will be developing up to four crisis diversion homes with 5-7 beds each which are staffed 24/7. This program will provide community-based stabilization in a home-like setting and is not long term or permanent housing, The lenth of stay for this program is dependent upon an individual's need and is anticipated to be up to 30 days. At a minimum, staffing will include licensed clinical social work staff, nursing coverage, behavioral health techician, and a prescriber. Although the crisis diversion housing is not permanent, individuals experiencing a recent psychiatric hospitalization or relapse will receive the support they need from professionally trained and dedicated staff to continue their recovery in the community in a home-like environment. The services and supports will be prioritized for individuals who are referred from Crisis Receiving Stabilization Centers and from Mobile Crisis Outreach Response Teams. By providing this additional level of care to the crisis continuum, the goal is to decrease the number of individuals in local emergency departments and emergency screening, including individuals longer than 23 hours while providing a mechanism for referral for crisis receiving and stabilization facilities for indiduals with complex behavorial health needs that require significant services and supports to return to the community. Additional referrals may come from community inpatient programs as a step-down from short-term acute inpatient services providing the opportunity to further stabilize the client and connect the client with services and supports depending upon availability. The Crisis Diversion programs will include linkages to peer supports, clinical services, and housing with a goal of community re-integration

to permanent or long-term housing and supports for the person receving services. DMHAS will not be using ARPA funds for capital expenditures.

Crisis Diversion Beds

The DMHAS contracts with mental health providers to provide 14 crisis beds in three different homes. These are residential settings that are staffed 24 hours a day 7 days a week. The homes focus on providing a recovery oriented residential setting for individuals to help avoid a mental health crisis. The length of stay in these homes is designed to be short term, and typically less than 30 days. The homes focus on rehabilitative skills, crisis planning, and individual recovery goals.

Peer Respite Beds

The DMHAS contracts with mental health providers to provide 20 peer respite beds across the state (4 homes with 5 beds each). These are residential settings that are staffed 24 hours a day 7 days a week. The majority of staff that work in these homes are peers. The homes focus on providing a recovery oriented residential setting for individuals that may need a respite from their current setting and/or may need this setting to help avoid a mental health crisis. The length of stay in these homes is designed to be short term, and typically less than 30 days. The homes focus on rehabilitative skills, crisis planning, and individual recovery goals. These homes will either provide direct prescriber services as needed, or work to link individuals to services as needed. The staff will assist the individual with locating long term housing as well as other services where needed.

Diversionary Beds

The DMHAS contracts with inpatient providers to purchase bed-days in inpatient facilities, known as "Diversion" contracts. The purpose of the Diversion contracts is to afford individuals age 18 and older who would otherwise be admitted to a state or county psychiatric hospital the opportunity to receive treatment in an inpatient setting, which may enable the individual to stabilize and be discharged to the community. The primary goal of the purchase of bed-days is to reduce admissions to state hospitals. Individuals who do not stabilize and require continued inpatient treatment may be transferred to a state or county hospital at the conclusion of their approved length of stay in the contracted Diversion bed. The hospitals that contract for Diversion beds maintain additional bed capacity that is not governed by their DMHAS Diversion contract, and serve a similar population in this additional capacity.

DMHAS currently contracts for access of up to 196 beds at three private psychiatric facilities including Carrier, Hampton, and Northbrook that offer an alternative to state psychiatric hospitalization. Most contracts specify a cost per bed-day of $745.08. The actual spending in calendar year CY 2021 was $7,049,111.08. There were 719 admissions utilizing 18,663 bed days and 92% were diverted from a state hospitalization. In CY 2022 there were 573 admissions utilizing 16,211 bed days and $6,486,550.70 and 90% were diverted from a state hospitalization.

4. Acute Care Services. **The SMHA currently funds and regulates a variety of acute mental health care programs for individuals with acute mental health needs and for those experiencing psychiatric crises. They include Designated Screening Centers (DSC), Affiliated Emergency Services (AES), Early Intervention Support Services (EISS), Involuntary Outpatient Commitment (IOC), and Short Term Care Facility (STCF) beds.**

Designated Screening Centers (DSC).

The SMHA funds 23 Designated Screening Centers (Screening and Screening Outreach) programs across the 21 Counties. The Screening and Screening Outreach Program is designed to provide psychiatric emergency services including screening, assessment, crisis intervention, referral, linkage, and crisis stabilization services, 24 hours per day, 365 days per year, in every geographic area in the state. According to the SMHA's Quarterly Contract Monitoring Report (QCMR) database of information self-reported by the screening programs, there were 65,870 episodes of care to these screening centers during SFY 2022.

Affiliated Emergency Services (AES).

The SMHA also provides annualized funding to 12 Affiliated Emergency Service (AES) programs, which provide for behavioral health staffing at high volume emergency departments. A mental health provider is responsible for the provision of emergency services to individuals in crisis presenting in hospital emergency departments. Emergency service includes mental health and social services provision or procurement and advocacy. Emergency services offer immediate crisis intervention services and service procurement to relieve the client's distress and to help maintain or recover his or her level of functioning. Emphasis is on stabilization, so that the client can actively participate in needs assessment and service planning. Emergency service is affiliated by written agreement with the geographic area Designated Screening Center. (N.J.A.C.10:31). During SFY 2022, the state's 12 Affiliated Emergency Service Programs delivered 25,255 episodes of crisis care (3 Hudson, 1 Middlesex, 3 Monmouth, 2 Morris, 1 Passaic and 2 Union Counties) and received $4.85 million in funding.

Early Intervention Support Services (EISS).

In 2008, the SMHA began investing $3.0 million annually in Early Intervention Support Services (EISS) programs in Morris and Atlantic Counties. These urgent care mental health clinics are intended to provide rapid access to short-term, non-hospital based crisis intervention and stabilization services for persons with a mental illness. These early intervention programs are community-based programs aimed at offering individuals mental health service options that can divert undue use of emergency room and in-patient programs. A comprehensive range of pharmacologic, therapeutic, recovery and supportive services are offered in order to divert undue use of emergency room and in-patient programs. Currently, EISS programs are funded for $21.3 million and serve all 21 counties. In SFY22, there were 17,544 individuals served.

Involuntary Outpatient Commitment (IOC).

DMHAS now funds eighteen Involuntary Outpatient Commitment (IOC) programs that serve all twenty-one New Jersey Counties. Annualized funding is $6.5 million to support these programs,

which have an aggregate statewide service capacity to serve 575 persons. During SFY 2022, a total of 892 persons were served in IOC, with an average active ongoing caseload of 450. IOC programs offer: court ordered out-patient based mental health treatment; assistance with linking with community based mental health services; monitoring of adherence to the court ordered plan; interface with the judiciary including transportation to court hearings and contact with the presiding judge, as needed. Challenges to program development and operations have included; provider recruitment and retention of psychiatrists; operationalization of some aspects of the law, such as managing "unwilling to receive treatment voluntarily" in an outpatient setting and "material non-compliance" with the outpatient treatment plan; matching the law's limits with the right group of persons.

Short Term Care Facilities (STCFs).

In order to meet the needs of individuals who require involuntary in-patient psychiatric services, the SMHA currently designates 420 Short Term Care Facility (STCF) beds. The SMHA has allocated $24.6 million in subsidies for STCF beds, half of the cost is paid by the state and the remaining 50% is paid by Medicaid. There are currently 410 STCF beds which are currently online in New Jersey in 23 general community hospitals. These beds serve all 21 New Jersey counties. Most of these agencies are community hospital based and the STCF beds permit the state's residents to access a hospital based level of psychiatric care at the local community level. For SFY years 2022, the state's System Review Committee database indicates that the occupancy rate for STCF beds was 82%.

5. Peer Recovery Support

The Office of Consumer Affairs in the Medical Director unit has a key role in insuring that individuals with mental illness, substance use disorder, or a co-occurring disorder receive a continuum of prevention, early intervention, treatment and recovery support services delivered by a culturally competent and well trained workforce. The Special Assistant for Consumer Affairs, is a person with lived experience, and leads the unit; oversees peer-run community wellness centers, respite programs, and other peer support programs; as well as contracts for peer training and other specialty services. DMHAS continues to look for opportunities to integrate individuals with lived experience into the workforce. One example is the integration of peers in mobile crisis outreach teams and CRSCs. Additionally, DMHAS has posted guidelines for organizations considering intergrating individuals with lived experience into their workforce. The Special Assistant for Consumer Affairs currently is a member of the DMHAS Divisions Executive Staff committee and is involved in leadership activities with providers. Feedback from the peer provider community is received directly in virtual meetings chaired by the Special Assistant that are held bi-monthly with peer providers, who share accomplishments and ideas, ask questions or raise concerns with each other and with DMHAS staff.

The Special Assistant supervises two full-time staff with lived experience. One staff member serves as DMHAS Ombudsman and as coordinator of a Secret Shopper program. The Ombudsman receives complaints or concerns about provider services, while Secret Shopper program involves peers making calls to agency providers while presenting typical client

scenarios. She also sits on panels that review and score RFPs and other proposals made to DMHAS, and is currently recruiting for a larger pool of potential peer candidates to help conduct these reviews. A second peer staff person works with individuals who have substance use and/or co-occurring mental health issues, and also to provide feedback to DMHAS staff overseeing co-occurring and SUD services. Because of the need to address the opioid crisis and related addiction concerns, this peer position was recently developed into a full-time position in the unit.

Some of the Key Priorities for the Office of Consumer Affairs within the Medical Director's Unit

- Collaborate to raise awareness and to provide tools and resources to address health inequities that result from significantly shortened life spans and high rates of chronic medical conditions in persons with serious mental illness.
- Provide funding and support to the peer community to address the impact of loneliness and isolation and the other social determinates of health.
- Raise awareness and leverage resources in mental health programs about the prevalence of co-occurring substance use disorders and the pronounced need to provide integrated services to persons who struggle to recover from both disorders as well as complex physical health conditions.
- Advocate and inform DMHAS leadership about the need to treat people with compassion and dignity, and to design a system of services and supports that are trauma informed and trauma responsive.
- Empower and support peers in their chosen path to recovery by promoting shared decision making, peer recovery support and harm reduction models, peer respite programs, and peer recovery warm-lines.
- Promote and support the development of a competent and compassionate peer workforce in New Jersey. Peer providers have been identified in the literature as, efficacious and preferred providers of service delivery; and promoting peer providers will help in grow a robust behavioral health workforce in the face of increasing demands, which requires:
    - Getting "buy-in" at a leadership level to impact service design, delivery and agency policies and practices, as well as to support adequate levels of compensation for peer work
    - Elevating the peer-provider profession through education of non-peer staff and professionals about the unique qualities and value of the peers in delivery of care
    - Providing proper peer supervision, mentoring for positive self-care, and supportive networks for work and social life balance are critical in overcoming the challenges of the peer workforce

<u>Collaborative Support Programs of New Jersey, Inc. (CSPNJ),</u>

CSPNJ is a peer-led not-for-profit DMHAS funded agency which provides flexible, community-based services that promotes responsibility, recovery, and wellness through the provision of community wellness centers, supportive and respite housing, human rights advocacy, educational and innovative programs for people with the lived experience of behavioral health conditions.

As a peer-led agency, CSPNJ is committed to peer support and values the dignity and diversity of each individual; relationships as the means for growth and connection; inclusive communities that promote a sense of belonging; people's potential and their ability to grow and change; self-sufficiency through interdependence; and innovation as a challenge to the status quo.

The COVID-19 pandemic undoubtedly had a profound impact on mental health worldwide, resulting in an increased need for mental health and substance use supports and services. The uncertainty, fear, loss and disruptions caused by the pandemic led to a surge in anxiety and stress levels; while social distancing measures resulted in social isolation and increased feelings of loneliness. As a result, many individuals, for the first time in their lives, began seeking behavioral health service to cope with these heightened emotions. For individuals already living with behavioral health challenges, the pandemic exacerbated and worsened these conditions. Factors such as disrupted routines, limited access to social supports and providers, and increased stressors have contributed to the worsening of existing behavioral health conditions.

Because CSPNJ's services are low barrier, the community wellness centers were and are at the frontline of this surge in demand. Thus, CSPNJ saw a dramatic increase in people seeking support and services to manage their behavioral health challenges at their Community Wellness Centers.

Peer Wellness Centers.

CSPNJ's Hudson County Integrated Services (HCIS) is a Community Wellness Center that welcomes and supports people with mental health and substance use disorders who are seeking to improve their quality of life. This is accomplished through individualized, flexible services that promote respect, self-sufficiency, peer leadership, recovery, and community integration. The essence of HCIS is the integration of membership, services and staff in a Community Wellness Center setting designed to sustain and strengthen recovery, wellness and basic living skills for individuals who have mental health and substance use disorders, who are homeless and who have physical and behavioral health challenges.

People come to the Hudson Community Wellness Center to be part of its community, for a safe place to meet people, to get help with basic needs; for referrals to community resources, and to participate in a community that accepts and respects each individual's worth and dignity. The Center attracts over 150 individuals per day. The Center is a community, and through the community experiences, isolation and loneliness are reduced. The Center provides individualized support services, assists people in identifying their needs and aspirations and navigating service systems to move towards greater independence. Center membership is voluntary and it does not require participation in Center activities. However, often members who are moving towards making more positive life choices, go to the Center to give back to other members, which creates a cycle of peer support and mentoring.

The Hudson County Center provides a place for community members to access basic living needs, including food, clothing, housing referrals, financial services, counseling, recreation and socialization activities and self-help groups. The Center provides linkage and referrals to local

and state community resources to help individuals obtain identification documents and mainstream entitlements, legal services, primary and acute physical and behavioral health care, literacy training, GED and educational opportunities, and services to reduce poverty. A partnership with the Community Court was established to allow members to attend virtual court to ensure they receive the assistance they need with their case. The Center currently supports approximately 90 members in Center sponsored permanent supportive housing and has continued working with the Hudson County Department of Corrections, the County Division of Housing and Community Development, and the County Continuum of Care Coordinated Assessment process to house more individuals and connect more center members to stable housing opportunities. Through this partnership, CSPNJ was able to offer Housing Navigation Services to individuals who have received a housing subsidy in Hudson County.

CSPNJ's **Housing Navigation Program** bridges a critical gap in services for individuals that need assistance due to current mental health challenges, as well as additional barriers such as poor credit, criminal, and eviction on their records. These individuals often struggle with housing search and placement also due to technology and literacy barriers, as well as difficulty in negotiating rents themselves and explaining the programs in ways that resonate with landlords. CSPNJ assists these members with application fees and transportation to the apartment viewing, as well as accompanying them if they request. The program provides assistance in way that helps people served to feel comfortable during this process and also helps them reach their goal of housing. CSPNJ has operated a Housing Navigation Program in Hudson County for 2.5 years and has housed 150+ households in that time. The success of the program has allowed the program to expand from one housing navigator to two to better meet the need of Hudson County. CSPNJ seeks to replicate its Housing Navigator Program in Essex County and anticipates serving 120 households within the first year of the program.

CSPNJ also operates **Hudson County's Warming Center** wherein low barrier services are provided to individuals experiencing homelessness, many of which are experiencing mental health and substance use challenges. The Warming Center assists in providing emergency shelter for over 120 guests a night and opens from November 15th through March 31 during Code Blue temperatures at a facility owned by Hudson County in Kearny, New Jersey. The goal of the Warming Center is to provide a low barrier, warm and safe place for unsheltered homeless individuals to spend the night during the winter months despite their personal challenges and disabilities. CSPNJ serves the needs of the overflow homeless population that are forced to live on the streets and in train stations during the winter months. CSPNJ's staff are trained and able to assist with the special needs of individuals who are homeless, and experiencing mental health issues, substance use issues, or intimate partner/domestic violence issues. The program provides peer services and connections to CSPNJs Wellness Center services and Respite locations to assist individuals who may be in crisis or need additional services to help them work on their wellness. CSPNJ also partners with Bridgeway's Mental Health Services/Crisis Intervention and CCBH program to help warming center guests address their mental health needs and also access primary medical care and substance use assistance through this program as well. This year, the program expanded its services to include on-site medical care every evening.

A **<u>Better Life Community Wellness Center</u>** located in Newark, is truly its own community and has been able to follow CSPNJ's Integrated Model and connect members with a variety of services. It is a place where people of all walks of life can come for assistance with mental health and substance use challenges as well as peer services, support groups and activities, get a hot meal, cup of coffee, or some cheer to brighten their day. The doors to this facility opened in July 2018 and have continued to flourish ever since and serves an average of 150 each day. The center has a resource specialist providing ID and birth certificate assistance, social service assistance, referrals to housing and recovery services. The wellness mentors provide peer support to members in the areas of advocacy, resume writing, computer training, professional development, employment linkage, housing applications, obtaining mainstream benefits include NJSNAP, WFNJ / Cash Assistance, SSI / SSDI, free phones / tablets, etc., and assisting members with obtaining health insurance benefits.

The center provides linkages to substance use inpatient & outpatient detoxification and long-term treatment. Within these years, over 200 individuals have been referred to treatment through Better Life. Many have maintained their sobriety and recovery from this service offered. As a result of their recovery, many of the individuals served that were homeless and facing co-occurring behavioral health challenges have secured housing. The Better Life CWC hosts outreach events on a regular basis to help members connect to services that may be available to them in their community. Some outreach services include COVID-19 testing, HIV testing, Hypertension & Glucose Screening, and Food & Clothing Giveaways. Better Life Community Wellness Center is a fast-paced, thriving center that provides essential mental health peer services that provides hope and resources so that people served can work toward their wellness and recovery goals and valued life roles.

CSPNJ also assists and performs outreach from peers in the community with New Jersey Transit at multiple train stations within New Jersey. CSPNJ was approached by the NJ Transit Inspector after he became aware of CSPNJ's Community Wellness Centers and the services that are provided at the centers. This outreach initiative provides Peer Services and links individuals to CSPNJ's Centers and to a variety of services such as mental health and substance use referrals, Detox, Respite Services, as well as documentation and housing assistance. Five locations throughout New Jersey were identified and include Newark Penn Station, Hoboken terminal, Paterson, Camden and Atlantic City stations as transit stops that were seeing an increase in people experiencing homelessness with behavioral health challenges. During this outreach effort two CSPNJ peer staff are paired up with a designated Outreach Officer that accompanies them throughout their days there, both assisting and providing transportation to CSPNJ's nearby Community Wellness Centers and to any additional linkages needed. This has been extremely effective and productive in both connecting individuals with much needed services and with helping to model for the Outreach Officers how it is best to engage this population and how to use a peer led housing first/ harm reduction model. This project also has a Court component that is used at the stations as well in conjunction with this effort, it allows for individuals that are experiencing mental health or substance abuse challenges to not receive a summons or ticket initially from these officers, but instead a referral to the Center services when appropriate. Collaborative virtual court services are provided with Newark Community Solutions out of the Better Life Community Wellness Center. This has helped create a productive and more positive person first and peer-based approach to what persons served are experiencing at the transit

stations. CSPNJ aims to continue to grow this relationship with New Jersey Transit as it has been extremely helpful to individuals served and has also helped to encourage them to seek services and utilize CSPNJ's Community Wellness Centers to help them get through their current crisis and give them a safe space they can come to daily when in need. The transit terminals have also reported seeing a decrease in individuals using them as a place to stay instead of seeking assistance and has had an all-around positive effect on each of the transit locations.

The Community Wellness Center was developed with the merger of the Center and the Wildwood Wellness and Recovery Center (W2R2). The W2R2 functions as an overnight retreat and training site for Community Wellness Center members and other persons receiving services statewide. The LRCWC has experienced an increase in membership of persons in recovery who cope with mental health issues as well as challenges of substance use, homelessness, shelter/motel residency and other special needs. The LRCWC of Wildwood has worked to develop more extensive and culturally sensitive services that meet the needs of their community. The services include Community Wellness Center activities and groups that are offered in person or virtually, linking members to and delivering food from the local community food pantries, linking members to community resources in order to obtain the services that are needed, and providing peer support and community outreach in the Wildwood/Rio Grande community and the surrounding area. The members and staff at the Learning Recovery Center have networked with various providers within the community. The LRCWC provides wellness and education groups that incorporate the eight dimensions of wellness. These groups include topics such as dealing with anxiety, stress management, recovery, WRAP, budgeting, wellness choices, diabetes, hypertension, men's/women's groups, healthy eating, and exercise. Members and staff alike were also provided the opportunity to receive training in the use of nasal naloxone to prevent death in the event of opiate overdose to a friend, acquaintance, or family member. Over the past year, the LRCWC has been instrumental in providing naloxone training to 119 members and staff. Upon receipt of naloxone training, the individual receiving training is eligible to receive their own naloxone administration kit free of charge if desired. The naloxone kit is replaced free of charge if expiration date is reached, or kit is used for opiate overdose reversal.

NJ State Psychiatric Hospital-based Wellness Centers have been working to increase their membership. These centers created new half-page fliers with the hospital-based center's information on them to show-case SAMHSA's eight dimensions of wellness. They created business cards, newsletters, and weekly calendars to remind hospital staff and members that the centers are available resources for wellness and recovery services to the population at the hospitals where they work.

Centers continue to use "Welcome to the community cards" which remind a person receiving services that when they are ready and when they get discharged into the community, after a long-term hospitalization, they have friends, family, wellness centers, peer-operated warm lines, agency support, including paid professionals, that they can reach out to for support and assistance in order to avoid re-entering the hospital system. Seeing the importance of the "Welcome to community cards" along with the isolation caused by COVID 19 and expansion of telehealth services and supports led to a new pilot program to address the need to have access to communication and connection immediately upon discharge.

In April of 2021, Collaborative Support Programs of New Jersey Wellness Centers partnered with New Jersey Department of Health to implement the cell phone pilot program at three of their four state psychiatric hospitals. The project targeted individuals being discharged from the hospital who had also participated in vocational/supported employment services. In September of 2022, the cell phone project was expanded to include all individuals being discharged from any of the four state locations. In year one 165 phones were provided with a goal of 555 phones to be delivered in year two. Prior to a person being discharged from the hospital they sign an agreement to have their new phone number provided to Community Wellness Center for ongoing peer support post discharge. Orientation and education are provided in collaboration with vocation teams on how to use the cell phone including: assist person with entering contact information for the community wellness center, providers, and natural supports, entering upcoming appointments in their calendar and set up a personal email account. There is also linkage to a Community Wellness Center located in county of residence pre discharge via telephone or virtual meeting. Brochures and calendars for Community Wellness Center and Peer Respites were also provided at time of discharge.

The Hospital-based Wellness Centers have been working toward utilizing the Recovery Library by incorporating the materials found at the site for use in support groups and one-on-one purposes. Personal Medicine cards are available to the membership as well as “public logins” that any of members can use when they need to and access the website information. There are many valuable resources in the library that the person receiving services can learn from. The Trenton Psychiatric hospital-based center has also been providing support to the Ann Klein Forensic Center (AKFC) since it began operating eight years ago. Originally the staff provided groups to the Transitional Alternative Programming (TAP) program at Ann Klein. Most recently, groups are offered on the Rehab units at AKFC. Examples of the groups at the forensic site are groups focusing on the materials found in the Recovery Library, WRAP topics, 8 dimensions of Wellness, “Shared Recovery Stories”, “Coping in a locked environment”, and other topics as requested by engaged group members.

One-on-one peer-to-peer mentoring and support does happen on a regular basis, although sometimes it is at special request by staff or by patients who are serving time there. In the one-on-one encounters individuals have sometimes expressed an interest in becoming peer support specialists when they get back into the community. In fact, one of the original peer mentors is currently working as a manager in the peer support community.

The expressed desire of center members to become peer mentors led to another new collaboration at Trenton Psychiatric Hospital to provide access and scholarships prior to discharge to enroll in peer certification programs. CSP-NJ the contracted provider for the on-grounds centers have currently supported six individuals starting their new career path and will expand this project at all three locations.

CSP’S Financial Services.

This program/services was developed in 2002 with the mission to given access to economic opportunities, people in recovery with psychiatric disabilities living in poverty will achieve financial stability, security and independence through increasing financial knowledge and

net worth. Poverty is one of the key barriers to recovery. CSP seeks to promote systems transformation that promotes asset building and economic prosperity. The Financial Services' mission today is "to promote self-determination, self-sufficiency, community integration and personal responsibility by offering products and services that increase a person's wealth through financial education, personal assets and employment. This is done through a wellness and recovery approach".

The following are the services provided:
Financial Management Accounts. This program provides financial management services to address the issues with budgeting, debt reduction and bill payment to an average of 135 supportive service recipients and community wellness center members across the state. To provide a more convenient service, debit cards have been provided to all money management participants from CSP locations across the state and have proven to be a very convenient and successful tool for our clients.

Social Security Administration (SSA) Representative Payee Service. This program is available to an average of 105 supportive housing recipients and community wellness center members across the state currently receiving the service.

Financial Coaching. This program offers one-to-one coaching with supportive housing participants and community wellness center members to work on financial assessments, financial planning, debt reduction, addressing credit and tax issues and setting short and long terms savings goals.

Savings Incentive Initiatives Accounts. These are offered to an average of 123 supportive housing recipients and community wellness center members across the state who are currently participating in one of the 3 match savings programs offered to acquire a productive asset, such as car maintenance, apartment security deposit, furniture, household items, clothing for employment, etc.

Emergency Micro-Loans. These loans are offered free of charge to assist supportive housing recipients and community wellness center members with short-term financial emergencies and unanticipated expenses. Participants are encouraged to participate and complete the financial education curriculum offered; develop a financial and savings plan that will ensure repayment of the loan; and establish financial security for the borrower by beginning or continuing to save towards a goal.

Financial Literacy Education. This program provides a series of one-on-one web-based or group training that is offered at chosen locations every year to CSPNJ administered community wellness center and/or office locations utilizing the Money-wise curriculum designed to engage and change a person receiving services' attitude about money and their relationship with money.

Vacation Club. In this program participants who are people with mental health and substance use challenges living in poverty. Participants will save money during the year and CSP coordinates the vacation club trips on a limited budget. The chance to get away, recharge and restore for even just a few days a year, is a critical step toward healing and recovery.

Fall Festival. The festival is an annual event where 300-400 peers all over the State, including those in the state psychiatric hospitals, get together to learn about different services available in the community and meet other members of the community. Presentations, games, talent shows are part of this event.

Peer Respite Centers.

There are four peer respite programs in New Jersey, three are peer-operated by Collaborative Support Programs of NJ (CSPNJ) and the fourth is operated by Legacy Treatment Services according to a peer respite model that is nationally recognized. The purpose of the peer-run crisis respite is to offer a low-stress, home-like environment to an individual who is experiencing either a crisis or an emotionally distressing episode to take a “time out” of life pressures to re-evaluate what is going on with him/her to understand the source of the difficulty and then to plan on how to move forward in a more deliberate, self-protective way in order to divert this type of situation from recurring. This is done with the help of a peer counselor as well as in a group setting with other guests at the respite. Respite has diverted many people in crisis from going into the hospital--saving money compared to a typical psychiatric stay and providing by all accounts a less traumatizing experience.

The peer respite houses are located within settings in New Brunswick, Newark, Haledon, and Tom’s River in NJ. The Wellness Respite Services provide an alternative to hospitalization which instills a sense of hope, empowerment, and self-determination in people in emotional distress fostering recovery and wellness in order to pursue valued life roles and personal goals. The peer-run respites are staffed 24 hours a day, seven days a week. They help Respite guests, i.e., people receiving services, to restore capability and balance. The respite sites provide intensive short-term support for individuals in the community through an alternative environment to inpatient hospitalization. They empower a person in crisis to re-establish healthy habits and routines. The respite helps enhance coping skills to manage crisis or distress in order to resume valued roles. They encourage and strengthen wellness self-care so that the guest can be successful in managing the immediate crisis and resume valued life roles and responsibilities. The respites provide linkage to local Community Wellness Centers and assist guests to become or remain linked with their healthcare providers, jobs, schools and communities.

They serve New Jersey residents who are 18 years of age and older and who are in crisis or emotional distress due to mental health and/or substance use issues. In SFY 23, Peer Respites have had over 462 individuals that were served in peer respite. Because the program is peer-run, the relationship between staff and guest is a collaborative one as staff comes from the perspective of a fellow traveler. Thus, Respite staff view the guest as the expert on himself or herself. The program offers up to a 10-day stay in a warm, safe and tranquil setting where the guests receive intensive support from peers which includes working through a Wellness Plan that addresses their emotional distress and overall health. The Wellness Plan consists of individuals’ self-defined recovery goals which address their current distress and help them to avoid future ones. The Wellness Plan is the primary focus of a guest’s stay. Staff and guests meet daily to work on their Wellness Plan. All guests are eligible for 30 days of follow up services

after their respite stay has ended, wherein guests continue to work on their wellness plan goals while transitioning back to their homes.

Referrals to the peer respite program come from a variety of settings including family physicians, case managers, therapists, psychiatrists, family members, and friends. However, anyone is able to self-refer to the program. All of the intakes occur directly over the phone and determinations are made during the intake process. CSPNJ respite staff members are actively involved in their communities. For example, the respite staff members are committee members of Middlesex County's Campaign to End Stigma. Respite staff also participate in a Behavioral Health and Justice Involved Taskforce and take part in multiple counties' Crisis Intervention Training for Law Enforcement which seeks to decriminalize mental health disorders and divert individuals from the criminal justice system. Furthermore, respite staff continue to collaborate with important groups such as NAMI and family supports such as IFSS. Additionally, in the Spring of 2022, CSPNJ staff wrote a journal article which was published in the Journal for Psychosocial Nursing titled "A Welcoming Space to Manage Crisis: The Wellness Respite Program" which distills the elements of Peer Respite which make them a vital and effective alternative to hospitalization (this article can be viewed at https://journals.healio.com/doi/full/10.3928/02793695-20220428-04) Furthermore, in the Fall of 2023, CSPNJ will be hosting a Conference about Peer Respite which will share best practices and the successes of the programs.

Residential Healthcare Facilities/Boarding Homes.

Outreach is provided by MHANJ and CSPNJ Wellness and Recovery Centers to individuals residing in Residential Healthcare Facilities and Boarding Homes. In Ocean County, the Journey to Wellness and Brighter Days centers have partnered with Ocean County Human Services, Police, social service agencies, and the NJ Department of Community Affairs to expand access to the services offered and bringing peer recovery services into the homes and transporting clients to community wellness centers. This effort has spawned legislation to create greater community engagement with the facilities. The residents have been assisted in setting up emails so that they can receive outside information that they sometimes request. The center staff are helping the boarding home residents with computer skills so that they can find phone numbers and addresses for various agencies in Ocean County. The centers provide groups based on the eight dimensions of wellness specifically for the Boarding Homes residents: Budgeting, Independent Living Skills, Health, Fitness, Nutrition, and Emotional Wellness. Center staff assist Boarding Home residents with transportation to and from The New Jersey Motor Vehicle Commision (MVC) to obtain identification and to Social Services for Social Security benefits. There have been many outreach opportunities including program opportunities, shopping opportunities, etc. Residents have been assisted with clothing, personal care kits, and are provided a meal by center staff when visiting the center. The residents enjoy many social/recreational activities at the centers and off-site activities such as: playing board games, music groups, holiday parties, barbecues, minor league baseball games (tickets are donated by the team), CSP-NJ Fall fest, and Coalition of Mental Health Consumer Organizations (COMHCO) Conference. There is much more that has been done in the past year to make the Boarding Home residents' lives just a little more hopeful and empowered.

Hearing Voices Self-Help Support Groups. These groups are transforming the lives of people all over the world by allowing them to understand and cope with the experiences that have long confused and frightened them. Statistics show that anywhere from 3-10% of the population hears voices that others cannot. Although the traditional attitude in the mental health system has been to eradicate these voices, research now indicates that voices should be viewed as a meaningful experience, linked to a person's life story, and that talking about the voices is in fact crucial to recovery. Studies have concluded that most people who hear voices have experienced some type of trauma. The New Jersey groups offer people a safe environment where they have the opportunity to share their experiences without the threat of censorship, loss of liberty, or forced medication. Hearing Voices groups are not only comprised of those who experience auditory hallucinations, but those who experience any sensation perceived to be unusual and separate from one self. These groups act as a source of information to voice hearers, caregivers, and the general community by offering coping skills, support, acceptance, validation, recovery, and most importantly hope. Currently groups are operating at most of the CSPNJ operated Wellness Centers, as well as, at the Riverbank Self-help Center in Burlington, NJ which is operated by Catholic Charities, Diocese of Trenton. In addition to live, in-person groups, CSPNJ also provides virtual groups online. This online delivery method has proven popular within the community. Anyone who hears voices or has unusual sensory experiences, caregivers, as well as anyone in the mental health field who may have an interest in the phenomenon of hearing voices, are encouraged to seek out HVN to determine firsthand whether the services provided may offer some benefit. CSPNJ HVN is a welcoming community that encourages inquiries.

GROW Support Groups: CSPNJ has worked to expand the number of GROW support groups offered statewide. What makes GROW unique? The innovative way the GROW groups are run. The groups are a twelve-step program that encourages and supports participants to become the person they want to be. The groups meet weekly, and participants are charged with working on something that they choose for themselves. Reports on progress are discussed weekly and positive reinforcement and suggestions are given. Each member is free to discuss any problem they encounter or to talk about how their feelings and where they are at in their recovery. GROW is about people helping each other where they are at in any given time and developing healthy coping skills. GROW is another alternative strategy to achieving good mental health.

Coalition of Mental Health Consumer Organizations of New Jersey Incorporated (COMHCO).

COMHCO is a statewide membership organization comprised of adults dedicated to improving the quality of life for themselves and their peers with serious mental illness through education, empowerment, and advocacy. The goal of COMHCO is to provide education on the key issues of self-determination, wellness and recovery and to work toward ending the stigma associated with mental illness. COMHCO is a forum for the presentation and discussion of information that guides mental health survivors in their quest to achieve empowerment and advocacy for themselves and their peers. The ideal of personnel development, education, employment, and public awareness are central to the values needed for individuals to become full and responsible members of the larger society. COMHCO General Membership consists of 4,000 individuals. An Annual COMCHO Consumer Conference is held each year. This year's conference COMHCO Going L.I.V.E. (Listening, Informing, Voicing and Educating) was held in April with a focus on

advocacy and the peer movement: history and future. There were 14 workshops offered on various topics including: Self-Advocacy, Individual Rights and CEPP status, Legal Advocacy, Legislative Advocacy, Systems Advocacy, History of Peer Movement, and development of 988. The Conference also offered a Resource room with both peer and professional groups sharing information.

Workshops were selected based on input from the membership and mirror ideas, as well as suggestions that were raised during the monthly meetings and from past conference evaluations. With an attendance of 265 individuals representing a cross section of state and county hospitals, Community Wellness Centers, Recovery Centers, Support Groups and other consumer organizations throughout the state, the conference offers not only topical workshops but affords the opportunity for inter-county networking, information sharing and gathering, as well a forum to share strategies used for both advocacy and wellness. A highlight of the conference is not only the yearly keynote address, which supports the yearly theme-based on suggestions and the approval of the membership, but the NJ Assistant Commissioner of the Division of Mental Health and Addictions Services Annual State of Mental Health in New Jersey presentation. The presentation provides an update to ongoing issues of importance and informs members of new initiatives. This forum reinvigorates members to the value of their partnership in their personal recovery and reinforces the place that NJ Mental health, addiction, and co-occurring person receiving services hold as stakeholders in NJ Wellness and Recovery Programs.

Members are encouraged to become active in developing and supporting COMHCO's organizational activities and network strategies. Monthly meetings provide a regular forum for persons with lived expertise to share their experiences while encouraging newer members to see the value of both personal and systems advocacy to strengthen the mental health system and to ensure that programs are aiding them in meeting their own Wellness and Recovery Plans while also reinforcing the values of the Psychiatric Advanced Directives in daily living. These monthly membership meetings, which are combined with quarterly Board Meetings, strengthen the members involvement.

COMHCO has developed working relationships with: Collaborative Support Programs of New Jersey, Disability Rights of New Jersey, State Consumer Advisory Committee, NAMI-New Jersey, Mental Health Association of New Jersey, Depression Bipolar Support Alliance of New Jersey, Consumer Provider Association of New Jersey, National Coalition for Mental Health Recovery, Supportive Housing Association of New Jersey. Members hold representation on various State and county boards and committees, such as: NJ DMHAS Behavioral Health Planning Council, New Jersey Mental Health Citizen Advisory Council, NAMI-New Jersey Board and Committee, Consumer Public Policy Committee, New Jersey Mental Health Coalition, NJ State Consumer Advisory Committee, NJ Suicide Prevention Advisory Committee, and County Mental Health and Addiction Boards.

<u>Wellness Dollars</u>: DMHAS reallocated some of its already existing funding dollars to create a competitive opportunity for Wellness Centers/Self-help Centers to apply for additional "Wellness Dollars." Through an application process in which the managers had to explain how they would use these particular funds to address the memberships needs surrounding specific

dimensions from SAMHSA's Eight Dimensions of Wellness, and how that additional funding would assist to enhance services in dimensions that were important to the members of each Center. This funding for these wellness directed projects plays a crucial role in supporting individuals in their recovery journeys by providing resources, services, and opportunities that are essential for their well-being and progress. For example, one Center chose Physical Wellness and used Wellness Dollars to purchase exercise equipment, (a treadmill and 2 exercise bikes) as the membership identified that having access to this equipment would help them reach their physical wellness and recovery goals.

The CSPNJ Wellness Institute

Under the direction and leadership of Dr. Peggy Swarbrick, the developer and leader of the 8 dimensions of wellness model adopted by SAMHSA, the Wellness Institute continues providing expertise and support to help implement the wellness in 8 D model for people at risk and living with a range of behavioral health, and stress related challenges.

In collaboration with the University of Illinois at Chicago (UIC), Dr. Peggy Swarbrick and CSPNJ developed and disseminated state of the art wellness resources which can be found at the following link: https://www.center4healthandsdc.org/solutions-suite.html.

The following are some of the training and publications of the Wellness Institute.

Peer Support Training

In the fall 2022, Dr. Swarbrick developed Ethics for Peer Support staff at CSPNJ Wellness Centers and facilitated small groups sessions to train 65 peer support staff working at the community wellness centers.

Dr Swarbrick has developed a **Peer Recovery Specialist Supervisor Training Manual (Swarbrick 2022. Peer Recovery Specialist Supervisor Training Manual Collaborative Support Programs of New Jersey).** Many have been seeking training and technical support guidance to ensure that all peer support supervisors are adequately prepared to fulfill the role especially masters prepared supervisors who have not completed the peer support training program.

New Wellness Products

The UIC Solutions Suite for Health & Recovery offers tools, curricula, and implementation manuals for free and immediate use in mental health centers, peer-run programs, or one's own life. The Suite is Co-Directed by Dr. Peggy Swarbrick. Its products are co-developed with the Collaborative Support Programs of New Jersey.

Updated the following resources

- ***Wellness Activities*** introduces people to strategies that help them create new health habits of their own choosing. Each lesson has been constructed as a group activity that maximizes learning through building positive interpersonal relationships and actively involving participants.
  https://www.center4healthandsdc.org/wellness-activities.html

- ***Physical Wellness for Work:*** Success at work requires a level of stamina, energy, and concentration that can be challenging to sustain without attention to daily wellness habits and routines. Physical Wellness for Work offers manageable activities to augment health and wellness. Its underlying philosophy is that even small changes in daily habits can result in increased energy and health for a better and more satisfying workday. https://www.center4healthandsdc.org/physical-wellness-for-work.html

Mental Health Association in New Jersey Peer Services

The Mental Health Association in NJ has been a leader in the creation and development of peer services in NJ since the late 1980's. Through grassroots partnership with persons receiving services and organizations, Collaborative Support Programs of NJ, Coalition of Mental Health Consumer Organizations, and the DMHAS sparked and operated the first drop-in centers, first consumer supported housing, peer case management, lead the wellness and recovery movements, certification of peer specialists, and launched peer run services independently and in partnership. Empowering the voice of peers is the overarching goal and continues to be the foundation of all their work today and in the future.

MHANJ operates three Wellness Centers: (Individuals in Concerted Effort (ICE) in Atlantic County, Journey to Wellness in Ocean County, and Esperanza- in Union County).

- Each center has emerged from the COVID Pandemic as a stronger- more integrated community center. During the pandemic- the centers combined resources to create "United By Wellness"- UBW is a virtual wellness center-that offers 7-day week menu of peer delivered support, education, recovery (including co-occurring), and socialization groups. Today UBW continues offering an average of 50 groups a week to each of the center's members and is open to individuals across the state. The shift back to face-to-face services from COVID has been slow, as the advantages of virtual support for many eliminated the barriers of transportation, childcare, and limited access to meetings and services. The return to more in person services has not decreased the engagement virtually, with these centers needing to maintain both tracts of services to meet the need of individuals served.
- Outcomes: This project has more than doubled the reach of each wellness center creating a large vibrant recovery community of over 2000 registered virtual members, specialized support groups including LGBTQI, Black Women, Co-occurring, and those with physical disabilities, Veterans, and a wide variety of music and fun groups. Centers have opened new partnerships to support the growth of peer support and attracted a more engaged membership.

Peer Outreach Support Teams are operated by MHANJ in four counties- Atlantic, Hudson, Ocean, and Union counties.

Each county POST program provides peer-to-peer one-on-one support and short-term basic case management services. The peers providing these services are certified as a mental health peer specialist (CRSP) and many as a substance use peer specialist (CPRS) and receive supervision from a more experienced peer, as well as ongoing training.

Referrals to this project can come through DMHAS funded programs, community and family programs, and self-referrals. During the COVID pandemic the program operated in a hybrid format with virtual video, text, and telephone support, with limited face to face contact. During COVID services expanded to assist with delivery of food, medication, and other necessities to those isolated. Client engagement focuses on peer-to-peer support to promote wellness, recovery, whole health, employment, and community integration. POST workers are the "experts on accessing local services – and mentoring peer support, and work extensively with persons with co-occurring substance use disorders.

- **Outcomes**: POST is funded in each county for between 1.5 FTE and 2 FTE and provided services averaging 60 clients per year, for a total of 220 in the previous year, with outcome surveys showing significant positive changes in both mental health and life situations The demand for peer support services- POST continues to grow – especially with MHANJ integrating it into other county based programs and contracts, especially in the Ocean county program- where POST is funded to provide specific peer services to family members, aging out youth, seniors, physically disabled and individuals with both housing and food insecurities- each on a fee for services basis. POST's certified peer support and case management, and behavioral health experiences fits a growing need in the community. POST program staff are integrated with re-entry programs, participate in Crisis Intervention Training (CIT) and are key referral sources in other criminal justice efforts.

Wellness Recovery Action Plan (WRAP) and Whole Health Action Model (WHAM) has been MHANJ primary vehicles to provide wellness tools to our adult and family communities.

The use of WRAPs began in 1998 as MHA sponsored a WRAP Conference with founder, Mary Ellen Copeland. WRAP has been integrated across all programs, messaging, and training- with completion of the WRAP 18 Hour Seminar #1 a requirement for all staff- as well as a pre-requisite for the CRSP peer certification. MHANJ is the only accredited provider of Certified WRAP Facilitator training in the state.

- **Outcomes**: In 2022, two- 35-hour Facilitator Trainings were provided for peers working in eight different organizations in the state. MHANJ has integrated WHAM into our peer training portfolio with 15 staff members accredited in Whole Health Action Management (WHAM) working across all MHANJ peer services, as well as providing WHAM training in the peer community. The pairing of these two models has created a strong interwoven toolkit for our staff to work effectively and consistently to support an individual in their recovery journey.
- **Challenges and Opportunities**: The challenges to expand WRAP as a peer centered tool are the lack of WRAP trained facilitators to implement the program to its fidelity. WHAM is a strong toolkit, but again, requires a commitment by organization to fully train their staff. Opportunities exist for both tools to be used to expand the footprint of peer services outside of traditional treatment and recovery services. As both programs easily apply to MHANJ, they have proven to be excellent tools to engage new partners

and communities – and funding to support the effort. Certified peers are excellent role models for both toolkits.

- **Building a strong Peer Workforce has been the Goal of MHANJ Consumer Connections program since it was founded in 1997**.
  Consumer Connections began training peers to work in paid positions within NJ's mental health system over 25 years ago. Since that time the program has evolved to a full-scale workforce development program, creating, and supporting NJ's only mental health peer certification- recognized by Medicaid – the CRSP - Certified Recovery Support Practitioner. During the COVID Pandemic, Consumer Connections became a fully virtual training platform- providing the CRSP training, weekly continuing education webinars, peer support groups, and continued to support provider agencies in the hiring process of peers. Consumer Connections also provides the CPRS- the NJ substance use certification training to all its CRSP graduates- to provide them with dual expertise and duel certification to work with co-occurring clients across NJ's system.
- **Outcomes**: In 2022, Consumer Connections graduated over 120 peers for Certification, provided 44 webinars, and multi-day specialty trainings for peers, and for supervisors of peers, and 35 receiving the CPRS SUD training for certification. The project is able to train <50% of individuals that apply for the CRSP certification. This has been one contributing factor to the growing peer workforce crisis in NJ.
- **Peer Recovery Warm line was launched in 2008 to provide a safe place for peer support.**
  The Peer Recovery Warm line (PRW) is entering its 15th year of operation and continues to be hub for peers looking for support. In 2022, over 39,000 calls were made to the PRW. The PRW is staffed with 15 certified peer counselors, seven days a week, including holidays. Using the Individual Peer Support (IPS) model, coupled with WRAP, the team provides support on a one-time basis, as well as providing weekly, and even daily support to individuals in the community. Working in partnership with NJ MentalHealthCares Call line and NJ Self Help Clearinghouse callers have access to a vast data base of services and support groups. In addition, PRW offers GOMO a text/chat component that proactively engages callers (upon their registration for the service) in daily messaging around maintaining one's wellness, and access to support and resources. PRW has become a significant referral source this past year for as the awareness grows of the value of peer support. Demand for these services continues to grow outside of fiscal resources.
- **Outcomes:** PRW received over 36,000 calls but were only able to answer 37% of the calls directly. Peer staff returned messages that increased the call response rate to 51%. This has been a consistent level of performance for the line. The PRW staff continues to focus on the needs of the callers, spending an average of 14 minutes on each call. Surveys of callers continue to report that having access to PRW is an alternative to seeking high intensity crisis support, calling 911 or going to the emergency room.

Empowering Peer Advocacy: A critical element of all MHANJ Peer Services

MHANJ embeds the value of peer advocacy across all peer specialist program staff- via their training, access to the latest advocacy issues, and involvement in legislative and public policy development. Peers have active roles in the development of MHANJ advocacy via the Peer Public Policy Committee, led a partnership between MHANJ, Collaborative Support Programs of NJ, and other consumer oriented organizations. This group provides direct input into proposed legislation, policy development, public testimony, and visits with Legislators on a state and national basis. Internal to the operations of all peer services is empowerment of clients and staff to impact individual client needs, advocacy within systems, and agencies and local government. MHANJ has developed strong partnerships with the substance use disorder network of programs and peer specialists to work together to address the needs of the peer movements and those with co-occurring disorders. MHANJ provides Psychiatric Advance Directive (PAD) training to our staff, peers in the community, and service providers.

- **Outcome:** Peers have established strong leadership positions within MHANJ, taking on the role of Director of our Ocean County Programs, nine peers in supervisor and leadership roles across the agency, and creating opportunities for new peer leadership development. Peers also participate in the development and delivery of testimony to legislators which has had an impact in the community in the areas of 988, mobile crisis response, and the importance of peer certification in the delivery of services.
- **Challenge and Opportunities**: Communication and engagement with younger and diverse populations of peers is a challenge, along with creating new leadership, especially bringing communities of color, LGBTQI+, Spanish speaking peers, and the growing diverse cultural, and spiritual communities. MHANJ has established a bilingual team of peers to develop outreach across NJ into multiple communities using a weekly virtual education/support zoom programs, creation of two LGBTQI+ virtual support groups, and participation in PRIDE parades (peer resource booth and marching), and sponsoring of BIPOC events. These efforts engage mental health peers into these communities in an effective manner that builds relationships and community partnerships.
- **NJ Self Help Clearing house connects peers to peer support.**
  The NJ Self Help Clearinghouse (NJSHCH) was created over 45 years ago and became a national model of developing community bases self-help groups across mental health, substance use, and growing to a wide variety of specialized emotional support groups ranging from grief to domestic violence to physical and chronic illness supports. Today, support groups are integrated across behavioral and physical healthcare, spiritual and wellness groups, and generally every area of our society. The NJSHCH continues today as a strong resource to provide training and technical assistance to help organizations start and grow their local group. With a small staff of 1.25 FTE, the Clearinghouse works to maintain a listing of active support groups across the state that is available to the public via its toll-free number and website.
- **Outcomes:** The Clearinghouse is working with many of the state's wellness centers to provide training to peer specialists to better facilitate groups and sharing this knowledge with partner organization in the community. Partnering with family support organization

within the substance use community has been effective in expanding the number of family facilitated groups. The use of virtual training has expanded the reach of the NJSHCH to reach a new audience, large and small to provide technical assistance and support.

- **Challenges and Opportunities**: The growth of peer specialists across healthcare and community systems will generate new peer support programs. The development of strong peer facilitators of these groups, and the training of members to continue and grow groups is a challenge to the system. This can be a growing opportunity for NJSHCH to continue to lead the growth of this invaluable part of New Jersey's community recovery system.
- **MHANJ's models a strong peer workforce.**
  MHANJ's commitment to build a strong and viable a peer workforce is demonstrated by the empowerment of peer leadership across the organization. MHANJ are one of the leading employers of self-identified peer providers with 45% of the staff having lived experience. Training for the entire staff is focused on the values of peer recovery support- wellness and recovery, and mission, vision, and values- are models for other organizations that MHANJ partner with, especially those new to understanding the value of peer recovery services and supports. An internal peer support meeting run by staff- Coffee Connections, as well as a majority of peer serving on Cultural Competency Committee, and established members of our Public Policy Committee. MHANJ has expanded its peer delivered services to new communities working with older adults, the homeless, and colleges.

Consumer Parent Support Network

Parents with mental illness face the same challenges that all parents face; however, they encounter the additional challenges of medication, hospitalization, the fear of loss of custody of their children and the isolation created by the stigma of mental illness. The Consumer Parent Support Network (CPSN) is an award-winning program whose purpose is to support parents with a diagnosis of a mental illness in their parenting efforts. The services offered include bilingual case management, one-to-one Peer-Parent support, referral and linkage to other services, parenting education and advocacy.

The Consumer Parent Support Network (CPSN) program has a long-standing reputation for providing quality services to parents 18 years and older diagnosed with a mental illness. The CPSN program addresses the critical needs of these underserved and unrecognized parents with mental illness who are caring for their children. CPSN strives to assist the Parent with managing their mental health and wellness needs. Parents typically enroll in CPSN when they are in crisis with multiple complex issues to address. The CPSN program has the opportunity to work with parents who are caring for their children from birth to age 18, offering support and intervention to the parent at different developmental stages of their child and establishing a longer-term relationship.

The majority of the parents who are served, live in unsafe neighborhoods in Paterson and Passaic and are living below the poverty line. The remainder live throughout Passaic County. Due to their mental illness and its impact, the parents often place their children at risk and they struggle to provide basic shelter, food, safety and care. Often the severity of the parents' mental illness causes them to misinterpret typical childhood behavior and desire for attention as misbehavior. CPSN provides parents with education about their own mental health needs so that they can effectively fulfill their desired parenting goals.

COVID-19 had a significant impact on the parents served and as a result, CPSN provided the majority of support services virtually or by phone. The need to interact with parents in that manner was a challenge because most of the parents live below the poverty line and did not have the necessary internet services, phones, available data or minutes and equipment to receive services from the program. MHA of Passaic County were able to ensure that each parent had internet, phone and equipment needed to function during this period. Essential basic needs such as rent, food, electricity, diapers, medication, masks, sanitizer, wipes and reliable phone service was assessed with each parent. Any parent that required assistance received referrals or direct assistance obtaining essential services and needs.

In response, CPSN continued to communicate with all clients regarding food pantry availability, food bag distributions, school/YMCA/Houses of Worship and other food distributions. Furniture, clothing, winter coats, scarves, gloves and hats were provided through donation and purchases. Legal advocacy was secured when needed due to property owner rental issues; illegal utility shut offs or threats to shut off water or power. The parents many of whom are Spanish speaking struggled to assist their children with their classes and schoolwork. Often these parents expressed increased mental health symptoms and received support, coping strategies and engagement with counseling as needed. CPSN provided additional direct assistance by purchasing supplies of masks, toilet paper, wipes, hand sanitizer, toiletries, cleaning supplies, grocery gift cards and clothing.

Despite these challenges and overwhelming needs, the program was able to complete the outcomes by supporting parents and intervening as needed to allow parents to provide a home environment that was safe, structured, and reduced the risk of abuse and neglect; and with stability during crisis periods by advance planning and decision-making. Parents were able to see that their children's needs were met in the following domains: mental health, basic needs health, legal issues, family system and school environment.

Parents were unable to participate in groups until January 2023 due to repeated episodes of COVID but received individual support and educational materials in the following areas: mental health, wellness, child development, stress and anger management, self-care, discipline, structure and establishing routines. They were encouraged to communicate with other parents in the program and join available virtual groups. Parents were able to access CPSN for guidance related to managing their mental health needs related to their parenting role.

CPSN was also able to provide some fun for the families by decorating the office for trick or treating and providing Halloween treat bags. Each parent received four donated wrapped holiday

gifts and 3 books to give to each child. Toiletries, laundry detergent and other household necessities were distributed on 4 occasions. The staff, Board of Directors and the Clifton PBA collected and donated toys, scarves, gloves, hats and gift cards. There is a continued need for clothing, shoes, school uniforms, and car seats, booster seats. Many parents struggled to provide the basic necessities. Food Insecurity is an ongoing concern and CPSN works with each parent to provide individual assistance in this area. Personal hygiene and basic household supplies such as toilet paper, laundry detergent, soap, toothpaste, diapers, feminine hygiene supplies, dish soap, shampoo and conditioner, deodorant, and all-purpose cleaners continue to be unaffordable. CSPN was able to secure and distribute feminine hygiene supplies to the parents who could not afford supplies and at times, they said they would need to stay home from work until they had supplies. The prices of food, personal hygiene and other essential goods has gone up to the point that parents are faced with difficult decisions in prioritizing spending. This year they will try to obtain a grant towards school uniforms since historically all the children need new uniforms and shoes. The cost of these mandatory items has gone up. Parents with multiple children are particularly effected.

Outcomes of this project are as follows:

Outcome #1- **Decrease out of home placements for children.**
Parents will provide a home environment that is safe, structured, and reduces the risk of abuse and neglect; and with stability during crisis periods by advance planning and decision-making.

Outcome #2 **- Enhance family self determination**
CPSN bases the self-determination oriented programming on concepts and recommendations from "Self-Determination in Mental Health Recovery: Taking Back Our Lives," by Mary Ellen Copeland and The Temple University Collaborative on Community Inclusion of Individuals with Psychiatric Disabilities Self-Determination materials. Wellness and Recovery materials and WRAP plans Self-Advocacy Planning workbooks, Psychiatric Advanced Directives and other Peer and research informed practices.

Outcome #3 **- Decrease hospitalizations for parents**
Parents will participate in parenting education and support groups with topics based on child development, resiliency, mental health, Stress and Anger Management, developing support networks and social emotional skills. They will identify when their emotions are interfering with parenting. Develop pro-social and non-violent methods of stress and anger management. Access help when their stress interferes with parenting.

CHOICES Program

Consumers Helping Others Improve their Condition by Ending Smoking

- CHOICES (Consumers Helping Others Improve their Condition by Ending Smoking), an innovative peer outreach program targeting smokers with mental illness in NJ, which employs mental health peer counselors is now ending it's eighteenth year and still going strong. Consumer Tobacco Advocates (CTA) work tirelessly to deliver the vital message to smokers with mental illness that addressing tobacco is important and to motivate them to seek treatment. For this

year the CTAs approach continues to be both an in-person and virtual outreach presentation, to provide consumers and agencies with linkages to tobacco treatment, referrals, support and provision of education materials.

- For grant year 2022-2023, as of April 21, 2023, CHOICES provided **91 site visits (32 virtual)** to NJ mental health treatment providers, interacting with **2,345** consumers who smoke. CHOICES published two newsletters which were distributed to over **1,500** consumers and mental health agencies. A major accomplishment achieved during the 2022-2023 funding year was the updated and revamped CHOICES PPT presentation, which now includes information on Tobacco Risk Reduction, also referred to as Harm Reduction, strategies. These strategies include the discussion of cigarettes per day reduction with and without Nicotine Replacement therapy, along with the recent FDA authorization of certain electronic cigarettes being used for cessation efforts.

- Another effort, which was initiated during the previous grant year and has continued to evolve, was the incorporation of educational information about the intersection between tobacco and cannabis use into the CHOICES presentation. This section includes points on potency, as well as the impact that regular cannabis use can have on mental health outcomes. The Risk Reduction Strategy and Cannabis sections of the presentation has been well received by staff and consumers alike and has provoked much discussion among attendees.

- Since 2005, as of April 21, 2023, CHOICES has conducted over **2,090** community visits reaching more than **58,000** smokers with mental illness. Over **13,013** individuals have received the CHOICES individual feedback session. As pandemic restrictions have been lifted and then reinstated in some locations, CHOICES has continued to offer both in person and virtual presentations. One component of the program, which was reinstated in April 2023, was the use of Carbon Monoxide Meters. This was discussed as a team, and seemed to be acceptable, with less concerns about transmission of Covid 19 and other illness at this time.

- This year, CHOICES was nominated by one of their partners at the George Otlowski Mental Health Center for the Social Innovations Journal "Community Voice Impact" Award, this was awarded for the recognition of CHOICES as a novel strategy to promote community voice inclusion and belonging that influence program and/or policy with a focus on improving health equity for medically underserved populations at greatest risk for poor health. This was a competitive award and voted on by the community members from various sectors. Additionally, CHOICES was invited to present to members of the Middlesex County Professional Advisory Committee in March, to provide an overview of the

revamped CHOICES presentation, along with ideas for how programs may begin to address tobacco among the population they serve.

Delaware House/Transportation Businesses

In 1977, a grant was awarded to Catholic Charities, Delaware House from the Division of Mental Health and Addiction Services to open a peer run "Drop–in Center" to serve the needs of individuals in Burlington County who had a mental health diagnosis. Catholic Charities had already opened a small drop in center two year's prior where individuals cooked and served dinner, played games, participated in recreational activities and planned groups. These activities continue today along with more recovery focused groups with the focus on self-help while following the guidelines of SAMHSA's eight dimensions of wellness. The center continues to grow and make changes based on research and trends in the mental health field and recently met with staff from the Whole Health Learning initiative and are taking advantage of their offered trainings. Each month the center is inviting outside resources in to make presentations to the members. The group, Choices, presented last month on smoking cessation and the County Library has presented on technology and using cell phones and computers.

The center fosters environmental wellness by creating a welcoming space that encourages growth and positivity. Each month there are several groups on emotional wellness including SMART recovery, Emotions in motion and a Men's and Women's group. There is a financial group every other month while intellectual wellness is encouraged through cultural trips such as seeing the Philadelphia Youth orchestra at the Kimmel Center, going to the Franklin Institute and spending a day at the Aquarium. The center is hosting on-going technology groups run by the Burlington County Library. Occupational wellness is made possible by the various work opportunities made available to the members. This helps them develop a sense of ownership in the center while encouraging them to practice work skills they can use in competitive employment. Daily walks help maintain physical wellness and as the weather warms, more outside activities are planned such as nature hikes and outdoor games. Spiritual and physical health are both promoted by yoga and tai chi each month led by a professional yoga teacher. Lastly and maybe the most important social wellness is fostered through an inclusive environment where people are free to express themselves and make social connections with the ultimate outcome of helping individuals reach their full potential, to become independent and move forward in their recovery.

This number continues to grow as they partner with the food bank and are now serving meals on every day the center is open. In addition, they provide canned goods and other items each week to the members to supplement their needs. During COVID they were presenting Zoom groups and were delivering a full meal each week to members. They no longer deliver a meal, but we have maintained a weekly zoom group for those who are unable to attend in person.

Peer-Oriented Transportation Service

As the self-help center grew, the state made additional funds available to create a peer run business that would expand employment opportunities to consumers. The Riverbank Transportation program (RBT) was created in 2001 to provide transportation services to mental health consumers who wanted to work but were unable to access public transportation. The services, exclusive to Burlington County, has been a dependable and affordable alternative to

other county transportation. The individuals using the service have benefitted by gaining independence through employment. For the past 22 years, the service has provided over 40 people employment opportunities. Many of the drivers who have started out part-time have moved on to full-time employment having gained work experience while working on their recovery. Satisfaction surveys are completed twice a year, with 100% reported satisfaction. RBT provides an average of 48 rides per week. Monday through Fridays, from 8:00am until 9:00pm, and is a door to door service for the cost of $2.00 per trip.

With the success of the Riverbank Transportation service, the self-help members were asked to identify other community needs peers could service. Transportation program expanded with Roads to Recovery (RTR) by offering transportation services to community recovery groups such as AA, NA and other recovery focus groups. Over the years, the other community groups that were accessed included Gamblers Anonymous, Sex-addicts Anonymous and Over Eaters Anonymous. One driver works Monday through Friday assisting consumers who would otherwise have no way to get the help they need to support their recovery. The program assists consumers within a ten-mile radius of Westhampton and is a free service.

Both transportation programs remained open during COVID with fewer members due to community recovery groups going virtual and many area businesses closing their doors. The drivers were able to maintain employment by providing transportation to other programs within the agency that remained open. Since COVID has ended, RBT has rebounded well, but fewer individuals using RTR. Some community recovery meetings continue to utilize zoom groups rather than in-person groups. RTR is working to increase numbers to pre COVID capacity. Staff continue to market all of these programs at hiring events, community tabling events.

***6. Family Support.* The SMHA contracts for Intensive Family Support Services (IFSS) and Acute Family Support Programs (AFS).**

Intensive Family Support Services (IFSS). IFSS has been a priority for the SMHA since the inception of the original eight funded programs in 1990. At the present time, an IFSS program is funded in each of New Jersey's 21 counties. These programs enhance family functioning by providing the family with a greater knowledge about mental illness, treatment options, the mental health system, and skills useful in managing and reducing symptomatic behaviors of the member with a serious mental illness. Families also learn patterns of communication and levels of environmental stimulation which have been demonstrated to reduce the number of psychiatric crises and hospitalizations.

Family psychoeducation is offered as part of an overall clinical treatment plan for individuals with mental illness to achieve the best possible outcome through the active involvement of family members in treatment and management and to alleviate the suffering of family members by supporting them in their efforts to aid the recovery of their loved ones. Family psychoeducation programs may be either multi-family or single-family focused. Core characteristics of family psychoeducation programs include provision of emotional support, education, resources during periods of crisis and problem solving skills. More specifically, family psychoeducation enhances family functioning by providing the family with a greater knowledge of mental illness, treatment options, the mental health system and skills useful in

managing and reducing symptomatic behaviors of the family member with a serious mental illness. Family psychoeducation is offered in each of New Jersey's twenty-one counties via the county IFSS Program. According to QCMR data reported by providers, there were 3,216 persons receiving services served by IFSS in SFY 2022.

Services offered include psycho-education presentations, family support groups, single family consultation, respite activities and referral/linkage. Services are delivered in the family home, at the agency or at other sites in the community convenient to individual family members. Engaging minority families has always provided a significant challenge for the IFSS programs. IFSS programs invest significant effort and energy in attempting to attract minority families. Visits occur on a regular basis to a wide variety of mental health programs.

IFSS staff also establishes contact with local churches and clergy as well as appearing at public meetings and events such as health fairs in their respective counties. Additionally, IFSS programs maintain a positive relationship with the New Jersey Chapter of the National Alliance on Mental Illness (NAMI NJ). NAMI NJ affiliate offices are located in each county. NAMI NJ is contracted with the SMHA to provide support, education, advocacy and referral services to four separate ethnic groups through the following programs: Family to Family en Espanol, South Asian Mental Health Awareness in New Jersey (SAMHANJ), Chinese American Mental Health Outreach Program (CAMHOP), and the African American Community Takes New Outreach Worldwide (AACT-NOW!).

Acute Family Support Programs (AFS)

The Acute Care Family Support Project is targeted to families with an adult member experiencing a psychiatric crisis and being assessed in a Screening Center or Affiliated Emergency Service. They provide onsite or offsite support to the family while their loved one is being assessed, educate them regarding services/treatment in an acute care setting, including the commitment process, and link them to existing family support in the community. Family may also include significant others and primary caretakers. In 2022, there were nine programs serving residents of nine counties, which include Atlantic, Bergen, Cape May, Essex, Hunterdon, Middlesex, Monmouth, Passaic, Union. In 2022, DMHAS awarded an additional program to serve the residents of both Burlington and Camden Counties. Due to COVID-19 restrictions on hospital units, there was a decreased activity in these programs through 2022. In SFY 22, there were 137 individuals served in AFS.

7. Treatment and Rehabilitative Supports

The SMHA contracts for Intermediate and Rehabilitative services including: Intensive Outpatient Treatment Support Services (IOTSS); Programs for Assertive Community Treatment (PACT); Project for Assistance in Transition for Homelessness (PATH); Community Support Services (CSS); Residential Services; Supported Employment (SE); Supported Education (SEd); Illness Management and Recovery (IMR); Justice Involved Services (JIS); Integrated Case Management Services (ICMS); Outpatient Services (OP); Partial Care (PC); Statewide Clinical Outreach Program for the Elderly (S-COPE) and Legal Services.

Intensive Outpatient Treatment Support Service (IOTSS). Since 2008, the SMHA has funded 25 IOTSS programs, located in the following counties (1 Atlantic, 3 Bergen, 1 Burlington, 3 Camden, 1 Cape May, 2 Cumberland, 1 Essex, 1 Gloucester,1 Hudson, 1 Hunterdon, 1 Mercer, 2 Middlesex, 1 Morris, 1 Ocean, 1 Passaic, 1 Salem, 1 Somerset, 1 Union and 1 Warren) in order to create quick access to intensive outpatient services for individuals seeking access to treatment through the acute mental health system. These new programs are designed to create dedicated access for person receiving services referred from emergency rooms and other acute settings. In SFY 2022, 3,680 person receiving services were served by IOTSS.

Programs in Assertive Community Treatment (PACT).

Programs in Assertive Community Treatment (PACT) is an evidence-based model of service delivery in which a multi-disciplinary, mobile, treatment team provides a comprehensive array of mental health and rehabilitative services to a targeted group of individuals with SMI. The program is designed to meet the needs of person receiving services, who are at high risk for hospitalization, are high service users and who have not been able to benefit from traditional mental health programs. In order to meet the unique needs of this targeted population, PACT teams offer highly individualized services, employ a low staff-to-person receving services ratio, conduct the majority of their contacts in natural community settings (e.g. person receving services residence) and are available to help individuals address psychiatric crises 24 hours a day. Service intensity is flexible and regularly adjusted to person receving services needs. Per the evidence-based model, person receiving services are eligible for PACT for an indeterminate period as clinically needed.

As a long-term program, in which the course of treatment has no pre-determined end point, most New Jersey PACT teams are staffed with eight to ten full-time equivalent direct care staff and can serve between 70-75 person receiving services at any point in time. There are 31 PACT teams in New Jersey, serving all of the 21 counties. The SMHA contracts with 10 different non-profit agencies that operate these teams. Since state fiscal year 2010, the SMHA has expanded twenty of the 31 teams with additional staffing. As an Evidence-Based Practice (EBP), ACT is endorsed by SAMHSA. PACT will continue to be integral to enhancing the network of community mental health services. Teams have responded to COVID with strategies to maintain face-to-face services by utilizing personal protective equipment, telehealth interventions, and vehicle protective equipment. According to QCMR data reported by providers, there were 2,415 persons receiving PACT services SFY 2022.

Homeless Adults/PATH. The SMHA is the recipient of the federally funded PATH program, which is matched with state funding. The PATH program is authorized by the Public Health Service Act Title 42 of the U.S. Code "The Public Health and Welfare", Chapter 6a "Public Health Service," Subchapter III-A, Part C - Projects for Assistance in Transition from Homelessness (PATH), the target population is homeless adults or those at risk of homelessness who have a serious mental illness, including those with co-occurring substance use disorders who are not currently engaged in and are resistant to mental health and other community support services. The primary objective of PATH is to provide outreach to, identification and engagement of the target population into an array of community services through active case management and referral.

All New Jersey PATH programs provide outreach, screening and assessment, case management and referral services for community mental health and substance abuse treatment services, financial benefits, primary health services, job training/vocational and educational services and relevant housing services including; emergency housing, transitional housing and permanent housing services. A limited number of PATH programs also provide some of the following services directly; security deposits and payment of back rent, mental health assessment and treatment, representative payee services and staff training. Recovery, community integration and housing stability are the long-term goals of the program, achieved through client-centered treatment planning.

The SMHA contracts with 25 non-profit agencies to operate PATH programs within the state's 21 counties. A small number of PATH programs use PATH funding to directly provide psychiatric assessment and outpatient mental health services. Many PATH providers are Community Mental Health Centers and link their persons receiving services to mental health services in their agency such as, outpatient or partial care programs. All PATH programs link individuals to behavioral health and co-occurring services, entitlements and housing (emergency, transitional and permanent) within their communities. In SFY 2022 there were 2,561 persons receiving services served by PATH.

All PATH providers are required to complete Intended Use Plans in which they identify the services to be provided, evidenced-based practices to be deployed, strategies for making housing available, the gender, race and ethnicity of the individuals they are serving in their community; the gender, racial and ethnicity of their staff; and to specify how their staff will provide culturally sensitive services and what cultural competency training and support their staff is provided.

Community Support Services (CSS). CSS is mental health rehabilitation service and supports necessary to assist the persons receiving services in achieving mental health rehabilitative and recovery goals as identified in an individualized rehabilitation plan (IRP); including achieving and maintaining valued life roles in the social, employment, educational and housing domains; and assisting persons receiving services in restoring or developing his/her level of functioning to that which allows them to achieve community integration and to remain in an independent living setting of his/her choosing.

The SMHA contracts with 39 CSS providers (including specialty support models such as Medically Enhanced [MESH], Enhanced Supportive Housing [ESH], Forensic [FSH], and Developmental/Mentally Ill [DD/MI] in all 21 counties. These services are person-driven and housing is leased-based. In addition, the State funds Residential Intensive Support Teams (RIST) which operate under a team-based Supportive Housing model with a high staff-consumer ratio and SMHA funded rental subsidies serving persons receiving services discharged directly from the state hospital system, as well as those at risk of hospitalization.

Individuals eligible for services may have challenging behaviors related to frequent untreated mental illness or lengthy hospitalizations and homelessness. This may include a history of non-engagement with services, refusal to leave a hospital setting, active substance use disorder, and lack of financial benefits and other support systems. Some may have co-existing developmental

disabilities or medical conditions that remain untreated due to lack of physical health services while homeless, or on-going conditions that need treatment and support.

CSS opportunities and program design paired with subsidies demonstrate the principles of supportive housing including lease-based or similar occupancy agreements. Preservation of housing is primary and recognized as essential to overall wellness and recovery. The housing setting will provide private bedrooms, comfortable living space, and adequate kitchen and bathroom facilities.

CSS promotes community inclusion, housing stability, wellness, recovery, and resiliency. Illness management, socialization, work readiness and employment, peer support, and other skills that foster increased self-direction and personal responsibility for one's life are also addressed. Person receiving services are expected to be full partners in identifying and directing the types of support activities that would be most helpful to maximize successful community living. This includes use of community mental health treatment, medical care, self-help, employment and rehabilitation services, and other community resources, as needed and appropriate. According to QCMR data reported by providers, there were 5,658 person receiving services served by CSS in SFY 2022.

Residential Services. DMHAS-licensed supervised residential options offering on-site staff support and assistance with activities of daily living according to clients' needs. Housing opportunities include supervised apartments, group homes, and family care homes. Additionally, residences may be targeted to address special needs: of individuals with serious mental illness and/or co-occurring substance use disorders, short-term Respite Care, Crisis, and Deaf/Blind. DMHAS is developing Crisis Diversion Homes that offer recovery oriented temporary transitional housing for up to 30 days, within a 24-hour supervised setting that includes therapeutic and social supports in a warm and safe environment to individuals who do not need further hospitalization. In SFY 2022, the SMHA served 2,356 persons receiving services in residential services.

Supported Employment (SE). The SMHA has been providing the evidence-based practice (EBP) of supported employment since 1988. SE is provided statewide for adults (18 years of age and older) with severe mental illness and/or co-occurring mental illness and substance use disorders are assisted to choose, obtain and keep integrated employment in jobs of their choosing within their skill and credential set. The SMHA provides SE through 20 fee for service (FFS) contracted community mental health provider organizations. In SFY 2022, 1,422 person receiving services were served by Supported Employment.

Supported Education (SEd). Contracts for SEd services have been awarded by the SMHA since 2006. SEd programs target individuals with SMI and or co-occurring disorders who either want to, or are currently matriculating in post-secondary education. The SMHA provides SEd through four FFS contracted community provider organizations. SEd is accomplished through mobile outreach services aimed to assist people with psychiatric disabilities to reach their postsecondary academic goals. Services are individualized and flexible based on student choice and career goals. In SFY 2022, 137 person receiving services were served by SEd.

Illness Management and Recovery (IMR). Training and consultation of the IMR program in the state psychiatric hospitals continues through a Rutgers University affiliation with the NJ Department of Health, which is called the State Hospital Psychiatric Rehabilitation Initiative (SHPRI). The mission of the affiliation is: to improve the quality of care provided at NJ's State Psychiatric Hospitals through consultation, education, program development, and evaluation, using psychiatric rehabilitation goals, values and principles as well as current research. SHPRI has created an online learning hub on a website as a reaction to the COVID19 pandemic. The site is a collaboration between Rutgers and the New Jersey Department of Health state hospital leadership. The site offers trainings across a variety of subjects including IMR and is free and accessible to all NJ state hospital staff. IMR was offered on-site at the three regional and one forensic state hospitals until about April of 2020, when COVID-19 required a rethinking of how to provide IMR because patients could no longer co-mingle in the hospitals' centralized treatment malls.

In an effort to continue providing IMR, Rutgers faculty made the program on a learning management system (LMS) called Bright Space, and Zoom meetings were also used to provide psychosocial programs including IMR with staff and patients using Verizon tablets. IMR was also added as a core part of the state's new clinical formulary. The clinical formulary is like a medication formulary except that instead of defining the medications available to treat a given condition the clinical formulary identifies the psycho social programs the state has available at each of its sites. As part of the clinical formulary, staff providing IMR will receive rigorous clinical supervision focused on the IMR Treatment Integrity Scale (IT IS) and will include IMR provided online, individually and in small groups. Also, as part of the formulary, basic outcome measures will be collected to check that the program is successful at achieving important clinical outcomes for patients.

DMHAS has incorporated IMR into the foundation of principles and practices central to a recovery-oriented, person-centered system of community mental health services. IMR continues to be incorporated into New Jersey's partial care/partial hospital (PC/PH) systems, community support services programs (CSS) and Programs for Assertive Community Treatment (PACT) programs, and it is supported by regulations. As part of outpatient mental health agencies' contractual agreements with DMHAS, IMR providers are asked to track persons receiving IMR services and the type of IMR delivered (group or individual sessions).

Through a contract with Rutgers UBHC-Technical Assistance Center (TAC), DMHAS provides the following services for agencies across the state and within a given fiscal year: three 2-day IMR introductory trainings, IMR post-training consultation sessions for individual agencies (via onsite, virtual and/or telephone), and monthly IMR Roundtables (virtual consultations for IMR-

trained and contracted community provider network). Reporting of fidelity measures is optional and done through self-assessment with individual agencies as part of their quality assurance protocol. Currently, the Rutgers UBHC IMR-trained network constitutes IMR-trained CSS Programs and IMR-trained Partial Care/Partial Hospital (PC/PH) programs.

Through the same contract with Rutgers UBHC-TAC, DMHAS launched the Agency-based IMR In-House Training and Consultation "Regional" Model in 2015. The model's goal is to help a group of agency-based IMR practitioners develop a collaborative and supportive infrastructure of IMR expertise within their NJ region and at their individual program settings. Participating agency program teams from five neighboring counties (in northern and southern New Jersey regions) complete the 3-day IMR Trainer training and then have follow up meetings with their regional trainer cohort and the Rutgers UBHC IMR team to support their trainer development skills and in-house IMR training programs. Participating IMR practitioners who meet all program model requirements within a 2-year period become NJ Agency-based IMR Trainers. To date, 10 agencies (6 in northern NJ region and 4 in southern NJ region) have actively participated in this program. A training for IMR onboarding Trainers was provided in 2018 to expand agency trainer teams, bringing 13 new Agency-based IMR Trainers to this program. Both cohort teams have operated as self-facilitating cohorts for periods of time and since pandemic are meeting quarterly with the Rutgers UBHC team. This program plans to expand in both regions in FY 2022, and to develop tools, such as the NJ Guide for Agency-based IMR Training, to assist with the expansion.

With regard to the number of behavioral health practitioners who received virtual training by Rutgers UBHC IMR in SFY 2022, IMR implementation continued despite the spike in numbers from the pandemic and continuous pivoting of the programming from in-person to virtual to in-person. The number of IMR practitioners trained was 54, and they represented 22 CSS programs. Another 38 IMR practitioners representing 25 partial care/partial hospital programs were also trained bringing the total IMR practitioners who were trained to 92. Data on service recipients is limited because some agencies did not file reports in FY 2022. However, data reported from 13 of 64 IMR-trained CSS providers indicate that the number of IMR recipients was 233, while 3,812 clients received services with IMR in PCs/PHs, according to reports from 40 of 111 PC/PH programs. Thus, the reported total number of clients services with IMR in FY 2022 was 4,045.

Monthly IMR Roundtables were held virtually have continued to be the core of the Rutgers consultation services. Over the course of a year, 114 staff of IMR trained agencies, including IMR practitioners, supervisors and clinical directors participated in the 90-minute meetings. On average, 10 IMR practitioners attended monthly, representing 24 unduplicated programs (PC/PH, CSS, inpatient hospital and residential).

Justice Involved Services (JIS) DMHAS supports many interventions and collaborations along the six intercepts making up the Sequential Intercept Model including a robust acute care system and funds. The SMHA is involved in very active collaborations with the Judiciary, Office of the Attorney General, local law enforcement, State Parole Board and Department of Corrections. JIS is provided to a diverse mix of persons receiving services, male and female as well as individuals of Caucasian, African American, Hispanic, Asian and Asian Indian backgrounds and from many different countries.

The SMHA has been providing JIS since 2000. SMHA funded JIS services and criminal justice initiatives include, but are not limited to, Pre-booking Diversion such as law enforcement CIT, Post-booking Diversion such as Persecutor division programs and Re-entry services from count jails in particular. The services work to avoid or divert from incarceration individuals whose legal involvement may have resulted from untreated mental illness or co-occurring mental health and substance abuse disorders. These are essentially criminal justice case management services which link persons receiving services who have been entangled with the criminal justice services to needed treatment, psychiatric rehabilitation and other community supports.

Pre-booking Diversion. Pre-booking diversion, Intercept 1, typically involves a police based intervention to avoid arrest for non-criminal, non-violent offenses. Police are trained to identify and de-escalate situations involving persons receiving services and diverting to mental health crisis or pre-crisis services. The SMHA's acute care screening services are a form of pre-booking diversion in that police are able to bring consumersperson receiving services to screening for mental health crisis or pre-crisis services. Crisis Intervention Team (CIT) are local initiatives designed to improve the way law enforcement and the community respond to people experiencing mental health crises. CIT is built on strong partnerships between law enforcement, mental health provider agencies and individuals and families affected by mental illness.

Crisis Intervention Team. DMHAS funds a CIT Center of Excellence through the Mental Health Association of Southwest New Jersey. The Center facilitated the development of new county CIT efforts. Presently nineteen of twenty-one counties as well as the NJ State Police provide training to law enforcement, dispatcher and mental health staff in CIT. These counties offer the training to other counties and municipalities as well as their own. As of May 2019, 276 of 565 municipalities have at least one certified CIT officer. As of May 2021, 5,696 law enforcement and mental health provider staff have been trained. An additional 15 40-hour classes have been scheduled to happen by the end of calendar year 2021.

The SMHA funds JIS programs in fifteen New Jersey counties; represented in Intercepts 1- 3. Additional resources are needed to establish JIS programs in the remaining six counties. Both the Municipal Court Liaison program and the Prosecutor Diversion Program are in limited counties but have been expanded since last writing. In addition, many of the existing JIS programs need additional staff to handle the increased population of probationers coming from the NJ court system. These JIS programs are the infrastructure to which additional resources can be directed to assist with re-entry from state prison and linkage for State Parole Board parolees to needed mental health services.

Post-booking Diversion. Post booking diversion involves an intervention by a mental health staff person so that consumersperson receiving services are released from detention earlier than they otherwise would be; released on their own recognizance or released from jail with mental health intervention and treatment conditions or helping to avoid detention altogether.

Superior Court. One form of post booking diversion that has been formally accomplished in NJ is through Prosecutor Diversion Programs. Prosecutor Offices identify a defendant who has a serious mental illness confirmed by the Mental Health JIS program who arranges for mental health and other services. These become a condition of a plea bargain or dismissal of the indictment.

Municipal Court. DMHAS funds Municipal Court Liaison (MCL) Programs which work directly with twelve Municipal Courts. These programs are officially sanction by the Administrative Office of the Courts (AOC). A case manager, known as a municipal court liaison (MCL) may be stationed at the Municipal Court to identify through the municipal prosecutor or public defender individuals who may have a mental illness and are in need of services. This may result in considerations from the prosecutor to downgrade or dismiss charges with successful engagement. The effort is ongoing with additional municipalities expected to be included as DMHAS resources are identified.

Re-entry Services (Intercepts 4-5) The SMHA has offered Re-entry services (Forensic Case Management) from county correctional facilities since JIS inception in 2000. Programs have between 1 to 2 case managers who interview and enroll potential candidate while in jail, provide pre-release planning and then successful linkage and coordination to mental health and other social/community services. No psychiatric or treatment services are directly provided by the programs but rather link existing mental health services. Counties include: Atlantic, Bergen, Burlington, Camden, Cumberland, Essex, Gloucester, Hudson, Monmouth, Morris (also included some county funding), Middlesex, Mercer (also included county funding), Passaic, Ocean, and Union. However, as a result of Criminal Justice Reform, the number of inmates in the county jails have been reduce by up to 20%, with upwards of 82% staying no more than 24 hours as a result of bail reform, a major component of criminal justice reform. This has resulted in a reduction of referrals to the JIS programs.

Veterans Prosecutor Diversion Program was established through legislative action in 2017. Operated by local prosecutor offices, it affords a veteran with lower level charges an opportunity to access treatment services with the potential reduction or dismissal in charges. The VPDP is potentially available in every county, however, the referral rate is low. The SMHA was actively involved in the implementation and in supporting training as well as providing mental health and support services for those veterans what are no eligible for VA services.

Chief Justice's Mental Health Committee: The Chief Justice of the NJ Supreme court through the Acting Administrative Director revitalized this committee in December of 2019. The committee is co-chaired by the Commissioner of the Department of Humans Services and a Presiding Judge. The Asst. Commissioner for the SMHA as well as a senior manager and other staff are represented on the committee. There are pilot, training, data and treatment subcommittees. Through a collaborative effort, the committee will examine points of intersect between person

receiving services and the judiciary and how mental health services may be accessed as well as examine best practices and potential pilot programs.

Attorney General Countywide Working Groups to Address Mental Health: The Attorney General's directive is designed to establish a framework for County Prosecutors to convene, or in some cases continue, working groups to improve law enforcement interactions with special needs populations and those living with mental or behavioral health issues (County Working Groups). The County Working Groups will review policies, programs and protocols to maximize the effectiveness of their county's response to those with disabilities or those in mental health crisis. In addition, in order to share best practices and provide support and resources to all counties, the Office of Attorney General will establish a Statewide Steering Committee to work collaboratively with the County Working Groups. The SMHA Assistant Commissioner is a member of the Statewide Steering Committee. As well local county mental health administrators and local provider groups will be actively involved at their local level.

Justice Reform. New Jersey accomplished a sea change in criminal justice with the New Jersey Criminal Justice Reform Act which took effect January 1, 2017. It essentially eliminated monetary bail in the state. The new system brought with it, the assumption that innocent people should not be in jail. People can be held only if, a judge reviews the flight risks and any other factors and can typically release the inmate their unless release poses an unacceptable flight risk or poses a danger to their community. A risk assessment was developed and all jail inmates are administered the assessment. As a result of this act, the number of detainees in county jails fell sharply the majority of offenders released from jail in 24 hours. Also, more summonses are issued by law enforcement keeping more consumers in the community.

Integrated Case Management Services. ICMS works collaboratively with the person receving services, their family/significant others (as appropriate) and other collateral contacts to assesses the individual's strengths and needs; develop a service plan based on this assessment; refer and link individuals to needed services, including medical and dental services; and monitor engagement in services. In SFY 2022, the SMHA served 4,934 with ICMS services through 3-16-23.

Outpatient Services. Outpatient services includes counseling interventions provided by trained clinicians to individuals living in the community who require non-immediate care that can be delivered on a scheduled basis. Interventions may include individual, group, and family therapy; medication counseling and maintenance, assessment and testing, outreach services, and referral. In SFY 2022, there were 89,586 persons served in Outpatient Services.

Partial Care. Rehabilitation services are provided within partial care and include engagement strategies that are designed to connect with individuals in order to enter into therapeutic relationships supportive of the individual's recovery. Activities assist a person receiving services to identify, achieve and retain personally meaningful community integration and other personal goals over time which help the person resume normal functioning in valued life roles in self-chosen community environments. In SFY 2022, there were 7,514 served in Partial Care services through 3-16-23.

Adult educational activities are tied to learning daily living skills or other community integration competencies such as financial literacy and basic computer literacy. These services also include a referral to SEd programs for post-secondary education as well as linkage to GED and other adult education programs. Some of the other services provided include:

- Coping skills, adaptive problem solving, and social skills training that teach individuals strategies to self-manage symptoms;
- Psycho-education that provides factual information, recovery practices, including evidence-based models,
- Development of a comprehensive relapse prevention plan that offers skills training and individualized support;
- Medication self-management, behavioral tailoring, simplifying a consumer's medication regimen, and motivational interviewing assist and support person receiving services in adhering to their medication regimens;
- Wellness activities that are consistent with the consumer’s self-identified recovery goals. Wellness activities may address common physical health problems, such as tobacco dependency, alcohol use, sedentary lifestyle and lack of physical exercise, and overeating and/or poor nutrition including connection to primary medical and dental services;
- Skill development needed for consumer-chosen community environments, facilitating consumer-directed recovery and re-integration into valued community living, learning, working and social roles by developing critical competencies and skills; and
- Age-appropriate learning activities which are directly tied to the learning of daily living or other community integration competencies such as financial literacy, learning basic computer literacy, and recognition of directions and safety warnings.

Statewide Clinical Outreach Program for the Elderly (S-COPE). Seeing a need to assist long-term care providers serve older adults with behavioral problems, DMHAS awarded a contract for a program to provide specialized clinical consultation, assessment, treatment and intervention to older adults who were residents of nursing homes and were at risk for psychiatric hospitalization. Trinitas Regional Medical Center in Elizabeth, NJ was the recipient and has been administering the S-COPE contract, which is fully funded by DMHAS and has been in operation since April, 2012. Older adults (55+) residing in nursing homes and state-funded residential care facilities are seen by S-COPE’s multidisciplinary team consisting of a geriatric psychiatrist (consultant), geriatric advanced practice nurse, and licensed clinical social workers, who are available 24 hours/7 days a week for telehealth or on-site consultations.

The multidisciplinary clinical team and advocates within the facility for management of behavioral issues for individuals who would not benefit from inpatient psychiatric stays. S-COPE equips staff by sharing best practices and offering trainings. S-COPE also gets referrals from screening/crisis to follow up with patients upon discharge back to their nursing homes. All assessments and treatment recommendation offered are consistent with promising practices and/or evidence-based practices. In calendar year 2022, 1029 individuals were referred to and served by S-COPE staff; these included 1456 face-to-face consultations (in-person, Zoom, ECHO) and 1620 phone consultations. S-COPE reports that numbers of residents who were diverted from referral to Screening Centers in 2022 as a result of their services was 162, while 120 individuals who were sent by nursing homes to screening were seen by S-COPE as a follow up to prevent re-referral to screening. S-COPE staff develop reports on their consultations, and

these are sent to the Pre-Admission Screening and Resident Review (PASRR) Coordinator in the DMHAS Medical Director's office on a monthly basis.

S-COPE staff also provide training to crisis/screeners, nursing homes, and state psychiatric hospital administrator and staff. All trainings are developed by the S-COPE team and trainings topics can be suggested by providers that they serve. In 2022, S-COPE provided a total of 134 trainings with 2210 attendees). S-COPE ensures that its programs are culturally and linguistically competent, accessible, and responsive to agencies, person receiving services and families and that the adult mental health service system in New Jersey does not discriminate with regard to diverse racial, ethnic and sexual /gender minorities.

Legal Services. Legal assistance provided to mental health clients, either through agency referrals or self-referral, by a network of DMHAS-funded legal service agencies. Assistance may include advice and guidance, case coordination, and court representation for issues such as government entitlements, housing, evictions, employment, etc. In SFY 2022, 2,030 persons receiving services were served by Legal Services.

8. State and County Psychiatric Hospitals

State Hospitals

The Department of Health (DOH) operates four adult psychiatric hospitals. The care at the hospitals serves people with persistent and severe mental illness who need intensive, inpatient care and treatment. Effective August 20, 2018, the Division of Mental Health and Addiction Services (DMHAS) was transferred to the Department of Human Services, while state psychiatric hospitals were transferred under the supervision of the Department of Health. The State Mental Health Authority (SMHA) previously operated the state hospitals until this reorganization. The SMHA and the Department of Health continue to work collarboratively to facilitate discharges from the state hospitals as well as increasing diversionary efforts which provide opportunities for individuals to live, work, and learn within their community. The average state hospital census for the three regional state hospital in SFY 2022 was 960 (a decrease of 53% from 2008 ((the year of the Olmstead settlement agreement)).

Each regional state hospital has a Community Wellness Center funded by DMHAS on the grounds of the campus. All the state hospitals have person-centered treatment planning, shared decision-making, Illness Management and Recovery (IMR), and Trauma Informed Care (TIC). The psychiatric hospitals are dedicated to patient-focused treatment planning, emphasizing a continuum of care that is holistic in treatment and highly individualized. The psychiatric facilities promote positive outcomes based on patient strengths and available supports. The full participation of each patient relies on shared decision making, client-defined outcomes, promotes patient choice, empowerment, resilience, and self-reliance.

Ancora Psychiatric Hospital (APH) has 505 Medicare certified beds as an adult inpatient facility that offers a multidisciplinary team approach for the development and implementation of care. Ancora meets the needs of its mentally ill clients in the areas of admissions, acute and chronic psychiatric units, gero-psychiatric units, a sub-acute medical unit, a secure care unit (forensic),

and a dual diagnostic unit. The mission of APH is to provide quality comprehensive psychiatric, medical, and rehabilitative services that encourage maximum patient independence and movement towards community reintegration with an environment that is safe and caring.

Greystone Park Psychiatric Hospital (GPPH) in Morris Plains, has 450 Medicare certified beds as well as cottages that are on the grounds. Greystone predominantly serves residents from this northern geographic area of the state. In July 2008, a state-of-the-art hospital was opened on its grounds, replacing five aging treatment buildings and the 131-year-old administration building. In addition to new housing and care facilities, the new Greystone Park Psychiatric Hospital contains a treatment mall with over 21 rooms for various activities, which include sensory rooms and a diner.

Trenton Psychiatric Hospital (TPH), located in West Trenton in Mercer County, primarily serves the residents of central New Jersey. Trenton Psychiatric Hospital has 400 Medicare certified beds, as well as cottages on the grounds. TPH provides a holistic approach to patient care from initial assessment and the treatment of the human response to current and potential mental health problems. TPH ensures its patients (and their families) competent, compassionate care as patients individualized care goals are reached.

Ann Klein Forensic Center (AKFC) in Trenton is a 200-bed psychiatric hospital serving a unique population with severe and persistent mental illness. The AKFC serves New Jersey's statewide forensic population. AKFC provides care and treatment to individuals suffering from behavioral illness, who are also under the custodianship of the legal system (e.g., Megan's law registrants, those found to be Not Guilty by Reason of Insanity, etc.) The population at Ann Klein requires a highly secured environment.

County Hospitals

The SMHA supports four county operated psychiatric facilities that operate as part of the continuum of services. These facilities are located in Bergen, Essex, Hudson, and Union counties.

These county hospitals receive most of their funding from the SMHA. The SMHA covers 85% of the per diem cost for most non-Medicaid patients, i.e., those who are determined to maintain residence in a specific county; the SMHA pays 100% of the cost for all other non-Medicaid patients. To the extent allowable, the county facilities are reimbursed by Medicaid for clients eligible under that program.

Olmstead Initiatives

Over the last few years, the SMHA has been successful in its delivery of services to persons receiving services. Much of this success is due to the implementation of various initiatives resulting from the Olmstead Lawsuit. In April 2005, New Jersey Protection and Advocacy, Inc., now known as Disability Rights of New Jersey (DRNJ) filed suit against the New Jersey DHS on behalf of psychiatric patients who were found to no longer meet commitment standards, but for

whom no appropriate placement was available. The official term for the status assigned is Conditional Extension Pending Placement (CEPP). The SMHA issued its initial Olmstead Plan known as the Home to Recovery CEPP Plan in January 2008.

Although the Olmstead Settlement agreement was the result of a lawsuit initiated in 2005, this Settlement resulted in an investment in the mental health system for needed community, residential and other services. The Olmstead Settlement agreement can be viewed at: http://www.state.nj.us/humanservices/dmhas/initiatives/olmstead/olmstead_settlement_agreement.pdf, and called for the following indicators of improved community integration, each with its own individual targets for every year covered by the Settlement Agreement:

1. Creation of community-based (i.e. Supportive Housing) placements;
2. Discharge of long-term CEPP persons receiving services awaiting discharge since July 1, 2008 or prior;
3. Increased rates of discharge within four to six months of CEPP designation

Based on a multitude of changes made to its service delivery systems, DMHAS was found to be in substantial compliance with the Olmstead Settlement Agreement such that the Agreement ended in June of 2016. Since that time, the Division's Office of Planning, Research, Evaluation, Prevention, and Olmstead (OPREPO), continues to focus its efforts on improving community integration for its state psychiatric hospital person receiving services.

The Division of Mental Health and Addiction Services (DMHAS) is in the process of revising Administrative Bulletin 5:11 in an effort to reduce hospital length of stay. Under this bulletin, persons receiving services in state psychiatric hospitals are assigned to community service providers whom have the option of either accepting the persons receiving services or requesting additional supports from DMHAS. In addition to community providers, state psychiatric hospitals have the option within their discharge planning process of collaborating with community service providers to request additional supports for the person receiving services in their potential new living situations outside the institutions. Such requests and other efforts toward successful discharge are to be documented within the Individual Needs for Discharge Assessment (INDA). Assignments are based on hospital treatment team recommendations as well as the individual's choice. The assigned provider is expected to participate in treatment team meetings. The early involvement of community providers in the treatment planning process fosters familiarity between provider and the person receving services, allowing for immediate planning on the part of the provider to prepare to meet the individualized needs of each person receving services upon discharge into their care. This preparation is critical to ensuring that the person receving services is provided with necessary community supports and thereby maximizes his/her chances of sustained integration within the community. It is born out of high-level interagency collaboration. Proposed revisions to the AB 5.11 aim to further strengthen the collaborative discharge planning process between the community providers and state psychiatric treatment teams with more clearly defined expectations of the outcomes during the initial team meeting of an assignment and for enhanced oversight of assignments with signfigant clinical concerns and discharge barriers.

As part of its Home to Recovery II Plan, DMHAS focused its efforts on enhancing community-

based resources available to persons receiving services. One such enhancement was the implementation of Community Support Services (CSS). A Medicaid rehabilitative service, CSS offers education to persons receiving services in the community on navigating daily activities, rather than performing these activities on their behalf. The goal of these services is to nurture independence and self-reliance on the part of the person receiving services, empowering them to thrive as functional and competent members of a community outside of an institutional setting.

DMHAS has enhanced its Supported Employment services to include an in-reach pilot within the three regional state hospitals. Implemented in July 2015, this pilot program targets individuals who are ready for discharge and examines their interest in competitive employment outside the hospital. This in-reach is supplemental to the Division's existing Supported Employment services, which are available in each of New Jersey's 21 counties. Supported Employment services include assistance accessing benefits counseling; identification of occupational skills and interests; and the development and implementation of a job search plan based on the consumer's strengths, interests, needs, and abilities. The ultimate goal for person receiving services receiving Supported Employment services is to obtain meaningful and competitive employment as a means of further ensuring sustained integration within the community.

The Home to Recovery II Plan includes outcomes geared toward monitoring sustainability of the Division's community integration efforts. These outcomes include, but are not limited to enhanced utilization of Supportive Housing, expansion of CSS opportunities, a reduction in census; fewer admissions to state hospitals; and a decrease in the number of individuals on CEPP. The average state hospital census for the 4 regional state hospitals in SFY 2008 (year of the settlement agreement) was 2,051, there were an average of 2,763 admissions per year, and the CEPP census on 6/30/2008 was 938. The percentage of individuals on CEPP of the the total census was 50.05% on 6/30/2008. Additionally, there were four regional hospitals, Hagedorn Psychiatric Hospital closed in SFY 2012. The average state hospital census for the three regional state hospital in SFY 2022 was 960 (a decrease of 53% from 2008), there were an average of 706 admissions (decrease of 74% from 2008), and the CEPP census on 6/30/22 was 273 (decrease of 70.9% from 2008). The percentage of individuals on CEPP of the total census was 27.94% on 6/30/2022 (decrease of 44.2% from 2008). In SFY 2008, there were 3,051 individuals receiving services in supportive housing. In 2022, there were 5,658 individuals served by CSS.

Validation of Vacancy Tracking Systems. The Bed Enrollment Data System (BEDS) was developed in 2013 for the furtherance of deliverables to the Olmstead lawsuit settlement agreement with Disability Rights NJ[1] to facilitate the communication of accurate information between state hospitals and community residential providers regarding bed needs and available housing inventory. The system has replaced the process of cold calls to agencies and the utilization of quickly outdated paper tracking sheets. In the Spring of 2021 BEDS was updated to contain functional improvements, including search features and the addition of short term care facility (STCF) beds, to give the SMHA a better view of the acute care system.

[1] https://nj.gov/humanservices/dmhas/initiatives/olmstead/

Most recently, BEDS has been used in conjunction with the Provider Weekly Report (PWR) and housing subsidy lists to give the SMHA a more complete picture of community-based housing resources and utilization. The Provider Weekly Report (PWR) is a data reporting protocol where over 73 different community based residential programs submit detailed data on: current housing capacity, vacancies, assignments, and updates on placements on a weekly basis. This data is compiled on a weekly basis to give the SMHA a more complete, and timely picture on the housing landscape—as it is self-reported by the contracted agencies themselves and provides information on the status of the referrals, barriers, delays, etc. The PWR provides capacity data, vacancy information, referral tracking, monitoring tool, and a communication tool. DMHAS provider submission rate for the PWR reports averages 95-98% compliance in weekly submission of the data to the OPREPO office.

Beginning in 2023, DMHAS will be utilizing Covid Supplemental and ARPA funding to procure a web-based data system for tracking referrals and vacancies for beds and services, including status of the referrals, disposition, and communication regarding the referrals. Additionally, the database will have a crisis management module for call center intakes and mobile outreach dispatch.

Enhancements to Community Capacity. From 2010 through 2014, DMHAS was charged with the creation of 695 beds expressly for the community placement of person receiving services on CEPP status in the regional state hospitals and 370 beds to be created for person receiving services who are already in the community and at high-risk for hospitalization and/or homelessness. This equates to a total of 1,065 placements to be created over the five-year period covered by the settlement. The SMHA met and exceeded this goal, creating 1,436 new placements. Of these, 941 were set aside for the discharge of CEPP person receiving services from state hospitals (exceeding the settlement target of 695 by 246 or 35%), and 495 were reserved for persons receiving services at risk of hospitalization (exceeding the target of 370 by 125 or 33.78%). In total, the SMHA exceeded its targets for placement creation by 34.83%, which amounts to 371 placements above its required deliverable. The Division continued creating new placements for these targeted populations, reaching a total of 1,808 new placements by the end of SFY 2016, with 1,274 reserved for CEPP discharges and 534 set aside for persons receiving services at risk of hospitalization. There were 900 number of new placements created from SFY2017 to SFY2023. This would also include recycled subsidies and multiple re issuance of subsidies. DMHAS will be funding 150 new subsidies in 2024.

Continued Utilization of the Intensive Case Review Committee (ICRC). All persons receiving services in the state hospital are reviewed by ICRC once every month to ensure that consumer assignments have been made in preparation for discharge in a timely manner, barriers to discharge are addressed, systemic issues are addressed, and compliance with length of stay targets are maintained. The purpose of these meetings is to develop strategies for resolution of barriers and systems issues.

Continued Utilization of Hospital Project Teams. Project Team meetings are higher-level meetings that occur immediately after ICRC and are typically chaired by the hospital CEO/DCEO or Medical Director. Follow-up on systems raised by ICRC and discussion of resolution strategies are disussed. In addition, policy or systems that may involve collaboration with another Division or state Department, are discussed at these meetings and elevated to

Olmstead leadership to address. Olmstead staff also use these meetings to update the hospital leadership on any new administrative bulletins, requests for proposals, updates or changes to the vacancy tracking system, and/or trends identified in the data.

Utilization Management of Statewide Residential Vacancies and Community Referrals: Meetings are held three times weekly between the Olmstead Unit staff and State Psychiatric Hospital Placement Entities to review residential vacancies and community referral requests. This frequent communication promotes efficiency in filling residential vacancies and managing the various requests for housing from Centralized Admissions, STCFs, and other entities who submit requests for DMHAS housing.

State Hospital Diversion Initiative. The Olmstead Office initiated a pilot program in 2016 with the Centralized Admissions Unit of the state psychiatric hospitals to provide diversionary activities for indiviuduals that do not meet criteria for commitment to the state hospital and are in need of less restrictive community settings. The diversionary initiative has grown over the years to include persons served in county hospitals, Short Term Care Facilities (STCFs), and/or other entities in which state hospitalization may have otherwise been explored as the next step. Regional Olmstead staff assist in securing additional supports needed for applicable person receiving services as a means of addressing their individualized circumstances and needs in the most integrated setting possible within their required level of care. This collaboration allows for reduced hospital admissions and a reduced hospital census as well as enhanced community re-integration of persons receiving services.

***Criterion 2: Mental Health System Data Epidemiology:* Contains a state-level estimate of the incidence and prevalence of SMI among adults and SED among children; and includes quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.**

New Jersey currently uses the federal definition of SED and SMI: Children with SED refers to persons from birth to age 18 and adults with SMI refers to persons age 18 and over; who (1) currently meet or at any time during the past year has met criteria for a mental disorder – including within developmental and cultural contexts – as specified within a recognized diagnostic classification system (e.g., most recent editions of DSM, ICD, etc.), and (2) display functional impairment, as determined by a standardized measure that impedes progress towards recovery and substantially interferes with or limits the person's role or functioning in family, school, employment, relationships, or community activities.

Prevalence. According to the Federal methodology proposed for estimating the prevalence of SMI, the proportion of adults within the state with a SMI is 5.4% (Federal Register, Volume 64, No. 121, p. 33890)[2]. The lower limit of estimate is 3.7% and the upper limit of estimate is 7.1%.

According to figures released by the United States Census Bureau, the 2022 adult population of New Jersey was 7,275,144. The size of the New Jersey child population was 1,992,555. Using the SAMHSA's SMI prevalence rate among persons 18 and older (5.4%) the estimated number of adults with SMI in New Jersey in 2022 was 392,858. Using the upper SMI limit of 7.1%, the

[2] https://www.gpo.gov/fdsys/pkg/FR-1999-06-24/html/99-15377.htm

estimated number of adults with SMI in New Jersey in 2022 was 516,535. Accordingly, using the lower SMI limit of 3.7%, the estimated number of SMI adults in New Jersey in 2022 was 269,180.

According to URS Table 2a, a total of 335,429 unduplicated persons ages 18 and over received services in programs provided or funded by the SMHA in FY 2022. SMHA served 121,616 unduplicated adults with SMI (refer to URS data table 14a) in FY 2022. That was 30.96% of the total estimated adults with SMI in New Jersey receiving services (392,858). The objective of the SMHA is to continually increase the number of adults with SMI that may receive emergency mental health services and non-emergency community mental health services.

Also shown in URS data table 14a and 14b, out of the total 121,616 unduplicated adult with SMI served by SMHA in FY 2022, 51,869 (42.6%) were ethnic minorities. SMHA will ensure that ethnic minority population continues to have access to mental health services in New Jersey.

New Jersey has not established a methodology to estimate incidence of SMI among adults.

Criterion 3: Children's Services: **Provides for a system of integrated services for children to receive care for their multiple needs. Services that should be integrated into a comprehensive system of care include: social services; child welfare services; educational services, including services provided under the Individual with Disabilities Education Act ; juvenile justice services; substance use disorder ; and health and mental health services.**

Please Refer to Children's Services Section of the Plan.

Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults: **Provides outreach to and services for individuals who experience homelessness; community- based services to individuals in rural areas; and community-based services to older adults.**

Services to Homeless Populations

DMHAS operates Projects for Assistance in Transition from Homelessness (PATH) program using a combination of federal and state funds. The target population is homeless adults or those at risk of homelessness who have a serious mental illness, including those with co-occurring substance use disorders who are not currently engaged in and are resistant to mental health and other community support services.

All New Jersey PATH programs provide outreach, screening and assessment, case management and referral services for community mental health and substance abuse treatment services, financial benefits, primary health services, job training/vocational and educational services and relevant housing services including; emergency housing, transitional housing and permanent housing services. A limited number of PATH programs also provide some of the following services directly; security deposits and payment of back rent, mental health assessment and treatment, representative payee services and staff training. Recovery, community integration and housing stability are the long-term goals of the program, achieved through client-centered treatment planning.

The SMHA contracts with non-profit agencies to operate PATH programs within the state's 21 counties. A small number of PATH programs use PATH funding to directly provide psychiatric assessment and outpatient mental health services. Many PATH providers are Community Mental Health Centers and link their persons receiving services to mental health in their agency outpatient or partial care programs. All PATH programs link individuals to behavioral health and co-occurring services within their communities.

In SFY 2022, the PATH programs in New Jersey provided outreach to 2,561 individuals and served a total of 3,629 persons. There were 637 program participants that were linked to mental health services, 101 to substance use treatment services, 236 to primary health/dental care, 301 to financial services, 266 to temporary housing/shelter, 296 to long term housing and 107 were linked to employment or vocational and educational services. In addition, the SMHA provides funding for At-Risk supportive housing beds for individuals who are at risk for hospitalization and homelessness.
Services provided under the CCBHC initiative are available to all who meet programmatic criteria without regard for race, ethnicity, age, gender identity, sexual orientation, religious affiliation, or place of residence. Policies such as "no wrong door" allows any consumer access to CCBHC services regardless of insurance or pay status, place of residence, or lack of a permanent address. An average of two percent of CCBHC persons receiving services at each CCBHC provider reported being homeless or living in a shelter during Demonstration Year 2. The two CCBHCs located in Trenton--Oaks Integrated and Catholic Charities, served the highest homeless populations at twelve percent and five percent, respectively. DMHAS manages housing vouches and provides CSS services to individulas who are homeless to prevent homelessnees.

Services to Rural Populations

The SMHA defines a county as "rural" if, according to U.S. Census figures, 25% or more of its population lived in rural areas. Using this definition, New Jersey does not have any rural counties but pockets in some counties with rural population. Since there are no federally recognized rural areas in New Jersey, the Office of Rural Health Policy's Rural-Urban Community Area (RUCA) definition was utilized.

Community-based services for rural populations were enhanced and expanded by Block grant funding and other federal grants. In December, 2016 New Jersey was selected as one of eight states from the Substance Abuse and Mental Health Administration (SAMHSA), Center for Mental Health Services (CMHS) to participate in a two-year Certified Community Behavioral Health Center (CCBHC) demonstration program. The program was funded as part of a comprehensive effort to bring behavioral health care in parity with physical health care and to improve community behavioral health services overall as part of the Protecting Access to Medicare Act of 2014 (PAMA, § 223).

New Jersey selected seven CCBHCs in six counties, including six CCBHCs in five metropolitan counties plus AtlantiCare in Hammonton, a rural underserved pocket of Atlantic County to be apart of the CCBHC's demonstration project funded by CMS. The CCBHCs offer services

within an integrative, holistic framework, thereby closing a treatment gap that frequently results in inadequate service provision for individuals with co-existing social, physical and behavioral health care needs. New Jersey's CCBHCs offer, through direct services or through affilation 24-hour crisis care, treatment for co-occurring substance use disorder and mental illness, ambulatory and medical withdrawal management, evidence-based outpatient counseling, case management, and family support services. CCBHC populations of focus include individuals with serious mental illness (SMI), those with severe substance use disorders (SUD), children and adolescents with serious emotional disturbance (SED), former or current military personnel experiencing Post Traumatic Stress Disorder (PTSD), and youth and adults with physical health risk factors and/or mental health diagnoses such as anxiety and depressive disorders other than Major Depressive Disorder who are not already covered in the target population. The CCBHC Demonstration Program was extended to September 2025.

In addition to the CCBHC Demonstration Project, a number of NJ providers have been awarded the SAMSHA CCBHC Expansion grants. The state is currently reviewing plans for sustainability of the CCBHC.

Services to Older Adults: Statewide Clinical Outreach Program for the Elderly (S-COPE)

Seeing a need to assist long-term care providers serve older adults with behavioral problems, DMHAS awarded a contract for a program to provide specialized clinical consultation, assessment, treatment and intervention to older adults who were residents of nursing homes and were at risk for psychiatric hospitalization. Trinitas Regional Medical Center in Elizabeth, New Jersey was the recipient and has been administering this Statewide Clinical Outreach Program for the Elderly (S-COPE), which is fully funded by DMHAS and has been in operation since April, 2012. Older adults (55+) residing in nursing homes and state-funded residential care facilities are seen by S-COPE's multidisciplinary team consisting of a geriatric psychiatrist (consultant), geriatric advanced practice nurse, and licensed clinical social workers, who are available 24 hours/7 days a week for telehealth or on-site consultations.

Criterion 5: Management Systems: **States describe their financial resources, staffing, and training for mental health services providers necessary for the plan; provides for training of providers of emergency health services regarding SMI and SED; and how the state intends to expend this grant for the fiscal years involved.**

State funding/training

The Division of Mental Health and Addiction Services (DMHAS) is dedicated to community--based mental health services and is advancing community supports for individuals who do not require hospital-based psychiatric treatment and those at risk of hospitalization. The DMHAS coordinates with community-based providers to administer behavioral health services, including prevention and early intervention, screening services, outpatient counseling, partial and day treatment services, case management, residential and supported housing, family support, self-help centers and supported employment. In SFY 2023, State General Fund appropriations for mental health community providers were $440 million. A significant portion of this amount is based upon the State's investment in the *Olmstead – Home to Recovery Initiative*, which has primarily provided funding for supportive housing placements for clients discharged from state

hospitals, as well as for clients at risk of hospitalization. Another key program area comprising State funding is Psychiatric Emergency Screening services (with contract ceilings of around $44 million).

Additionally, DMHAS is now over six years into the transition of moving select community based mental health services from cost-reimbursement contracts to fee-for-service contracts, also known as the Mental Health Fee-for-Service Program (MH-FFS Program). This transition, which began January 1, 2017, represented an historic transformation for the New Jersey public mental health system. The State has transitioned providers and clients to Fee for Service reimbursement, and away from fixed cost or overall cost reimbursement contracts. Concurrent with this, reimbursement rates were enhanced for many services and additional state funding (roughly $20 million) was appropriated for this purpose. Further, DMHAS received $27 million of additional annualized State funding to increase rates and cost-based contract ceilings during SFY23. The proposed SFY 24 Governor's Budget also reflects an incremental annualized $27 million of growth for this purpose ($6.3 million of which would be house in the Divison of Medical Assistance and Health Services/Medicaid, with the rest to DMHAS. DMHAS believes that the combination of more attractive Medicaid rates and the transition to a direct Fee for Service reimbursement approach for non-Medicaid services (with enhanced rates), will continue to lead to greater access for clients and a more transparent, accountable and efficient behavioral health service delivery system.

As part of its remaining cost reimbursement contract base, DMHAS continues to fund training and technical assistance for community providers. The total contracted amount for SFY 2023 was approximately $5.7 million. In addition, DMHAS hosts regular quarterly meetings and webinars that served as training opportunities for the provider community. DMHAS staff deliver these trainings, which are funded by our State General Fund appropriations. DMHAS is partnering with the Medicaid authority to plan for the carve-in of behavoiral health services into the managed care organizations. A robust stakeholder processs has commenced since 1115 waiver authority approval was moved by Centers for Medcaid Servcies (CMS) in March 2023.

Federal funding

The Division also leverages other sources of funding to support community services. In addition to the Mental Health Block Grant, the other primary sources of federal funding in SFY 2023 were the Projects for Assistance in Transition from Homelessness (PATH) grant and the Coronavirus Relief Fund (CRF). The PATH grant provided $2.1 million to support our contracts for that program.

DMHAS also moved quickly to establish policies and procedures to distribute roughly $5 million of CRF funds to community providers. The funding was used to reimburse providers for emergency pay to direct service employees, virus mitigation costs, COVID testing costs and to provide the necessary HIPAA-compliant technology to allow staff to serve clients remotely when in-person visits were not feasible.

Staffing

As of April 30, 2023, total staff in the New Jersey Division of Mental Health and Addiction Services (DMHAS) were 231, consisting of 163 full-time employees and 68 staff on a part-time or consultant basis. 17 staff are dedicated to Mental Health Block Grant (MHBG)-specific activities. Many other staff across the Division dedicate time and effort to mental health programs and contracts.

Overall, staff are dedicated to administrative and programmatic functions, including Community Services, Contract Monitoring, Planning and Research, Housing and Treatment, Legal and Finance. Primary responsibilities include program and policy development, day-to-day oversight and monitoring of community providers, development of request for proposals, data analysis, information technology operations and administrative (fiscal/legal/management) support.

While the COVID-19 pandemic created many operational challenges, DMHAS staff have met them with the objective of maintaining access to vital community services. Early in the pandemic, staff pivoted quickly to development of interim policies including those related to financial reimbursement of providers and telehealth service delivery. In addition, we adapted to a remote working environment, with Information Technology (IT) solutions ramped up quickly, allowing all staff to access their workstations from home. In addition, meetings shifted to remote platforms such as Microsoft Teams and Zoom. Regular meetings with the provider community, including technical webinars, were therefore able to continue. In additional, contract monitoring, including fiscal oversight, shifted to desk review of provider documentation. Secure File Transfer Protocol (FTP) sites were established, allowing providers a streamlined solution to upload their documents for review by DMHAS staff.

Mental Health Block Grant (MHBG) Expenditure plan

In State Fiscal Year 2024, DMHAS will continue to expend MHBG resources on prescribed and allowable activities. This reflects our commitments for First Episode Psychosis (FEP) programs (10% of the grant), Crisis services (5% of the grant), Planning Council activities, Administrative functions (limited to 5% of the total grant), resource and development and training.

As always, the largest portion of our anticipated expenditures reflects community care programs for clients with Serious Mental Illness (SMI). While New Jersey currently has cost-based contracts and Fee for Service arrangements with 111 unduplicated agencies that provide eligible Community Mental Health services, to facilitate fiscal reporting and administration, and minimize the audit burden on our providers, DMHAS has allocated the available Block Grant funding to a select group of about 24 provider agencies who deliver services under Fee for Service arrangements. These agencies provide direct treatment services (including Outpatient, Residential, Partial Care and Case Management) to clients, most of whom have SMI. DMHAS Fiscal staff review data from our expenditure claiming system to allocate the funding appropriately.

Other Trainings of Providers of Emergency Health Services Regarding SMI and SED

1. Screener Certification: The SMHA contracts with Rutgers University Behavioral Healthcare technical assistance center to provide Screener Certification Courses for psychiatric emergency service staff. These courses, offered four times per year new staff,

are comprised of eight full days of instruction and include training related to the wellness and recovery model, New Jersey's civil commitment statute, providing care in the least restrictive environment, suicide assessment, outreach with police and working with youth.

2. The Mental Health Awareness Training Grant: The goal of this initiative is to empower anyone working with adolescents and young adults, first responders, or veterans to increase their mental health awareness, equip them with resources on how to appropriately react to crisis and link to professional, peer, and social supports as well as self-help resources, reduce stigma, and understand the critical role they can play in contributing to somebody's quality of life. Mental Health First Aid, Youth Mental Health First Aid, and QPR, Question, Persuade, refer are the evidenced-based suicide prevention trainings offered at no cost through the initiative.

   During this past year, the Disaster and Terrorism Branch has exceeded the annual objectives for the Mental Health Awareness Training (MHAT) grant.

   Objective: 24 training sessions annually with an aim of 600 training participants.
   Outcome: 759 training participants completed the 8-hour Mental Health First Aid course.

   Objective: 48 training sessions annually with an aim of 960 training participants.
   Outcome: 1480 training participants completed the 2-hour Question, Persuade & Refer course.

   In year 2022, there were 2,239 individuals were trained Statewide; surpassing our goal of 1,560. Data indicators were submitted into SPARS (SAMHSA's Performance Accountability and Reporting System) on a quarterly basis as required. The following objective was surpassed with an outcome of 100%. Objective: 85% or more training participants will indicate an improvement of knowledge, attitudes and beliefs related to mental health prevention and promotion. To add, quarterly monitoring meetings continue to be completed with our assigned SAMHSA representative. Monthly flyers with training dates and zoom links are distributed to State and county partners and posted on the State website. Additionally, we are receiving and fulfilling more request for in person trainings.

   We continue to offer these important suicide prevention trainings to school districts/personnel, case management organization, and the general public. In an effort to advance the grant's reach the following staff changes were made: Promoted one Trainer to Lead Trainer/Coordinator to specifically act as a liaison with vendors, recruit prospective training participants and coordinate all MHAT trainings. Hired Grants Management Specialist to oversee all grants and supervise Lead MHAT Coordinator.

3. <u>Disaster Response Crisis Counselor Certification:</u> The DRCC training curriculum was created in response to the need for a trained and vetted workforce to provide crisis counseling to NJ residents in the event of a community crisis or larger scale disaster response. The core courses for initial certification are:
    1. Introduction to Disaster and Trauma Counseling: Basic Training for Disaster Response Crisis Counselors
    2. Cross Cultural Issues in Disaster Response and Recovery
    3. Ethical Issues in Crisis Response
    4. Key Concepts in Psychological First Aid
    5. National Incident Management System (NIMS 700) /Incident Command System (ICS 100) Note: NIMS and ICS training can be taken on-line.

    In 2022, there were five opportunities for individuals seeking certification to complete the required courses named above. Additionally, current DRCC's are expected to maintain their certification by attending recertification courses, last year sixteen recertification courses were conducted by Disaster and Terrorism Branch staff.

    As of April 2023, there are a total of 446 Active DRCC's (see chart below). At this time, DMHAS is creating a funding opportunity that will help County Mental Health Administrators recruit, engage and sustain their respective DRCC volunteer workforces.

County	Response
Atlantic County	71
Bergen County	71
Burlington County	76
Camden County	64
Cape May County	49
Cumberland County	44
Essex County	72
Gloucester County	55
Hudson County	48
Hunterdon County	41
Mercer County	61
Middlesex County	81
Monmouth County	130
Morris County	84
Ocean County	100
Passaic County	64
Salem County	40
Somerset County	69
Sussex County	48
Union County	78
Warren County	38

4. <u>APN Program:</u> As licensed independent practitioners, psychiatric Advanced Practice Nurses (APNs) are an important component of NJ mental health service system and serve

in a variety of settings in both inpatient and outpatient services. Psychiatric APNs provide almost all of the services that psychiatrists provide (e.g., intake, assessment, etc.), except that they must prescribe medication under a joint protocol (collaborative agreement). While DMHAS had a program that funded psychiatric.

Under the COVID emergency relaxation of state licensing regulations, APNs did not have to have a collaborative agreement with a physician to prescribe, and they have also been able to prescribe buprenorphine with a DATA waiver. However, the Data or X waiver is no longer a requirement for prescribing buprenorphine. Also, Executive order 112 removing the APN requirement for a collaborative agreement may end and bring back the requirement for a collaborative practice agreement. While the capability to use telehealth during the pandemic has eased the prescriber shortage in the state workforce, psychiatric APNs continue to have a critical role in providing mental health services.

5. Technical Assistance Center: DMHAS continues to fund the Technical Assistance Center through UBHC, Staff and consultants from the TAC provide technical assistance training to community providers in priority areas identified by DMHAS. Some of the examples of projects include training in crisis management, emergency response, services to nursing home residents with psychiatric disorders, multicultural concern, Tobacco Cessation, wellness and recovery programs, and Illness Management and Recovery training.

6. Multicultural Services Trainings: DMHAS contracts with two Cultural Competence Training and Technical Assistance Centers designed to improve mental health and substance use services and outcomes by enhancing the cultural competence of mental health professionals and their organizations. The Centers accomplish this through the provision of cultural competence resources, on-site and virtual training, and technical assistance, and consultation for agencies, self-help centers, community wellness, and recovery centers seeking to develop proficient plans and improve organization cultural competence. The overall goals of the Centers are to:
    - Work in collaboration with the DMHAS Multicultural Services Advisory Committee (MSAC) to ensure programming, technical assistance, and outreach stays abreast of mainstream issues in the state and country to match the needs of DMHAS agencies.
    - Provide technical assistance to DMHAS agencies in the implementation of cultural competence plans based on information from the CLAS Standards and SAMHSA CSAT TIP 59.
    - Provide accredited trainings that enhance the cultural and linguistic competencies, skills, and needs of staff.
    - Design and implement curriculum to provide ongoing training and technical assistance to DMHAS agencies, staff, volunteers, and administrators.
    - Develop and review needs assessments relating to the cultural competency of the DMHAS system of care.
    - Use pre and post tests and follow-up surveys to evaluate program effectiveness and agency change following training and technical assistance.

Through contract, each Center offers annually a conference on topics relating to social cultural foundations and at least 6 full-day accredited trainings provided to DMHAS contract agency and

managerial staff. To date the Centers have conducted more than 30 trainings, training more than 1300 individuals on topics included but not limited to Intro to Cultural Competency, Unconscious Bias, Micro Aggressions, Accountability and the Art of the Apology, Native American Culture, Historic and Intergenerational Trauma. Additionally, the Centers hold regional technical assistance hands-on workshops to assist agencies with developing a cultural competency plan.

Children's Behavioral Health Services

The New Jersey Department of Children and Families (DCF) – Children's System of Care (CSOC) is responsible for overseeing the public system of providers who serve children with emotional and behavioral health care challenges, children under the age of 21 with developmental disabilities and youth up to age 18 with substance use challenges.

In New Jersey, adult and children's mental health systems were separated in 2006 for those programs that served children only. On July 11, 2006, legislation was signed creating the New Jersey DCF, the state's first Cabinet-level department focused solely on child and family well-being. All services provided by the DHS Office of Children Services were transferred to the DCF. On June 29, 2012, Governor Chris Christie 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. This realignment of services is intended to remove barriers to accessibility, provide more complete care through all service offerings, and improve efficiency for those families served by DCF throughout the state. The substance abuse programs that serve children under 18 years were transferred from DHS to CSOC in July 2013 and children in the South Jersey Initiative were transferred in December 2013. CSOC coordinates the state mental health plan for children, youth and young adults; provides support and assistance to child welfare youth who need to access intensive or multiple mental health services; allocates state and federal resources for mental health programs; promulgates standards for services; and is now responsible for the provision of services for children, youth and young adults with developmental disabilities as well as substance use challenges.

A separate detailed overview of the New Jersey DCF's CSOC is provided by CSOC.

II. Description of the Organization of the Public Behavioral Health System at the State and Local Levels including the Roles of the SMHA

State Government

The SMHA supports adult services in the following capacities: (1) direct service provider; (2) purchaser of services; (3) regulator of standards and services; (4) coordinator for immediate mental health disaster and acts of terrorism response; and (5) systems planner. In executing these functions, the SMHA must ensure continuity of care and coordination of services within the state and between the public and private sectors. In order to do so, the SMHA must provide leadership in the: (1) interface between the state and county psychiatric hospitals and community providers; (2) establishment and participation in key advisory boards and committees whose missions

impact upon the delivery of mental health care and treatment; (3) promotion of effective communication internally as well as in the broader mental health and human services communities; (4) advocacy of the needs of the mental health community at the state and federal levels; and (5) initiation of planning activities with input from key constituents and interested parties, that address the changing needs of New Jersey's residents.

County Government

In New Jersey, county governments also play an important part in the overall functioning of the public behavioral health system. Each of New Jersey's 21 counties has a mental health board that is staffed by a mental health administrator. The boards advise the SMHA and the Behavioral Health Planning Council of issues and programs that are of significance to their locale and residents. A Mental Health Administrator representative is a member of the Behavioral Health Planning Council. Additionally, the SMHA meets with the mental health administrators at their bi-monthly Association of County Mental Health Administrators meetings.

III. Roles of Other State Agencies with Respect to the Delivery of Behavioral Health Services/ Interdivisional and Interdepartmental Collaboration

Department of Human Services, Division of Medical Assistance and Health Services (DMAHS). The SMHA and DMAHS collaborated to implement a prior authorization process for community partial care that began on July 1, 2009. As a result, both DMHAS and DMAHS have realized both cost savings from this initiative as well as the first step in transforming the long-term day program into one that is more recovery oriented, shorter term, focusing on rehabilitation and attaining community integration and inclusion goals.

The SMHA and DMAHS have developed a State Plan Amendment (SPA) for community support services which was subsequently approved by CMS, effective October 1, 2011. The SMHA is currently pursuing a SPA to bring in federal funding for crisis remediation services. This will allow for greater community-based rehabilitation services while drawing down federal funds to best leverage existing resources. In addition, a staff member from DMAHS is part of the membership of the Behavioral Health Planning Council.

The DMHAS and DMAHS are collaborating on several initiatives that are part of the New Jersey approved Medicaid Comprehensive Waiver. These include: transitioning of services for person receiving services with the dual diagnosis of Intellectual/Developmental Disorders and Managed Long Term Services and Supports (MLTSS); collaboration related to the carve-in of managed psychiatric inpatient services, including the waiver of IMD specialty private hospitals; and the development of Behavioral Health Home (BHH) Services.

The DMHAS works with DMAHS and the Division on Aging Services (DoAS) to continue to coordinate the Managed Long Term Services and Supports (MLTSS) services. MLTSS refers to the delivery of long-term services and supports through New Jersey Medicaid's NJ FamilyCare managed care program. MLTSS is designed to expand home and community-based services, promote community inclusion and ensure quality and efficiency. MLTSS uses NJ FamilyCare managed care organizations (also known as MCOs/HMOs/health plans) to coordinate all MLTSS

services. MLTSS provides comprehensive services and supports for individuals who meet clinical eligibility, whether at home, in an assisted living facility, in community residential services, or in a nursing home.

Effective July 1, 2014, MLTSS includes an array of services but is not limited to: Personal Care, Respite, Care Management, Home and Vehicle Modifications, Home Delivered Meals, Personal Emergency Response Systems, Mental Health and Addiction Services, Assisted Living, Community Residential Services (CRS), and Nursing Home Care. The MLTSS Service Dictionary for a complete list of MLTSS services is available at http://www.state.nj.us/humanservices/dmahs/home/MLTSS_Service_Dictionary.pdf.

The following behavioral health services are included in the MLTSS benefit through NJ FamilyCare/Medicaid MCOs: Partial Care/Partial Hospitalization, Adult Mental Health Rehabilitation (Group Homes A+ through D), Independent Practitioner (Physician, APN, Psychologist), Mental Health Outpatient Clinic/Hospital Services, Opioid Treatment Services, and Inpatient Psychiatric Hospital Care. PACT, Transitional Case Managers (TCMs) and BHH are not covered by MCOs in MLTSS since they are duplicative care management services and remain Medicaid FFS. However, MCOs are required to coordinate these services for MLTSS members, as clinically appropriate.

NJ was also a recipient of a CCBHC Demonstration Grant, which includes a variety of services such as screening and referral for physical health needs and Health and Wellness services. Currently, seven CCBHCs are in operation (as of 7/1/17) as a part of the Demonstration Grant. Medicaid has been a partner throughout, having developed the Prospective Payment System that NJ is utilizing for this project. SMHA continues to partner with Medicaid to monitor and assist in the ongoing implementation of the CCBHC. DMHAS also works with Department of Children and Families (DCF) on implementation of the CCBHC. Currently, DMHAS and NJ Medicaid are woking to sustain the CCBHC model in NJ.

In 2020-2021 staff from DMHAS, NJ Medicaid division and the Department of Health participated in an Integrated Care Learning Community led by NASADAD and Center for Excellence in Integrated Health Solutions. The NJ team identified goals for promoting integrated care in our state and was able to make significant progress toward those goals.

Building on the relationships we have developed with our partners and the knowledge we have gained through our learning activities, NJ applied for and in March 2020 was awarded a SAMHSA PIPBHC Grant. Through that grant NJ is working with two FQHC to provide integrated care to individuals with OUD and hepatitis C and/or HIV. Program outcomes for this integrated care have been encouraging.

Department of Human Services, Division of Developmental Disabilities (DDD). SMHA Olmstead staff collaborate with DDD staff regarding discharge planning of dually diagnosed person receiving services with both intellectual developmental disabilities and mental illness (DD/MI) in the state psychiatric hospitals. Staff from DDD are also members of the Behavioral Health Planning Council. The SMHA has developed an RFP process to promote the development of community-based supportive housing opportunities and other support services for person receiving services with co-occurring mental health and developmental disabilities. DDD has also

hired full time Transitional Case Managers (TCMs) that are stationed at each respective state hospital. The DDD TCMs have their sole or primary responsibilities at the state hospitals focusing on the state hospital DD/MI population, the DDD referrals, and working with hospital staff to address any discharge barriers that may be present. Joint DDD and State Hospital meetings occur at each hospital on a monthly basis to discuss discharge planning and address any systems issues. In addition, biweekly meetings with DMHAS and DDD Olmstead management occur to address systems level issues and barriers to community re-integration.

Department of Children and Families. Interdivisional and interdepartmental collaboration between DMHAS and the DCF CSOC is frequent. Executive Staff from each Division have collaborated to make system recommendations for youth with mental illness and/or substance use challenges and families currently served in the CSOC whose youth are emerging adults. Recommendations were made in the form of policies, procedures and protocols that will ensure a seamless transition of youth and their families to all adult mental health services. In addition, several staff from CSOC attend monthly Behavioral Health Planning Council meetings to better coordinate services.

DMHAS Medical Director's Integration Office. The SMHA Medical Director's Office has an Integration unit with the goal of promoting integration between behavioral health agencies and primary health care providers. The main goal of the initiative is to increase person receiving services with mental health and/or substance use disorders (SUDs) access to primary care and improve collaboration between behavioral health agencies and primary health care providers. The Division of Medical Assistance and Health Services (DMAHS) and the office are working closely on a number of initiatives to provide case management, increase medication assisted treatment, and ensure collaboration between behavioral health and primary care practitioners. Behavioral health homes and certified community behavioral health clinics (CCBHCs) are specific initiatives that the integration office are overseeing. Also, a grant-funded initiative called 'Promoting Integration in Primary and Behavioral Health Care' provides integrated treatment for HIV and Hepatitis C in primary care clinics to clients in opioid treatment programs and harm reduction centers (syringe access programs). One accomplishment of this work has been to remove the Medicaid requirement for an infectious disease consultant to manage treatment of individuls receiving direct-acting antivirals for hepatitis C.

Staff are also actively working with the licensing office in the Department of Health to revise licensing regulations so that integrated care is facilitated. DMHAS is also meeting regularly with the Communicable Disease Service-Infectious & Zoonotic Disease Program in the Department of Health (DOH) on a task force that is addressing hepatitis C treatment, because of concerns about the high rates of infection in people who inject drugs. There is a potential to provide case management and navigator services to more directly address the medical needs of the population while they are receving substance use disorder services.

DMHAS continues its work with the Department of Health licensing office to develop integrated ambulatory regulations with the goal of streamlining the regulations and increasing integration of behavioral health and primary care services. The plan is to develop a single, unified regulation that will remove current barriers and allow integrated services to operate seamlessly. Althought much work has been done to develop a set of regulations that integrate these services, work in this area continues.

NJ Housing and Department of Community Affairs (DCA). On January 1, 2019, the Supportive Housing Connection (SHC) was transferred to the Department of Community Affairs (DCA), Office of Housing. All direct care staff of the SHC were transferred to DCA. The role and function of the SHC remains intact. The MOA between the HMFA and DMHAS, expired December 31, 2018; the new MOA between DCA and DHS/DMHAS, has an effective date of January 1, 2019.

The Supportive Housing Connection (SHC), pays housing subsidies for individuals served by applicable DMHAS programs. Under this MOA, the SHC acts as fiscal agent and by agreement follows all DHS policy decisions. The SHC contracts with property managers and owners, completes all necessary apartment inspections makes subsidy payments to property managers and landlords. The SHC recruits landlords, provides training, assists individuals in completing paperwork and distributes welcome packets to afford a smooth transition for individuals. The SHC assists individuals in referrals for affordable housing units, administers DMHAS housing subsidies, and expands relationships for housing opportunities through developers and or other HMFA housing projects. In the event of disputes between individuals and landlords, the SHC brokers disputes and contract issues. In SFY 2017 through 2020, DMHAS issued supportive housing contracts that are for services only. When individuals require a housing subsidy the SHC processes the subsidy requests and pays awarded subsidy payments directly to the landlord.

The NJ SMHA relies on Community Support Services (CSS) as its standard for community integration in providing housing and mental health services. CSS is a rehabilitative service intended to increase consumer choice in the types and sources of mental health services that they receive. It is also intended to involve the consumer in the development of an individualized rehabilitation plan designed to improve the chances of those diagnosed with mental illness to maintain valued life roles in employment, education, housing, and social environments. The SMHA reports 4,938 individuals served by Community Support Services (CSS) in SFY 2021 and 5,658 individuals served in SFY 2022.

The SHC will continue to manage supportive housing subsidies, conducting crucial related services such as apartment inspections and rental payments to landlords. The SHC will respond to all submitted subsidy applications within one business day of receiving a complete package. The SHC will provide apartment inspections within five days of the provider's submitted request. The SHC will also make rental payments by the payment due date for all individuals with a subsidy managed by the SHC.

The Chief Justice Mental Health Committee collaborated with DMHAS to issue an RFP in four counties. The purpose of this voluntary mental health diversion program is to support and connect individuals on pretrial monitoring, to critical mental health, co-occurring mental illness and substance use disorder (COD) treatment, housing, medical and other essential social services. Individuals in the target population who choose to voluntarily engage with the behavioral health team described in this RFP shall receive a social determinants of health (SDOH) mental health screen. Based on the identified needs, linkages to community-based services, behavioral health treatment and a mental health assessment or evaluation. Individuals with criminal charges who are eligible to continue services with the team and also meet legal and clinical criteria can apply for admission into a current or newly created voluntary mental health

diversion program track, integrated with the County Prosecutor's office and courts, and outcome of participants is the possible deferral disposition of the criminal charges pending successful completion of this diversion program. It is anticipated that individuals who are agreeable to treatment will be referred and seen for an initial diagnostic assessment within seventy-two (72) hours. Proposals should include detailed information about how initial assessments will be provided directly or arranged by the applicant within the 72-hour timeframe. If providing assessments directly, the applicant must be licensed by the Department of Health (DOH), Division Certificate of Need and Licensing (CN&L), as a Mental Health Outpatient Program. For applicants arranging for assessments, applicants must include written agreements indicating partnerships and collaborations with MH agencies which outline specific processes for handling such referrals.

988 and Collaboration With Other State Agencies: In preparation for the transition to 988, the New Jersey 988 Team worked with the five Lifeline centers and DMHAS leadership to envision the structure and function of 988 in this state. A Key Stakeholder Coalition was established to serve as an advisory group for the DMHAS 988 Team. This Coalition met monthly during the planning phases of the NJ 988 network bringing both ideas and perspective to the planning discussions. The Coalition continues to meet quarterly. This provides an opportunity for sharing of both ideas and updates to and from Coalition members. On July 16, 2022, NJ successfully transitioned from the previous ten-digit National Suicide Prevention Lifeline number to the 988 Suicide and Crisis Lifeline.

To establish a "no wrong door" philosophy for 988, NJ DMHAS has been working closely with multiple agencies including the Department of Children and Families' (DCF) Children's System of Care (CSOC)/PerformCare (CSOC's Contracted System Administrator serving children and adolescents), ReachNJ (substance use treatment resources and referrals), the Attorney General's Office (OAG), the Department of Human Services' Division of Developmental Disabilities (DDD), NJ211 and New Jersey's Office of Emergency Telecommunications Services through The Office of Information Technology (NJOIT). This collaborative work has helped to develop connections with NJ's comprehensive system of acute care and crisis response. DMHAS is developing warm transfer protocols for the 988 network. Plans include bi-directional warm transfers with 911/Public Safety Answering Points (PSAPs), CSOC/PerformCare, NJ211, ReachNJ, DDD and other statewide services. These transfers will be used after an initial assessment determines specialists on other call lines could be helpful to the individual in crisis.

IV. Description of Regional, County and Local Entities that Provide Behavioral Health Services; How These Systems Address the Needs of Diverse Racial, Ethnic, Sexual, and Gender Minorities

In NJ, the administration and organization of the mental health system includes both centralized, and county or locally based characteristics. A broad array of mental health services is offered in the community, with a number of well-established programs that operate in all NJ counties. The SMHA funds community agencies that provide an array of services including intensive services such as Integrated Case Management Services (ICMS). Persons receiving ICMS services are linked to services upon discharge from a state hospital, county hospital or Short Term Care Facility (STCF) for 12 months post discharge from an inpatient setting. Other key mental health

services available in all parts of the state include Psychiatric Emergency Screening Services, Early Intervention Support Services (EISS), Programs for Assertive Community Treatment (PACT), Outpatient, Acute Partial, Partial Hospital, Supported Employment, and Community Support Services (CSS). Additional programs such as Coordinated Specialty Care (CSC) and Jail Diversion are available in many regions of the state, with expansion efforts in progress.

The population in NJ is diverse in its ethnic and cultural makeup, and several counties have significant minority ethnic populations. Staff providing services must be culturally competent, and education must ensure consumer access. Mental health agencies are required to adhere to licensing standards that require culturally competent services. The state has not announced specific goals in regard to the Patient Protection Affordable Care Act (PPACA), but it has been actively working to promote structures to support the medical home component, and these are required to be culturally competent and meet the needs of a diverse population.

The SMHA provides services to a diverse population of persons receiving services. Several programs and the populations that they serve are described below. In addition, cultural competence mandates and training are also discussed. By virtue of setting (e.g. hospital emergency departments), coverage (e.g. urban, suburban, rural entities), admissions practices, and regulatory protections, acute mental health care programs serve individuals of racial, ethnic and sexual/gender minorities.

All Project for Assistance for Transition from Homelessness (PATH) providers are required to complete Intended Use Plans in which they identify the gender, race and ethnicity of the individuals they are serving in their community; the gender, racial and ethnicity of their staff; and to specify how their staff will provide culturally sensitive services and what cultural competency training and support their staff are provided. At minimum, all agencies provide cultural competency training at initial hiring and at least annually thereafter. A number of agencies take advantage of the trainings offered by the regional Cultural Competency Training Centers and other regional training opportunities. All PATH programs are informed by SMHA staff of any and all cultural awareness trainings being offered through SAMHSA or the Homeless Resource Center.

Multicultural and sensitivity training is mandatory for staff (per DMHAS regulations) upon hire to CSS programs and on an annual basis. This training is provided to ensure that staff are sensitive to age, gender and racial/ethnic differences of clients. Language is included in request for proposals (RFPs) that require the successful bidder to describe their efforts to ensure workforce diversity and inclusion in the recruiting, hiring, and retention of staff who are from or have had experience working with target population and other identified individuals served in this initiative. Additionally, the grantee is required to ensure that there is a training strategy related to diversity, inclusion, cultural competence, and the reduction of disparities in access, quality, and outcomes for the target population and that the trainings include education about implicit bias, diversity, recruitment, creating inclusive work environments, and providing languages access services.

Supported Employment and Supported Education are provided to a rich mix of diverse person receiving services: male and female as well as individuals of Caucasian, African American, Hispanic, Asian and Asian Indian backgrounds and from many different countries.

DMHAS Services to Special/Target Populations

The SMHA provides services to adults with SMI and children with SED with block grant funding. There are also special populations that have been assessed as target populations. They include persons receiving services who are at risk of hospitalization and homelessness, population experiencing First Episode Psychosis (FEP), persons receiving services in need of SE/SEd, individuals in crisis or receiving emergency services, older adults, individuals who have involvement with the criminal justice system, and youth population who are aging out of the children's system and into adult's system.

The SMHA provides outreach to and services for individuals who experience homelessness; community-based services to individuals in rural areas; community based emergency services; and community-based services to older adults. A description of these services was provided in section I, when mental health Criterion 1 and 4 were addressed. Additional services to special populations are described below.

First Episode Psychosis

First Episode Psychosis (FEP) refers to the early stages of someone experiencing psychotic symptoms or a psychotic episode. Coordinated Specialty Care (CSC) is a collaborative, recover-oriented approach involving persons receiving treatment, members of the treatment team, and when appropriate, family members as active participants. CSC is an evidence-based practice to optimize an individual's overall mental and physical health. Components of CSC include cognitive behavioral therapy, supported employment and education, case management, psychopharmacology, family psycho-education, and outreach. The population served by CSC are individuals between the age of 15-35 who have experienced psychotic symptoms for less than two years and their psychosis is non-organic and non-affective. There were 329 individuals served in SFY 2022. NJ currently funds three teams. A need has been identified to increase availability of services to individuals with FEP, provide access to services for individuals with affective psychosis, as well as provide step down services for CSC. DMHAS will be utilizing Covid Supplemental and ARPA funding to develop these services.

Crisis Continuum

<u>Crisis Call Centers</u>

988 Implementation is funded by both the COVID Supplemental Plan and ARPA plan. New Jersey has five (5) locally based crisis call centers that provide services for the 988 Suicide and Crisis Lifeline. The centers are certified by Vibrant Emotional Health (Vibrant) for meeting the minimum clinical, operational and performance standards. On July 16, 2022, New Jersey successfully transitioned to the 988 Suicide and Crisis Lifeline. Comparing data from January 2022 and January 2023, call volume increased 27%. Despite this increase in volume, centers managed to increase the number of calls answered by 19%. Calls not

answered in NJ were handled by Vibrant's national backup centers.

NJ is currently in the planning stages for several key programs along the crisis continuum, including Mobile Crisis Outreach Response Teams (MCORTs), Crisis Receiving Stabilization Centers (CRSCs), and Crisis Diversion Homes (CDHs).

Mobile Crisis Outreach Response Teams (MCORTs)

MCORTS will be established as the "Someone to Come/Respond" for the NJ 988 system. The SFY23 budget includes $16 million for the establishment of statewide MCORTs. These teams are designed to respond 24 hours a day, every day of the year to non-life-threatening mental health, substance use or suicidal crises in the community. MCORTs will be comprised of a two-person unit in the field under remote supervision by a third professional from a centralized location. The professionals include: trained peer support specialists, bachelor's level professionals with related educational and professional experience (in the field), and master's level supervisors providing clinical consultation. MCORTs will be dispatched by the NJ 988 Managing Entity after a 988 Lifeline Center determines a community-based response, without emergency responders, is necessary and appropriate.

Crisis Receiving Stabilization Centers (CRSCs)

CRSCs will be established with the mental health block grant 5% crisis set-aside, Covid Supplemental Plan and ARPA Plan. The DMHAS will develop crisis receiving stabilization centers (CRSCs) which will advance the development of the crisis continuum in NJ based on the National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit. The target population are individuals 18 years of age and older with a primary SMI and/or SUD experiencing acute symptoms that could interfere with community tenure. DMHAS will be using the "no wrong door" concept and partnering with community crisis responders. Services will be available 24 hours per day, 7 days per week, 365 days a year and include access to trained staff who can provide assessment, crisis stabilization, intensive supports, engagement, psycho-education, identification of strengths, collaborative problem solving, and individualized crisis planning. Services will be offered in a safe, clean, in a home-like non-hospital environment conducive to the recovery process. Medication management, administration, and education will also be offered. Medication-Assisted Treatment will also be available at the CRSCs. The program will offer continuity of care promoting continued stability and ensuring linkages are arranged that meet the needs of the individual. The goal of this program is to decrease the utilization of local hospital emergency services, designated screening centers, and in-patient psychiatric hospitalization while maintaining crisis stabilization treatment. DMHAS is planning to develop up to five centers.

Crisis Diversion Homes (CDH)

CDH is funded by the ARPA plan and will be established for the purpose of offering temporary transitional housing for up to 30 days, within a 24-hour supervisd setting. DMHAS will be developing up to three crisis diversion homes with 5-7 beds each which are staffed 24/7. CDHs will serve individuals 18 years of age or older with an SMI or a co-occurring substance use disorder, forensic involvement, or co-occurring developmental disability. This program will

provide community-based stabilization in a home-like setting and is not long term or permanent housing. Therapeutic and social supports will be provided in a warm and safe environment to individuals who do not need further hospitalization. The length of stay for this program is dependent upon an individual's need and is anticipated to be up to 30 days. At a minimum, staffing will include licensed clinical social work staff, nursing coverage, behavioral health techician, and a prescriber. Although the crisis diversion housing is not permanent, individuals experiencing a recent psychiatric hospitalization or relapse will receive the support they need from professionally trained and dedicated staff to continue their recovery in the community. Referrals to a CDH are prioritized for CRSCs and MCORTs and accept referrals assigned by DMHAS. By providing this additional level of care to the crisis continuum, the goal is to decrease the number of individuals with a primary SMI served in local emergency departments and emergency screening, including individuals longer than 23 hours while providing a mechanism for referral for crisis receiving and stabilization facilities for indiduals with complex behavorial health needs that require significant services and supports to return to the community. The Crisis Diversion Homes will include linkages to peer supports, clinical services, and housing with a goal of community re-integration to permanent or long-term housing and supports for the person receving services. DMHAS will not be using ARPA funds for capital expenditures.

Crisis Diversion Beds

The DMHAS contracts with mental health providers to provide 14 crisis home beds with 3 different providers (3 homes). These are residential settings that are staffed 24 hours a day 7 days a week. The homes focus on providing a recovery oriented residential setting for individuals to help avoid a mental health crisis. The length of stay in these homes is designed to be short term, and typically less than 30 days. The homes focus on rehabilitative skills, crisis planning, and individual recovery goals.

Inpatient Diversionary Beds

The DMHAS contracts with inpatient providers to purchase bed-days in inpatient facilities, known as "Diversion" contracts. The purpose of the Diversion contracts is to afford individuals age 18 and older with an SMI who would otherwise be admitted to a state or county psychiatric hospital the opportunity to receive treatment in an inpatient setting, which may enable the individual to stabilize and be discharged to the community. The primary goal of the purchase of bed-days is to reduce admissions to state hospitals. Individuals who do not stabilize and require continued inpatient treatment may be transferred to a state or county hospital at the conclusion of their approved length of stay in the contracted Diversion bed. The hospitals that contract for Diversion beds maintain additional bed capacity that is not governed by their DMHAS Diversion contract, and serve a similar population in this additional capacity. DMHAS currently contracts for access of up to 196 beds at three private psychiatric facilities -- Carrier, Hampton, and Northbrook that offer an alternative to state psychiatric hospitalization. There were 719 admissions utilizing 18,663 bed days and 92% were diverted from a state hospitalization. In CY 2022 there were 573 admissions utilizing 16,211 bed days and 90% were diverted from a state hospitalization.

Peer Recovery Support

Peer Respite Beds

The DMHAS contracts with mental health providers to provide 20 peer respite beds across the state (4 homes with 5 beds each). These are residential settings that are staffed 24 hours a day 7 days a week. The majority of staff that work in these homes are peers. The homes focus on providing a recovery oriented residential setting for individuals that may need a respite from their current setting and/or may need this setting to help avoid a mental health crisis. The length of stay in these homes is designed to be short term, and typically less than 30 days. The homes focus on rehabilitative skills, crisis planning, and individual recovery goals. These homes will either provide direct prescriber services as needed, or work to link individuals to services as needed. The staff will assist the individual with locating long term housing as well as other services where needed.

Acute Care Services

Designated Screening Centers (DSCs)

DSCs are designed to provide psychiatric emergency services including screening, assessment, crisis intervention, referral, linkage, and crisis stabilization services, 24 hours per day, 365 days per year, in every geographic area in the state. The SMHA funds 23 Designated Screening Centers (Screening and Screening Outreach) programs across the 21 Counties. According to the SMHA's Quarterly Contract Monitoring Report (QCMR) database of information self-reported by the screening programs, there were 65,870 episodes of care to these screening centers during SFY 2022. Of the 65,870, there were 53,104 adults served and 12,766 youth served.

Affiliated Emergency Services (AES)

AES provide for behavioral health staffing at emergency departments, including a mental health provider who is responsible for the provision of emergency services to individuals in crisis presenting in hospital emergency departments. Emergency service includes mental health and social services provision or procurement and advocacy. Emergency services offer immediate crisis intervention services and service procurement to relieve the client's distress and to help maintain or recover his or her level of functioning. Emphasis is on stabilization, so that the client can actively participate in needs assessment and service planning. Emergency service is affiliated by written agreement with the geographic area Designated Screening Center. (N.J.A.C.10:31). There are 12 Affiliated Emergency Service programs which are located in the following counties: 3 in Hudson, 1 in Middlesex, 3 in Monmouth, 2 in Morris, 1 in Passaic and 2 in Union. AES programs serve both the adult and youth population. There were 25,255 individuals served in SFY 2022. Of the 25,255, there were 19,993 adults served and 5,262 youth served.

Disaster Response

Mental Health Awareness Training Grant (09/30/2021 – 09/29/2026)

The goal of the Mental Health Awareness Training (MHAT) Grant is to empower anyone working with adolescents, young adults, first responders, or veterans through education about mental health. Individuals will leave these trainings with the knowledge and ability to appropriately react and respond to behavioral health crisis situations. Trainings will equip participants with resources to connect to professional, peer, and social supports while gaining tools to promote self-help resources, reduce stigma, and understand the critical role they can play in contributing to saving someone's life or increasing their quality of life. MHAT is made up of two training curriculums, Mental Health First Aid (various modules available such as youth and veterans) and Question, Persuade, and Refer (QPR).

Mental Health First Aid teaches the identification and response to signs of mental health and substance use concerns. The 8-hour course introduces participants to risk factors and warning signs of mental health concerns, builds understanding of their impact and provides an overview of common treatments. Through role-playing and simulations, it demonstrates how to assess a mental health crisis; select interventions; provide initial help; and connect people to professional, peer and social supports as well as self-help resources. Mental Health First Aid is evidence-based, evidence-informed and proactively updated. A number of research studies have shown that training in Mental Health First Aid results in better knowledge, attitudes, and help-giving.

QPR stands for Question, Persuade, and Refer — the three simple steps anyone can learn to help save a life from suicide. Just as people trained in CPR and the Heimlich Maneuver help save thousands of lives each year, people trained in QPR learn how to recognize the warning signs of a suicide crisis and how to question, persuade, and refer someone to help. QPR training is two-hour curriculum.

Both Mental Health First Aid and QPR trainings and materials are provided at no cost to hosting agencies and the public. These training are made possible through the Substance Abuse and Mental Health Services Administration Grant, that was awarded to the NJ Division of Mental Health and Addiction Services DMHAS, Department of Human Services (DHS).

CDC NJ DOH Grant (3/1/2022 – 08/31/2023)

The NJ Department of Health (DOH) was awarded the CDC NJ COVID Disparities Grant to promote resilience and sustainability of the NJ DOH public health workforce as a result of the pandemic. This initiative named "Hope for Health" is based on the SAMHSA Crisis Counseling Program model key principles: strengths-based, anonymous, outreach-oriented, and designed to strengthen existing community support systems. It does not provide clinical services but refers to existing mental health resources in the community.

Hope for Health Program Goals:

- Helping health workers understand their current situation and reactions
- Reducing stress and providing emotional support

- Assisting in reviewing recovery options
- Promoting the use or development of coping strategies
- Connecting health workers to resources

Hope for Health program supports the following interventions:

- Individual and group crisis counseling including hotline/helpline support
- Psychoeducational groups
- Community networking and support
- Assessments, referrals, and resources
- Development and distribution of educational materials

MHBG BSCA (10/17/2022-10/16/2024)

The DTB will use the Bipartisan Safer Communities Act (BSCA) funding to expand its existing behavioral health services continuum in the aftermath of traumatic events that impact the psychological health of New Jersey residents. Outlined below are multiple initiatives that help support this work.

Disaster Response Crisis Counselor

In 2007, DTB began the Disaster Response Crisis Counselor (DRCC) Certification Program. DRCC's are trained and background-checked volunteers who are deployed in a county or Statewide in the immediate aftermath of a community crisis. With the help of BSCA funding, DTB will increase the numbers and scope of the DRCC program in order to have a more specialized crisis taskforce for specific response types such as mass casualty events, impacting target populations such as rural communities, those with severe mental illness, and those who are deaf and hard of hearing, etc. In order to best communicate with individuals who, have access and functional needs, the support of technology is vital and is an included budget line item. The development of such unique task force teams to deploy to incidents of mass casualties will require coordination with law enforcement, medical examiner offices and healthcare systems. The preparation of DRCC teams to respond to more complex anticipated and no-notice events is a vital part of response efforts.

Disaster response is always local and the DTB has cultivated successful working partnerships with the County Mental Health Administrators and the County Alcoholism and Drug Abuse Directors; they are responsible for the planning of behavioral health services in their counties. A stipend will be given to each county to fund recruitment, completion of exercise drills, training activities as well as engagement efforts for Disaster Response Crisis Counselors; each county will be awarded up to $15,000 per year based on application and budget quality.

The DTB will promote the DRCC program throughout New Jersey through dissemination of printed materials, electronic newsletter, and podcast or recorded informational pieces of current responses, lessons learned and emerging trends in the field.

Learning Management System

With BSCA funds, DTB would like to secure a robust learning management system (LMS) in order to ensure consistency and quality of training and messaging. The learning management system would consist of informative video clips, interactive quizzes, pre and post knowledge test that engage and enhance the learning of participants. The target audiences for the LMS are Disaster Response Crisis Counselors, first responders, behavioral health providers, county behavioral health coordinators, emergency managers, non-profit organizations, and the disability, access and functional needs community.

Critical Incident Stress Management

Critical Incident Stress Management (CISM) is a comprehensive, integrative, multicomponent crisis intervention system. CISM is considered comprehensive because it consists of multiple crisis intervention components, which functionally span the entire temporal spectrum of a crisis. CISM interventions range from the pre-crisis phase through the acute crisis phase, and into the post-crisis phase. CISM is also considered comprehensive in that it consists of interventions which may be applied to individuals, small functional groups, large groups, families, organizations, and even communities. CISM teams have been an important part of the behavioral response for first responders in New Jersey for the past two decades, but attrition has led the teams to fold or be chronically understaffed. DTB proposes coordinating with the remaining CISM teams in New Jersey to increase training for law enforcement, fire, dispatchers, and EMS to rebuild the CISM Infrastructure.

Traumatic Loss Coalition

The DTB deploys DRCC's to work with all residents of New Jersey. However, when there is an incident primarily impacting youth and young adults, DTB works closely with New Jersey's Traumatic Loss Coalition (TLC). DTB proposes strengthening this partnership through cross-training. For this effort, the plan is to train 250 lead responders in the "Managing Sudden Traumatic Loss" (MSTL) response model. Specifically, the goal is to:

- Build Statewide capacity to respond to youth and young adult related incidents such as significant incidents of school violence, with 10-15 responders per county
- Offer 5-6 trainings with an audience of 40-50 people
- Conduct staff training with two co-facilitators/trainers for each offering
- Provide in person or virtual or hybrid trainings
- Provide manuals to participants

Sustainability would be possible as teams will be located in each county; and can cross-train as DRCC's to also work with the adult population. Volunteers have no ongoing costs for deployment.

BTAM Team Initiative

The NJ BTAM (Behavioral Threat Assessment and Management) Team is a centralized resource focused on the sharing of information and knowledge, and leveraging support of law enforcement and behavioral health professionals for the purpose of threat management. When law enforcement identifies a community threat, the team convenes to provide consultation in reviewing individuals at risk for engaging in violence or other harmful activities, and recommending intervention strategies to manage the risk of harm for individuals who pose a potential safety risk. The team includes representatives from several agencies and organizations including law enforcement, intelligence, education and behavioral health sectors. Each member of the team has advanced training in behavioral threat assessment, and works collaboratively to prevent targeted acts of violence through early identification, consultation, and management of individuals displaying concerning or threatening behavioral indicators. The team's goal is to reduce the number of incidents that occur by creating diversion pathways for at-risk individuals into programs for behavioral health or other services. DTB will play an integral role in the BTAM, a DTB staff person will lead DTB efforts and engagement with the team. The DTB Trainer will engage with the New Jersey Behavioral Health Provider network for a series of trainings to recognize the signs of radicalization, pathways to violence, and how to engage with law enforcement to prevent future episodes of mass violence.

Vulnerable Populations

New Jersey has incredible diversity and DTB will connect with faith-based, LGBTQ+, and other cultural and racially vulnerable populations. DTB will partner with these organizations to prepare for incidents of mass violence. Areas of training will be recognizing the pathways to violence, responding to active shooters, and Stop the Bleed training.

FAC's and Reunification Exercises

The DTB works in coordination with the NJ Department of Human Services' Office of Emergency Management (OEM) in planning for the aftermath of a mass casualty event. We propose using this grant to conduct regional exercises for Reunification and Family Assistance Centers. The increase in mass fatality incidents in the past decade – natural, man-made, and intentional – underscores the need for communities to be able to provide specialized behavioral health support to the families directly affected by these tragic incidents. In the aftermath of a mass casualty event, a Family Reunification Center (FRC) will be operational to facilitate the reunification of those affected by the event with their family members. Reunification is the process of reuniting friends and family members who have been physically separated as the result of an incident. After a crisis event, such as active shooter, the FRC is the gathering place where family reunification can occur.

The FRC may run in concert with Family Assistance Centers (FAC). The FAC is established to provide an array of support services to those impacted by the event. There are many services provided at a FAC. Some require or benefit from behavioral health support. Here is a list of some services provided at a FAC:

- Family Briefings
- Antemortem Data Collection (to assist in identifying victims)
- Death Notifications
- Call Center/Hotline
- Reception and Information Desk
- Spiritual Care Services
- Behavioral Health Services
- Medical/First Aid Services
- Translation/Interpreter Services
- Child Care

DRCC's and DTB specialized behavioral health crisis response teams are an integral part of assisting the families at these centers to aid survivors and their families with their immediate crisis mental health needs while they are at the FAC. By conducting disaster behavioral health exercises, DTB will prepare members of the DRCC's and other specialized crisis teams for their role in Reunification and Family Assistance Center operations. At the completion of the Reunification and FAC Training Exercise, DRCC's and other specialized disaster behavioral health teams will be prepared to assist with Reunification and FAC's, provide behavioral health support to individuals affected by a mass casualty incident.

County and State Emergency Partners Workshops

The facilitation of local, county, and State workshops with all emergency management partners will ensure coordination and collaboration ahead of a community crisis or mass causality incident. The goal is to break down existing silos to prevent duplication of services and to educate partners about the importance of and improved behavioral health outcomes when behavioral health issues are addressed in the immediate aftermath of a community crisis. The workshops will include education and planning for all partners on specific needs of individuals with serious mental illness and those living with substance use disorders, specifically those in need of medication assisted treatment. County Alcoholism and Drug Abuse Directors and Mental Health Administrators are a vital part of increasing communication and planning to ensure better behavioral health outcomes for NJ residents after an event.

DOH PHILEP (7/1/2019 – 6/30/2024)

NJ's Department of Health Division of Public Health Infrastructure Laboratories and Emergency Preparedness awarded the DTB funding to fulfill the following grant goal: to be prepared for the medical, behavioral and mental health needs of disabilities, access and functional needs individuals, such as senior citizens, children, minorities and individuals with disabilities, access and functional needs and first responders in the community in the event of a public health emergency. The annual objectives outlined for this initiative is as follows:

- Attendance at twenty emergency preparedness meetings/forums.
- Participate in a minimum of four emergency preparedness exercises.
- Participate in a minimum of four meetings/forums with Offices of emergency management, health and behavioral health officials for collaboration and partnership building.

- Conduct a minimum of four stress management trainings for health providers.
- Conduct four emergency preparedness training for faith-based groups.
- Maintenance of the Disaster Response Crisis Counselor program by way of recruitment, training and retention of volunteers.
- Participate in meetings that foster coordination of public health, medical and behavioral health services.
- Support the ability of the community's healthcare system to prepare, respond and recover from disasters.
- Attend meetings as a member of the Healthcare and Public Health Coalition Advisory Panel.

TMHFA Pilot (6/15/2022 – 9/30/2025)

The Disaster & Terrorism Branch (DTB) has partnered with the Mental Health Association in New Jersey (MHANJ) to provide Teen Mental Health First Aid (TMHFA) to high schools throughout NJ. Teen Mental Health First Aid (TMHFA) is designed for teens aged 15-18 or those students in grades 10-12. This course reviews typical adolescent development, common mental health challenges for youth, and teaches a 5-step action plan for how to help young people in both crisis and non-crisis situations. TMHFA training gives teens the tools of awareness; assisting them with the ability to identify when they or their friends are experiencing emerging mental health challenges, worsening signs and symptoms, or experiencing a crisis. Because one in five teens will experience a mental health challenge by age 18 (National Council, 2023), the TMHFA model is an investment in our youth and those adults that are in regular contact or caring for them.

Governor's Mental Health Initiatives

- *TMHFA Expansion*
  - The Division of Mental Health and Addiction Services' Disaster and Terrorism Branch (DTB) will fund the expansion of Teen Mental Health First Aid for high school students and school personnel in several NJ schools. Building on DTB's initial implementation and lessons learned of TMHFA in eighteen (18) New Jersey high schools, this expansion will allow the Mental Health Association in New Jersey (MHANJ) to broaden the project to include thirty-five additional high schools offering multi-year support for teens, school staff and families. To add, youth serving organizations will be invited to join the project and partner with schools to support continued training and sustainability. The project will extend through two academic years with materials and consultation made available in the third year to imbed TMHFA into school curriculums for sustainability.

- *MHFA on College Campuses*
  - The National Council of Mental Wellbeing, the facilitators of the Mental Health First Aid curriculum, have a module specifically for the higher education community which will be utilized. This allows students, faculty, administrators and other school staff to identify risk and protective factors as well as to reduce the stigma of receiving needed services. Mental Health First Aid (MHFA) is a way to identify and respond to behavioral health changes in our young adults.

MHFA was designed to extend the concept of first aid training to behavioral health. MHFA teaches participants to recognize signs and symptoms, listen nonjudgmentally, and appropriately refer a person to supports and services. The Division of Mental Health and Addiction Services' Disaster & Terrorism Branch (DTB) will make MHFA available on college campuses throughout New Jersey. This initiative will assist in the identification of students at risk and in need of behavioral health intervention. The development of a sustainable model of providing MHFA on campuses regularly is an integral part of this initiative to assist students. Each campus will be invited to nominate staff to become MHFA instructors in order to sustain the curriculum on campuses long-term.

- *Higher Education Peer Counseling*

  In coordination with NJ's Office of the Secretary of Higher Education, the DMHAS will host several college campus initiatives, to include the following:

  1. Conduct a survey of colleges and universities in order to identify strengths and needs in the higher education community. This survey will garner information about existing programming, ongoing student needs and identify potential opportunities for additional resources and services.

  2. Conduct focus groups with university students, faculty and staff. Students will provide feedback and insight related to their needs and areas in which they desire assistance.

  3. Develop a statewide student-led advisory group, to establish and support student wellness activities; providing ongoing dialogue on the needs and impact of programs on campuses.

  4. Develop regional student-led learning communities to establish a sustainable model of student volunteers that promote a culture of wellness on college campuses.

<u>Services to Veterans, Service members and their families.</u> The SMHA has consistently provided mental health and related support services to members of the armed forces and veterans as part of its regular behavioral health service delivery system. When possible, the service member is connected to the VA healthcare system if eligible, however this is typically on 13%. During SFY 2020, SMHA served 8,223 individuals who identified themselves as veterans, a16% increase since last reported. They were provided with a range of services, the most frequent being emergency services, outpatient, partial care, case management, Justice Involved Services, Supported Employment, and Supported Education. The SMHA, based upon discussion with the NJ Healthcare System (VA)VANJ, believes that the actual number served is closer to 14,000 because many active or former service members may not consider themselves veterans in response to provider intake questions.

The SMHA has periodic meetings and communications with the NJ Healthcare System (VA) to enhance collaboration, particularly around acute care services. A SMHA representative continues communication with the NJ Department of Military and Veterans Affairs (DMAVA) and collaborates regarding needed services for New Jersey Nantional Guard and other military service personnel. Discussion included providing NJNG with Mental Health First Aid training, the result of a SAMHSA grant, and reestablishing a points of contact between the two divisions for referrals to services. A SMHA representative recently provided an overview of the mental health and substance abuse system in New Jersey and how to access services for the Semi-Annual State and County Veteran Service Officers; it was very well received.

Behavioral health prevention, early identification, treatment and recovery support system efforts targeted to New Jersey's population of veterans is a high priority. The SMHA's Anti-Stigma Council has partnerships with federal and state military and veteran's organizations and spearheads initiatives such as the "Life Doesn't Have to Be a Battlefield – Don't Let Stigma Stand in Your Way" campaign. This campaign is designed to increase participation in state mental health services among veterans. The Anti-Stigma council also works to forge linkages to veteran's programs such as Vet2Vet and other veteran's referral, treatment and training programs.

Justice Involved Services (JIS).
The SMHA has been providing JIS since 2000. The services work to avoid or divert from incarceration individuals whose legal involvement may have resulted from untreated mental illness or co-occurring mental health and substance abuse disorders. This is a criminal justice case management service which links the person receiving services who has been involved with the criminal justice system to needed treatment, psychiatric rehabilitation and other community supports. The SMHA funds JIS programs in fifteen New Jersey counties; represented in Intercepts 1- 3. Additional resources are needed to establish JIS programs in the remaining six counties. JIS is provided to a diverse mix of person receiving services, male and female as well as individuals of Caucasian, African American, Hispanic, Asian and Asian Indian backgrounds and from many different countries.

Deaf and Hard of Hearing. New Jersey has an array of services throughout the state for individuals who are Deaf and Hard of Hearing and have mental health issues. ACCESS at St. Joseph's Medical Center in Paterson is contracted to provide on-site outpatient services at several outpatient locations in the Northern region of the state, with Master's level clinicians who are specialists in Deaf Culture and fluent in American Sign Language (ASL). They also provide 24/7 statewide consultation for psychiatric emergency services (Clinicans can be reached onsite during business hours by phone/Videophone) and after hours by calling our on-call service number). Consultation is also available to inpatient settings, and outpatient programs. ACCESS staff participates in the NJ training for Certified Psychiatric Screeners. The purpose for this is so that screeners are able to understand, navigate, and explain the state's screening process when working with an individual who is Deaf to ensure the Deaf client is assessed in a linguistic and culturally appropriate manner. Additionally, ACCESS provides onsite clinical consultation and liaison services to NJ's Short Term Care Facilities (STCFs), assisting with treatment and discharge planning for each deaf patient.

ACCESS operates residential services in Passaic County. These include an eight bed 24-hour supervised community residence for deaf individuals with mental illness who have been discharged from a New Jersey state hospital or its equivalent, a four bed supervised residence, three semi-supervised apartments, and supportive housing services at apartments with person receiving services who are deaf and hard of hearing with a mental health diagnosis living in the community. Two additional community programs managed by ACCESS are located in the Northern Region of the state that provide services to the deaf and hard of hearing population with mental health issues. Integrated Case Management Services provides a staff member to work with this specialty population in the community, and the Partial Care program in Paterson has a specialty track for persons with SMI who are deaf and hard of hearing.

NJ has the Statewide Specialized Inpatient Program (SSIP) for the Deaf at Greystone Park Psychiatric Hospital. The SSIP consists of a 25-bed inpatient unit in the main hospital building and an eight bed capacity less restrictive residential cottage to prepare individuals for discharge. All SSIP staff are trained in ASL and Deaf culture. Certified ASL Interpreting staff are available for patient and staff interfaces, particularly clinical contacts.

The Statewide Deaf Advisory Committee meets quarterly to review systems of care, as related to Deaf services and mental health in the State of New Jersey. Pursuant to Administrative Bulletin 5:07 [Section 504 of the Rehabilitation Act of 1973 (P.L. 93-112), and the Americans with Disabilities Act (P.L. 101-336)] the Committee is responsible for advising DMHAS concerning policy, program, training and quality assurance issues/activities involving the service systems for individuals who are, deaf and also suffering from serious and persistent mental illness.

The Alcohol and Drug Abuse Program for the Deaf, Hard of Hearing and Disabled and a Program Advisory Committee were established pursuant to PL 1995, c.318 (NJSA 26:2B-36 to 39), and continue to meet on a quarterly basis to ensure quality substance abuse treatment services are provided to individuals who are identified as being deaf, hard of hearing or disabled in the community.

Culturally and Linguistically Appropriate Services and Diversity

Multicultural Services Advisory Committee (MSAC). DMHAS defines cultural competence as: "…the ability to honor and respect the beliefs, languages, interpersonal styles, and behaviors of individuals and families receiving services, as well as staff members who are providing such services. Cultural competence is a dynamic, ongoing developmental process that requires a long-term commitment and is achieved over time" (HHS 2003a, p. 12).

The Division has had a long standing commitment to issues of cultural and diversity, originally forming a Multi-Cultural Advisory Committee in 1981. Since that time, the role and membership of this group has changed to meet the changing needs of the system. Currently the MSAC devises strategies that are appropriate to the lifestyles, special needs, and strengths of New Jersey's diverse populations and cultural groups, and most recently, addresses challenges to ensure that BIPOC (Black, Indigenous, People of Color) receive quality equitable services in the behavioral health system of care. Additionally, MSAC makes recommendations to DMHAS regarding training content, membership eligibility, statewide cultural competency goals, agency

self-assessment processes, and in collaboration with other stakeholders, ensures that cultural competency principles are disseminated across the State and to other disciplines. MSAC membership includes broad representation from providers in the behavioral health treatment community, consumer representatives, peers, LGBTQ, administrators, and academics.

All DMHAS funded behavioral healthcare agencies are required to have a written cultural competence plan and adhere to Culturally and Linguistically Appropriate Services (CLAS) in their delivery of services. The CLAS standards "provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs." As such, each agency is required to develop a cultural competency plan that establishes culturally and linguistically appropriate goals, policies, and management accountability and infuses them throughout the organization's planning and operations.

To assist agencies with preparing and maintaining a culturally and linguistically responsive delivery plan, the Centers provide technical assistance in the form of workshops, group, and customized individualized support to assist in the development of cultural competency plans. Additionally, a statewide diversity consultant assists the two Centers with collecting, reviewing, and analyzing the plans. As a result of DMHAS' commitment to cultural competency and the efforts of the Centers, there has been in increase in the number of agencies in the state developing and implementing cultural competency operations and practices.

Diversity Consultant
DMHAS has allocated funding for a Diversity Consultant to increase efforts to provide research-based training, assessments, and outreach with behavioral health agencies. The diversity consultant collaborates Centers and MSAC to:

- Review provider agency cultural competency plans for relevance with regards to service delivery.
- Quantitatively and qualitatively analyze cultural competency plan data and make recommendations for system-wide changes.
- Chair the Multicultural Services Advisory Committee, prepare agenda, and minutes.
- Provide guidance and support to the Training and Technical Assistance Centers.
- Network with leaders in the field to advance cultural competency throughout the State.
- Assist in the development of cultural competency training and workshops sessions.
- Research subject matter and make recommendations to provide evidence-based, timely training, workshops, and conference content.
- Research and utilize assessment tools to measure and assess cultural competency trends and delivery.
- Represent the MSAC and DMHAS' efforts to engage and encourage community and key stakeholder's involvement with cultural competency activities.
- Develop outcomes to measure the effectiveness of DMHAS' agencies' cultural competency plan development, implementation, and sustainability of services.

<u>ARRIVE Together Community Resource</u>

ARRIVE Together is a coresponder law enforcement and behaviorial health professional co-reponder model. It is a transformative and powerful model, de-escalating situations without use of force with a dramtic decrease in transport to the emergency derpartmen/room?.

In most jurisdictions, mental health professionals accompany plainclothes officers in unmarked police vehicles to respond to 9-1-1 calls for service relating to mental or behavioral health crises, although each county may employ a slightly different framework of interaction between the mental health and law enforcement responders based on what would best serve the community. Different health care providers around the state have signed on to to work with police on this effort, which is designed to form relationships between individuals needing help and law enforcement and mental health professionals, in order to de-escalate situations and transition away from law enforcement relying on emergency rooms or use of force.

The deployment of mental health professionals, in concert with New Jersey State Troopers, has provided vital services to those experiencing mental health distress at the time it is needed the most. It is recognized that the trusted partners of the ARRIVE Together Program have the ability to mitigate crisis, reduce the risk of physical harm, and potentially bridge the gap into continued compassionate care for citizens struggling with mental health issues.

A law enforcement response is rarely the most effective or appropriate way to help someone experiencing mental health crisis. New Jersey's ARRIVE Together program – which puts mental health professionals at the center of the intervention – is an evidence-based solution to address this national and systemic challenge. This expansion of ARRIVE Together will continue to improve public safety, prevent tragedies and serve NJ residents more effectively.

The initaitve is led by and directed by the NJ Attorney General's office in partnership with DHS the program has continued to expand since initiated and will be available in select munciplalities in all 21 counties municipalities before the end of SFY2024.

Initatives funded under Covid Supplemental and ARPA

<u>Coordinated Specialty Care (CSC) and CSC Community Integration- </u>Covid Supplemental 10% Set Aside - $2,670,000.20; Additional Covid Supplemental funding - $2,340,000.00; ARPA 10% Set Aside - $3,912,136.60; Additional ARPA funding - $3,150,000

Since its inception in November 2016, NJ Coordinated Specialty Care (CSC) programs have gone through a rapid expansion. This initiative, which is covered statewide by three providers, was designed to serve 105 clients annually. The CSC initiative now serves over 210 clients annually with some clients receiving service after two years in the program. The programs have doubled in size since inception and have reached their capacity. Some of the programs function over their capacity and have waiting lists indicating the need for expansion. Each agency currently covers 7 counties. This presents a challenge for providers in covering the vast territory as well as for individuals receiving services because of the time spent traveling to the provider agency and the lack of access in the county of residence. DMHAS will be expanding CSC for a

total of six programs. CSC will continue to serve individuals with First Episode Psychosis. Additionally, DMHAS will be expanding the size of the teams to be able to serve individuals with affective psychosis. Currently, existing teams cannot serve individuals with affective psychosis but expansion of the admission criteria to serve both criteria will help in serving NJ's most most vulnerable individuals. The increase in the size of the teams and the staffing for each time will also provide for a step-down program know as a CSC Community Integration (CI) program.

Since most outpatient programs do not specifically fit the programmatic needs of an individual discharged from a CSC program, there is a need for a step-down program with services that are flexible and comprehensive to meet the person's needs. The need for a community integration program comes with the increasing number of FEP consumers in need of a transitional support program post-CSC intensive treatment. Individuals will be able to move to the step-down and titrate down in the services needed or move back up to CSC if needed for a more intensive level of services. The transition will be seamless to the individual as their treatment team will remain the same avoiding the need to terminate with one team and develop relationships with a new team. Treatment and supports will be geared toward reintegration of the individual back into the community, return to school/work, symptom stabilization, diversion from inpatient services and a reduction of screening center utilization. The program will maintain a supportive environment where the client can access an array of services and remain connected in the community, thus reducing hospital recidivism, integration of health and behavioral health via continuity of care between the CSC APN and the client's primary care practitioner, reduction in duration of untreated psychosis, increase in medication adherence, and increase in functioning.

Crisis Receiving Stabilization Centers- Covid Supplemental 5% Set Aside - $1,132,460.60; Additional Covid Supplemental funding - $3,597,268.00; ARPA 5% Set Aside - $1,956,068.30; Additional ARPA funding - $8,412,450.70

NJ DMHAS will develop up to five new crisis receiving stabilization centers which will advance the development of the crisis continuum based on the National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit. The target population is individuals over age 18 with a primary SMI and/or SUD diagnosis, experiencing acute psychiatric symptoms that could disrupt community tenure. Referring entities, including first responders and law enforcement, providers, family members, and self referrals. At a minimum, services will include 24/7 access to trained staff who can provide assessment, crisis stabilization, intensive supports, engagement, education, identification of strengths, collaborative problem solving, and individualized recovery planning. Medication prescription, administration and education will also be offered. The program will offer continuity of care in an effort to promote continued stability by ensuring the linkages put in place are suitable for the individuals' needs. The goals of this program are to decrease the utilization of local hospital emergency services and in-patient psychiatric hospitalization, while maintaining crisis stabilization treatment and linkage to community services.

Crisis Diversion Homes- Covid Supplemental funding - $187,000; ARPA funding $5,000,000
The SMHA has identified gaps in its system of care that are attributable to extended emergency room stays. As such, the SMHA will be looking to bridge the gap between homelessness and permanent housing by developing community-based housing that is staffed 24/7. This is a

transitional program providing services that are provided until the client is stabilized and community supports, services and permanent housing have been arranged. This will provide the client the opportunity to remain in the community with needed supports. Services provided by this program are on a temporary basis. Referrals will be prioritized for the Crisis Receiving Stabilization Centers and Mobile Crisis Outreach Teams. Referrals will be made thru DMHAS.

Psychiatric Emergency Screening Services (PESS) Peer Support Diversion:

Psychiatric Emergency Screening Services (PESS) Peer Support Diversion Initiative is funded by both COVID Supplemental plan and ARPA plan. DMHAS has awarded funding to our contracted Psychiatric Designated Screening Center providers and Affiliated Emergency Services providers. DMHAS invited all PESS providers to submit to DMHAS a plan to prioritize hiring peer staff to work with individuals presenting to utilize psychiatric screening services via the emergency room or mobile outreach by screening staff multiple times throughout the year. Hiring non-peer staff is permitted if the organization cannot hire peer staff. Staff will work with hospitals and systems partners to provide follow-up services to high utilizers of the psychiatric screening services, including to provide follow-up calls, linkages to needed services, in-person visits as needed, collateral contact and information services to family members and enhanced case management services to individuals presenting to the emergency rooms frequently utilizing psychiatric screening services, with the goal of decreasing emergency room visits and inpatient hospitalizations. Some medication services through the use of a prescriber may be provided as part of this initiative for follow-up services. Through enhanced case management service linkages with services and supports, including mental health and other co-occurring needs, will be provided. 25 of 35 providers submitted applications, and all were approved. Covid Supplemental Funding $4,541,000 and ARPA funding $4,541,000 funding amount.

DMHAS is currently in the process of issuing a Request for a Letter of Intent (RLI). Intensive Outpatient Treatment Services and Support (IOTSS) program staff would work with hospitals to provide psychiatric evaluations, medication management, counseling services, and enhanced case management services to individuals presenting to the emergency rooms frequently with the goal of decreasing emergency room visits and inpatient hospitalizations. Through enhanced case management services linkages with services and supports, including mental health and other co-occurring needs will be provided.

CHLP - Community Health Law Project- Covid Supplemental funding for this initiative was $480,000. ARPA funding was $150,000

The Community Mental Health Law Project - Legal Assistance due to Covid/Housing Stability was funded by both COVID Supplemental Plan_and ARPA plan. These resources will also be used to support legal needs of SMI persons recieving services that have arisen as a result of COVID, e.g., evictions. New Jersey and the federal government have eviction moratoriums in place related to COVID. Once the eviction moratorium is lifted, landlords will be able to commence eviction proceedings. Housing stability is an important component of recovery. The DMHAS will use funds to support housing stability to avert homelessness through eviction. DMHAS will use the MHBG COVID Supplement ($350,000) to enter into a contract with an agency that is staffed to provide landlord/tenant legal services to individuals with SMI facing

eviction. Services will be provided statewide. DMHAS will use ARPA grant funding to continue to fund the Community Mental Health Law Project for 1.5 years. The funding will not be used for rent.

CTR-Recovery Oriented Cognitive Therapy – Funding for CTR from Covid Supplemental was $600,000.

CTR-Recovery Oriented Cognitive Therapy is funded through MHBG COVID Supplemental plan. DMHAS plans to fund a Wellness program which is intended to improve individuals self-esteem and practicing positive self-care using empirically proven interventions. The peer-run centers that provide support and recovery services to a diverse population of consumers around the state have received training and supervision on Recovery-Oriented Cognitive Therapy (CT-R) along with Peer Wellness Coaching.

DMHAS will use funds to offer Recovery-Oriented Cognitive Therapy (CT-R) training to providers. Guided by Dr. Aaron T. Beck's cognitive model, CT-R is an evidence-based practice that provides concrete, actionable steps to promote recovery and resiliency. Originally developed to empower individuals given a diagnosis of schizophrenia, CT-R applies broadly to individuals experiencing extensive behavioral, social, and physical health challenges. CT-R is highly collaborative, person-centered, and strength-based, and tailored to those who have a history of feeling disconnected from and distrustful of mental health professionals.

Between December 01, 2022, and March 31, 2023, the New Jersey Department of Mental Health and Addiction Services and the Beck Institute Center for Recovery-Oriented Cognitive Therapy have collaborated to initiate a Center of Excellence for Recovery-Oriented Cognitive Therapy (COE) funded by a SAMHSA block grant. Together, the team:

- created of a COE website to publicize training opportunities, provide resources to providers across the state, and host CT-R training materials (guidelines, useful tools, videos)
- recruited New Jersey nonprofit agencies that provide services to adult outpatients who have a primary diagnosis of a serious mental health condition
- conducted a virtual kickoff for agencies from across the state
- began to train (focus groups and the workshop) the first cohort of 7 programs
- intensified recruitment efforts for a second and third cohorts of training on Community Support Services teams and Group Homes
- created promotional materials to get the word out about the COE
- set up incentivizing process to get money to trainees
- provided technical support consultation to Peer Providers

MHFA-Mental Health First Aid – Covid Supplemental funding for tMHFA was $1,800,000. ARPA funding for this initiative is $400,000

Teen Mental Health First Aid is funded by both COVID Supplemental Plan and the ARPA plan . The NJ Mental Health Awareness Training project will provide mental health first aid training by a team consisting of experienced, certified full-time and part-time trainers from DMHAS. They will train personnel in the evidence-based Mental Health First Aid (MHFA) model. The funding

was originally allocated for providing Mental Health First Aid curriculum for the adult population (3/16/23-9/15/24).

On May 25, 2022, the DMHAS submitted a waiver request to use the $400,000 in the Mental Health Block Grant (MHBG) ARPA to fund the Teen Mental Health First Aid (t-MHFA) curriculum from the National Council on Mental Wellbeing. Using the MHBG Covid Supplemental, the Division has begun a Teen MHFA Pilot which has been successfully launched and has several additional schools interested in participating. The ARPA funding will allow nine additional school to begin a Teen MHFA project in their school, which includes training school staff as instructors for sustainability.

The Teen Mental Health First Aid curriculum can mitigate the need for hospitalizations and higher levels of care for the SED population by identifying those at high risk and creating safe interventions. The curriculum will also address the stigmatization that this vulnerable population can feel as they navigate the high school environment. By teaching teen peers to identify signs and symptoms of significant mental health disorders such as anxiety, depression, substance abuse, and psychosis to create a safety plan including a trusting adult, students with developing or current severe emotional disturbances can receive assistance before a crisis develops.

988 Implementation – A total of $500,000 each was allocated to this initiative from the Covid Supplemental and from the ARPA funds.

Co-occurring SMI/DD initiative. This initiative is funded by the ARPA plan in the amount of $1,418,330.70. The SMI/ID/DD Community Support Program will serve the target population of individuals who are dually diagnosed with a primary SMI and co-occurring ID/DD, and who frequently seek help from the acute care system. The Program will offer services in the community to these individuals with the goal of providing a “stepdown” plan for individuals in EDs or on inpatient units (including state psychiatric hospitals, Trinitas 2D and Short Term Care Facilities (STCFs)). Services will include: Assessment of SMI/ID/DD, medication and situational needs (in person as needed); Behavioral Plan; Prescriptions and medication management; Education regarding disabilities and symptom management; Psychological support; and Coordination of community-based services. The Community Support Program team will include: a prescriber, a therapist, a peer family member, a behavioral analyst and a consulting medical professional. The program will serve individuals statewide and include a mobile outreach component that can meet potential Program person receiving sercives at their ED or hospital location. The Program is expectedto serve 100 unduplicated individuals per year.

Implementation of a web-based electronic referral and crisis management system

Electronic Referral Systems. The SMHA currently does not have the capacity to fully track housing and service inventories and referrals. Part of the referral process is tracked manually. The SMHA needs to enhance the communication process for referral tracking via a Web-based Electronic Referral System. Additionally, the SMHA has identified a need for a crisis module to track crisis calls and response as well as disposition and linkages with services and housing supports.

Web-based Electronic Referral System and Crisis Management Module is funded with $1,500,000 in Covid Supplemental funding and $3,065,000 in ARPA funding.

Web-based Electronic Referral System Funding will enable DMHAS to procure a web-based data system that provides a registry for behavioral health beds and services to facilitate access for persons with SMI. The data system will maintain information and communications on community and hospital referrals and provide the information needed to monitor referrals and intervene to facilitate placement and linkages to services. The ability to manage behavioral health bed vacancies and ongoing referral communications in one system allows for timely response in efficiently managing diversionary efforts. The electronic registry will assist in diverting admissions from emergency rooms and inpatient settings including state hospitals. The electronic registry is necessary to enhance movement along the continuum of DMHAS services. The data system will foster a continuum of community-based care that meets the needs of the individual where they live. The registry will contain a public facing portal for individuals to be able to request an appointment with a service provider.

Web-based Electronic Referral System - Crisis Management Module

The crisis management module expedites access to assessment and treatment for those in crisis, tracks their journey from crisis call to treatment, and coordinates all stakeholders' information within a crisis management system. The module, combined with the vacancy treatment and referral system, supports collaboration between the state, law enforcement organizations, local community organizations, faith-based organizations, and other behavioral health stakeholders in their efforts to ensure the integrated delivery of culturally competent, evidence-based, and family-centered services. The system provides a real-time connection between crisis call center professionals, crisis response teams, and treatment providers. The Service Availability dashboard displays the availability and location of mobile crisis teams, along with the directory and availability of behavioral health providers at two distinct dashboard tabs. The Crisis Management professional at the call center can document their intake interview and perform a validated assessment, toggle between the Crisis Provider and Behavioral Health Provider dashboards, and select which pathway is necessary for the client. The dual dashboard expands and collapses as needed, bringing into focus the necessary services to quickly serve the consumer. Crisis teams are dispatched using GPS-enabled technology and can view the caller's intake information, accept the dispatch, and document their assessment and plan at the scene. The crisis teams can, in turn, use the Service Availability dashboard to find available crisis beds or refer for an outpatient assessment and treatment. The module's framework is based on SAMHSA's crisis management best practices and core elements of 1. No "Wrong Door" Access; 2. Regional Crisis Call Centers; 3. Mobile Crisis Team Response; and 4. Crisis Receiving Stabilization Facilities. The technology provides real-time situational awareness and connection to all crisis stakeholders so that crisis professionals can connect persons receiving services to care more quickly.

Performance Improvement -Evaluation of programs

Performance Improvement Evaluation is funded by ARPA in the amount of $1,400,000.00. DMHAS will contract for performance improvement activities, including an evaluation of the impact of these county and project specific initiatives supported by the ARPA grant on the acute

care system in New Jersey. The vendor will be tasked with completing a needs assessment that examines outcome measures of each initiative. The vendor will identify potential best practices that may be further implemented throughout the state and areas of strength as well as potential weakness in the acute care system that can be further improved upon.

CSOC-Acute Care Services Capacity Improvement Program

Children's System of Care (CSOC) Acute Care Services Capacity Improvement Program is funded by ARPA funding plan in the amount of $1,677,563.00.

Psychiatric screenings centers and CCIS units may benefit from additional training with youth with co-occurring disorders including youth with mental health and intellectual or developmental disabilities or youth with mental health and substance use challenges. In addition, these agencies/programs do not always have a method for maintaining a resource directory and guidance for families regarding services available through the Children's System of Care and/or understand the process for linking youth and families to the sub-acute providers. As a result, youth are sometimes discharged without being linked to an appropriate provider. The goal is to increase the capacity of psychiatric screening centers and CCIS units to utilize best practices in working with youth with mental health including youth with co-occurring disorders and to enhance their ability to link youth and families to appropriate community-based services that promote youth and family wellness and may reduce unnecessary use of the acute care system.

The proposed project is to create a statewide consultation and technical assistance center (Center) dedicated to psychiatric screening centers and CCIS units that will assume a systems and direct practice approach to improving the quality of care for youth with acute behavioral health needs. The Center will be charged with conducting a multi-systemic needs assessment of each agency to distill training and consultation needs from "door to discharge" that will serve in enhancing the work force and the delivery of quality care for youth with co-occurring disorders. Equally important, the needs assessment will identify system barriers that impede the delivery of services. Information gathered through the assessment will be used to develop an agency specific and statewide training and consultation curriculum. Similarly, information gathered related to system barriers will be utilized to inform the evolution of state-driven policies and contractual requirements. Following the review of the needs assessment data, the Center will design and offer agency specific and statewide training and technical assistance that will be complemented by subject matter experts in areas such as best practices in supporting and treating youth with IDD challenges with acute psychiatric needs and their family. In addition to providing training and consultation, the Center will concurrently develop structured forums for screening centers and CCIS units to consistently communicate with New Jersey Department of Health (DOH), DMHAS and Department of Children and Family (DCF) with an agenda that elicits acute care service system strengths and challenges and nurtures collaboration. In addition, a best practice forum will be created amongst agency medical directors and led by the DCF Medical Director. Best practice forums will serve in unifying medical directors across the state and provide an opportunity to highlight and discuss optimal treatment strategies in acute care settings. Progress towards curriculum and forum goals will be monitored quarterly and will include gathering and reviewing data related to workforce confidence and consumer satisfaction. The work plan will be revised as needed through an iterative process. The work of the Center will serve in

complementing an initiative funded through the Garrett L Smith grant aimed at supporting emergency departments in linking youth who present as suicidal and their families to targeted services and supports. The project will be implemented over a three-year period.

Older Adults Expansion for 50+ yrs. Population

Older Adult expansion services is funded by ARPA in the amount of $641,438.40. The IMPACT (Improving Mood, Promoting Access to Collaborative Treatment) and PEARLS (Program to Encourage Active, Rewarding Lives for Seniors) programs were replaced with an older adult expansion initiative described below.

DMHAS intends to draft an RFP to expand outpatient services in 3 Counties that will focus on serving the SMI older adult population. Older adults are defined as 55 years and older. DMHAS will utilize census data as well as a survey on outpatient access to determine need based on which Counties have a large older adult population, and have delayed access to outpatient services. The total amount of $641,438.40. The funding will be divided among each of the 3 awards. DMHAS anticipates making one award per each region of the state (North, Central, South). This will improve access to services for this population and focus on the specific needs of the aging in population.

Outreach Navigation/Underserved Populations

Outreach/Navigation – Undeseved population/crisis response is funded by COVID supplemental funding plan in the amount of $1,800,000.00. SMHA awarded 8 grants of up to $150,000 each for the provision of mental health services and 9 grants of up to $150,000 each for the provision of SUD services through SUPTR funding. Funding is intended to provide direct services, reach underserved populations that are often underserved, help to assist those that may benefit from services, and those that may be in crisis.

The awardee will ensure that the services provided ensure diversity, inclusion, equity, and cultural and linguistic competence to the target population. The bidder will continually assess and utilize demographic data of participants' service area in its development and delivery of programming, evaluation, and program outcomes to ensure it is relevant to the population served. Additionally, the awardee will analyze data to implement strategies to increase program participation.

Peer Wellness Program

Peer Wellness Program is funded by COVID supplemental funding plan in the amount of $475.000.00.

The Mental Health Association in New Jersey, Inc (MHANJ) was awarded the Whole Health Learning Collaborative (WHLC) and started taking actionable steps in program towards program implementation. After contract negotiations, it was determined a more "hands on" technical assistance approach was needed to each of the wellness centers to create a more collaborative effort with the initiative. It was further determined more in-person, verses virtual, would be more

appropriate in the program's roll out and deliverables. Project funding began 1/1/2023, with the Annex A approved on 03/31/2023. Since January of 2023, NJ Peer Connection- the name of the project (NJPC) has had meetings with all leadership of all division funded wellness centers and has started to meet in person to each wellness center for one-to-one technical assistance. Technical assistance is described as in person collaboration/conversation and an informal needs assessment between NJPC and Wellness Center staff and membership, gathering ideas for events, wellness center specific whole health initiatives past and/or present, current barriers/goals since COVID19, etc. NJPC has launched specialty resource webinars through its United by Wellness (UBW) virtual platform who has existing membership comprised of wellness center staff and membership. The first webinar/resource was held on 03/29/2023 and had 36 participants from centers across the state. These webinar/resource will occur twice a month for remaining 9 months of contract. In addition, MHANJ has been working with GoMo Health working on the creating the dashboard and implementation of the texting platform. This platform will be live by April 16th, 2023, in time for the in-person launch at COMCHO later this month. MHANJ has additionally applied to present the whole health initiative of NJ Peer Connections for the 2023 COMCHO event. Lastly, NJ Peer Connections has set the date for its first Statewide event which will be located at Pines Manor on May 30th, 2023, from 9-4. The project is gaining strong momentum and engagement with our wellness centers who are eager learn and be heard.

Wrap Around Service - Wrap Around Service is funded by ARPA funding plan in the amount of $200,000.00.

Realignment of the service system to be proactive and responsive requires mobilization of resources to meet the needs of the individuals we serve in the community. Wrap dollars may be used to support an individual's community integration and housing needs by providing temporary financial support. Wrap dollars may be used for services, additional staffing, specialized medical or clinical services not covered by consumer benefits or insurance, specialized clinical services, interpreter services, or court mandated services. Funding is requested from 10/1/21-9/30/25 or until funds are available.

Law Enforcement Crisis Diversion Pilot Collaborative

Law Enforcement Crisis Diversion Pilot Collaborative is funded by the ARPA funding plan in the amount of $41,310.00.

A pilot program to be implemented between a DMHAS crisis diversion funded program such as Early Intervention Supportive Services (EISS) program or Crisis Receiving and Stabilization program, and a local police department where individuals in crisis will be able to communicate with a clinician on the EISS or Crisis Receiving and Stabilization team via an IPAD for assistance and potentially avoid an emergency room admission or an inpatient psychiatric admission through this intervention. The use of electronic platforms such as Doxy.me is free for the minimum service. The budget includes a cost of 90 IPADs equipped with Wi-Fi + cellular connectivity. The requested funding for this initiative is from 10/1/22-9/30/24.

Acute Care Systems Review Committee (SRC) Technical Assistance - After moving $400,000 from Diversion-High End Utilizers program, the funding for the Acute Care TA program was increased to $800,000.

The contract for this initiative was effective as of August 22, 2022 and is funded by COVID supplemental funding plan ($800,000.00). The agency has begun to work to hire staff that will provide technical assistance to County based mental health system review committees in examining wait times in emergency rooms for psychiatric services. This program focuses on assisting the SRCs in developing performance improvement projects to create a structure for the SRCs to review and revise processes that lead to more expeditious outcomes for individuals requiring hospitalization. The SRC TA service will: review current data and propose other data to be collected; conduct resource mapping to identify all resources available in county; conduct needs assessment for the identified counties; produce report outlining each county's challenges and needs; support each SRC in design of a performance improvement project to address identified needs using the Plan, Do, Study, Act (PDSA) model; support each SRC in data collection, analysis, and in the implementation of the performance improvement project.

The Single State Authority on Substance Abuse (SSA)

Planning Step 1: Assess the Strengths and Needs of the Service System to Address the Specific Populations

Statewide Plan for Substance Use Disorder, Prevention, Treatment and Recovery Services for Individuals, Families and Communities (Criterion 1)

Organization of the Public Behavioral Health System at the State and Local Levels

The Department of Human Services (DHS) serves more than 2.1 million of New Jersey's most vulnerable citizens, or about one of every five New Jersey residents. DHS serves individuals and families with low incomes, people with mental illnesses and/or substance use disorders, developmental and intellectual disabilities, late-onset disabilities, blind, visually impaired, deaf, hard of hearing, or deaf-blind, and aging individuals. In addition, the Department serves parents needing child care services, child support and/or healthcare for their children, as well as families facing catastrophic medical expenses for their children. DHS has the following Divisions, Commission, and Office: Division of the Deaf and Hard of Hearing; Division of Developmental Disabilities; Division of Disability Services; Division of Family Development, Division of Medical Assistance and Health Services; Division of Aging Services; Division of Mental Health and Addiction Services (DMHAS); Commission for the Blind and Visually Impaired; and Office of New Americans. DHS provides many support systems for the families of children served by the Department of Children and Families (DCF).

On July 11, 2006, legislation was signed creating the New Jersey Department of Children and Families (DCF), the state's first Cabinet-level department focused solely on child and family well-being. All services provided by the DHS Office of Children Services were transferred to the DCF. The new Department included the following Divisions: Division of Child Protection and Permanency (DCP&P) formerly Division of Youth and Family Services (DYFS), Children's System of Care (CSOC) formerly Child Behavioral Health Services (CBHS), Families and Community Partnerships (FCP), formerly the Division of Parole and Community Programs (DPCP). It also includes the Office of Education. Through the DCF-funded University Partnership with Rutgers University headed by Rutgers University School of Social Work, DCF's Office of Training and Professional Development collaborates with Rutgers in the New Jersey Child Welfare Training Partnership.

On June 29, 2012, Governor Chris Christie signed a bill that further reorganized DCF into a single point of entry for all families with children, youth and young adults living with either developmental disabilities or substance abuse disorders, or both. This realignment of substance abuse treatment and developmental services is intended to remove barriers to accessibility, provide more complete care through all service offerings, and improve efficiency for those families served by DCF throughout the state. The transfer of these services to DCF's CSOC from DHS began January 1, 2013. The bill also established and renamed four divisions within DCF. As mentioned earlier, the former DYFS is now known as the Division of Child Protection and Permanency (DCP&P). This Division is the state's child welfare agency and is responsible for child protection services for New Jersey youth. The former DCBHS is now the CSOC and continues to coordinate

the state mental health plan for children, youth and young adults; provide support and assistance to child welfare youth who need to access intensive or multiple mental health services; allocate state and federal resources for mental health programs; promulgate standards for services; and is now responsible for the provision of services for children, youth and young adults with developmental disabilities as well as substance abuse disorders. The former Division of Parole and Community Programs, DPCP, is now the Division of Family and Community Partnerships. The Division on Women has been transferred to DCF from the Department of Community Affairs. Additionally, the Office of Education and the New Jersey Child Welfare Training Academy remain under the auspices of DCF.

In 2011, DHS merged its Division of Mental Health Services and the Division of Addiction Services into the Division of Mental Health and Addiction Services (DMHAS). The merger provided an opportunity to integrate adult mental health, substance abuse and co-occurring disorders treatment at all levels of service in an efficient and coordinated manner from the statewide and regional level to the local levels, thus enhancing access to services, coordination of services, alignment of policies and contracts, and workforce development efforts.

As a result of these changes, New Jersey manages the public behavioral health system separately for adult and children services. Specifically, the adult behavioral health system is managed by the Department of Human Services (DHS), Division of Mental Health and Addiction Services (DMHAS) while the children's behavioral health system is managed by the Department of Children and Families (DCF), Children's System of Care (CSOC). Prior to 2006, the DHS managed both the adult and children's mental health and substance use disorder systems. Later, in 2013, the adult and children's substance use disorder treatment systems were separated. The substance abuse programs that serve children under 18 years were transferred in July 2013 and children in the South Jersey Initiative were transferred in December 2013. DMHAS continues to manage the Children's Crisis Intervention Services (CCIS) and blended mental health programs for families (serving both children and adults).

In 2017, the State provided funding to open substance use disorder residential beds to treat 18 and 19 year olds as the system at the time did not allow treatment for this age as children. The expansion through DCF allowed their licensed residential facilities to treat 18 and 19 year olds and expand residential capacity by an additional 200 beds.

On June 29, 2017, Governor Christie filed an executive reorganization plan with the State Legislature transferring the institutions and programs under DMHAS and its staff that support the provision of mental health and addiction services from the Department of Human Services to the Department of Health (DOH). The plan stated that "transferring the provision of mental health and addiction services to DOH is necessary to improve health care, remove bureaucratic obstacles to the integration of physical and behavioral health care and effectively address substance abuse disorder as the public health crisis it is." The reorganization plan was effective August 28, 2017.

On June 21, 2018, Governor Philip Murphy issued a reorganization plan to return the Division of Mental Health and Addiction Services to the Department of Human Services. The purpose of the plan is to ensure that the State is delivering behavioral health services in the most efficient, effective manner possible to patients by connecting behavioral health services with critical wrap-

around services administered by DHS that support the treatment, recovery, and long-term well-being of individuals struggling with substance use and mental health issues. DHS also houses the State Medicaid Agency which plays a significant role as the primary payor for mental health and substance use treatment in the State, as it is the insurance provider for approximately 1.7 million NJ residents. The reorganization plan was effective September 29, 2018. DOH continues to operate the State psychiatric hospitals and licensing of mental health and addiction services programs and facilities.

Overview of the Delivery of Substance Use Disorder (SUD) Services

DMHAS is the Single State Authority (SSA) for substance use disorder treatment and services in New Jersey. Between the Substance Use Prevention, Treatment, and Recovery Services (SUPTRS) Block Grant and other federal and state resources. The SSA provides services across the continuum of care, which includes prevention, early intervention, treatment and recovery support. In FFY 2022 and 2023, the SSA funded: a) 19 community-based prevention coalitions serving all of NJ's 21 counties for the provision of prevention programs with a focus on environmental strategies, b) over 30 community-based prevention providers that offer a variety of evidence-based curricula for children, adolescents, older adults, and families, c) two state institutions of higher education that provide early intervention services (Rutgers University and The College of New Jersey), e) four recovery-based housing residences and case management and supportive services for consumers with an opioid use disorder (OUD) who are homeless or at risk of homelessness, f) a Women's Intensive Supportive Housing (WISH) program, g) two Intensive Supportive Housing (ISH) programs, h) 24-hour Addictions Hotline services, i) two non-profit corporations for the operation of recovery support centers, Recovery Center at Eva's Village and Living Proof Recovery Center, j) 21 smaller Community Peer Recovery Centers, k) 21 Opioid Overdose Recovery Programs, l) 21 Support Teams for Addiction Recovery, m) 20 Older Adult Education Programs, n) three Family Support Centers, o) a Telephone Recovery Support program, p) an addictions workforce training and development initiative, q) 21 county governments for the provision of services throughout the continuum of care, r) funding through a Request for Letter of Intent (RLI) for all county jails to incorporate or enhance Medication Assisted Treatment (MAT) as well as case management services for inmates with an Opioid Use Disorder (OUD) at the jail, s) 5 Integrated Opioid Treatment and Substance Exposed Infants programs and t) 7 regional Maternal Wraparound programs.

DMHAS utilizes the American Society of Addiction Medicine (ASAM) principles in client placement. Within its treatment continuum, ASAM levels of care range from Withdrawal Management (ambulatory and residential), Outpatient, Intensive Outpatient, Residential (Short-term, Long-term, Halfway House), Partial Care and Opioid Maintenance. As of May 2023, there were 261 licensed substance use disorder treatment provider agencies accounting for 349 Standard and 332 Intensive Outpatient sites, 52 Opioid Treatment Program (OTP) sites, 26 Halfway House sites, 30 Long-Term Residential sites, 28 Short-Term Residential sites, 18 Ambulatory Detox sites and 18 Residential Detox sites. A significant achievement is that there is an OTP in 19 of NJ's 21 counties.

The SSA is also responsible for: 1) the Statewide Intoxicated Driving Program (N.J.S.A. 39:4-50), which processes the conviction records of drivers convicted of driving under the influence and

schedules these drivers for detention, evaluation, education, and treatment referral by the county-based intoxicated driver resource centers and makes funding available to address the treatment needs of indigent individuals convicted of a Driving Under the Influence (DUI) who meet diagnostic criteria for treatment through the Driving Under the Influence Initiative (DUII), 2) the development of treatment services for people involved in the criminal justice system, 3) the Co-Occurring Network to serve individuals with co-occurring mental illness and substance abuse disorders, 4) the special substance abuse treatment needs of people who are deaf, hard of hearing or disabled; women who are pregnant or have dependent children; minorities; and middle-aged or senior citizens, and 5) promoting and training on evidence based programs such as Medication Assisted Treatment, co-occurring services, motivational interviewing and "The ASAM Criteria Treatment Criteria for Addictive, Substance-Related and Co-Occurring Conditions, American Society for Addiction Medicine Third Edition, 2013."

In Calendar Year (CY) 2022, there were 85,266 substance use treatment admissions and 84,437 discharges reported to the SSA through its New Jersey Substance Abuse Monitoring System (NJSAMS). Of these admissions, 45,914 were unduplicated. In CY 2022, there were 11,586 fee-for-service (FFS) admissions. For primary drug at admission, 44% reported heroin and other opiates and 37% reported alcohol. Data from NJSAMS for CY 2022 indicate that only 16% of Methadone is planned and 12% of Buprenorphine in treatment for clients admitted to treatment, yet heroin and other opiates are the primary drugs for 44% of admissions entering New Jersey's addiction treatment system. Most admissions were to outpatient care (19%), followed by intensive outpatient care (20%). Regarding age, 1% were under 18 years old, 3% were 18-21 years old, 17% were 22-29 years old, 64% were 30 to 54 years old and 15% were over 55 years old. For race/ethnicity, 58% were white, 25% were black and 15% were of Hispanic origin. Clients who did not have insurance at admission decreased (11%). Those who had Medicaid was 72%.

The SSA's primary population served are individuals who are indigent and in need of substance use disorder treatment. Priority is given to special target groups: persons who inject drugs (PWID), pregnant women and women with dependent children, and individuals with/or at risk of HIV or TB. Other special target groups include individuals with the following: co-occurring mental illness; homelessness; deaf, hard of hearing or disabled; criminal justice involvement; older adults; lesbian, gay, bisexual, transgendered and questioning (LGBTQ); military service, and intoxicated drivers.

Description of the Organization of the Public Behavioral Health System at the State and Local Levels for the Delivery of SUD Services

State Government

The SSA strives to promote the prevention and treatment of substance abuse, support the recovery of individuals affected by the chronic disease of addiction, and promote the use of evidence-based practices. The SSA is responsible for regulating, monitoring, planning and funding substance abuse prevention, early intervention, treatment and recovery support services in New Jersey. In addition, the SSA assists with training the addiction treatment, prevention and recovery workforce. The SSA provides leadership and collaborates with providers, consumers, families, and other stakeholders to develop and sustain a system of client-centered care that is accessible, culturally

competent, accountable to the public and grounded in best practices that yield measurable results. The SSA monitors substance use disorder treatment provider agencies for quality assurance and compliance with required assessment and treatment protocols and for other contractual requirements.

County Government

In New Jersey, county governments also play an important part in the overall functioning of the public behavioral health system. Since 1983, a portion of the proceeds of the state's alcoholic beverages tax has been dedicated to the production and implementation of county comprehensive plans in all 21 counties. The plans correlate county resources to the needs of individuals with alcohol and drug use disorders. Originally, the scope of these plans was limited to the needs of individuals with an alcohol use disorder. In 1989, both the scope of the county plans and corresponding financial resources for which the counties were made responsible expanded to include the needs of individuals with drug use disorder. Additionally, in the same year, a governor's advisory council was established to coordinate the actions of all departments and divisions of state government with regard to substance abuse and to oversee locally-driven prevention efforts by municipal alliances.

Presently, the SSA oversees county alcohol and drug comprehensive planning in collaboration with counties that has gradually elevated quality assurance standards of county planning for the entire continuum of care, from prevention to early intervention, treatment and recovery support services. The SSA does this by issuing: a) guidelines for plan content, format and planning process, b) compendia of secondary source data, c) reports of survey findings, and d) technical assistance tailored to the needs of county behavioral health planners. The SSA works collaboratively with the 21 County Alcoholism and Drug Abuse Directors. A representative of their association is a member of the Behavioral Health Planning Council.

The SSA's current county planning activities focus on the upcoming 2024-2027 planning cycle as the current 2020-2023 cycle is concluding. As New Jersey continues to implement its Medicaid Waiver (1115) establishing a managed behavioral health care organization, counties will provide the state with a critically-important monitoring and feedback function "on the ground," as well as develop investment proposals for early intervention and recovery support services that remain the least well developed segments of the continuum of care. Additionally, the county plans will direct greater attention than ever before to the problems of citizens dually afflicted with both substance use disorder and mental health illness. Thus, the county Mental Health Administrators were invited to participate in the community-based planning certificate program DMHAS sponsored in 2013 and the comprehensive planning process with the hope that, over time, both the substance abuse and mental health planning processes and products will integrate under a single county comprehensive, behavioral health plan. Currently, the County Alcoholism and Drug Abuse Directors and county Mental Health Administrators continue to have several joint Director meetings every year.

Roles of Other State Agencies with Respect to the Delivery of SUD Services/ Interdivisional and Interdepartmental Collaboration

Department of Human Services, Division of Medical Assistance and Health Services (DMAHS). NJ FamilyCare's Comprehensive Demonstration ("The Waiver") was renewed on March 30, 2023 and continues include an Opioid Use Disorder (OUD)/Substance Use Disorder (SUD) continuum which provides authority for the New Jersey Department of Human Services' Division of Medical Assistance and Health Services (DMAHS), to serve individuals with a substance use disorder or opioid use disorder in a full continuum of care. The continuum matches beneficiaries with the most appropriate services to meet their need, and provides an efficient use of resources grounded in evidence-based practice. This includes services provided in residential treatment settings that qualify as an Institute for Mental Disease (IMD) consistent with key benchmarks from nationally recognized, SUD-specific program standards. Beneficiaries have access to high quality, evidence based, OUD and SUD treatment services ranging from acute withdrawal management, ongoing chronic care in cost effective settings, and care for comorbid physical and mental health conditions.

Specifically, New Jersey has waiver authority to:

- Claim expenditures for services provided in an IMD for a statewide average length of stay of 30 days.
- Add a new level of care to the continuum for long term residential treatment, ASAM 3.5;
- Develop peer recovery support specialist and care management programs that engage, support and link individuals with an SUD in the appropriate levels of care; and
- Move to a managed delivery system that integrates physical and behavioral health care.

The Comprehensive Demonstration is a five-year demonstration and is now valid through the end of June 2028.

As part of the waiver requirements New Jersey is expected to continue reporting data as part of the SUD Monitoring Protocol and track progress toward the demonstrations goals.

The SSA, in collaboration with NJ FamilyCare, has established and is expanding mental health and SUD service providers who are able to enroll consumers needing treatment services in 24 -72 hours through presumptive eligibility (PE). PE allows a certified provider to enter information directly in the FamilyCare enrollment application that is then checked, and a temporary Medicaid number assigned. The application goes through verification, and if successful, a permanent Medicaid number is assigned. As of July 14, 2023, 224 behavioral health provider agencies have been certified to take PE applications.

Division of Medical Assistance and Health Services and Department of Children and Families. DMHAS was selected to be one of the eight Certified Community Behavioral Health Clinic (CCBHC) demonstration states. The NJ CCBHC demonstration providers began services in July 2017. This project is a collaboration between the Department of Human Services' Division of Medical Assistance and Health Services (DMAHS) and DMHAS and the Department of Children and Families (DCF). NJ has been working with our partners at the DCF Children's System of Care (CSOC) in an effort to improve the CCBHC provider capacity to increase the numbers of children served.

There are seven behavioral health providers that are part of NJ's demonstration and that have been certified as CCBHCs by the DMHAS. The Federal Demonstration was extended to September 2025. DMHAS and DCF are working with our sister agency, DMAHS to develop a Medicaid State Plan that will sustain the service. In addition, in NJ, there were 11 providers in 2022, 6 providers in 2021, and 9 providers in 2020 who were awarded SAMHSA CCBHC expansion grants.

Department of Children and Families. Interdivisional and interdepartmental collaboration between DMHAS and the Department of Children and Families' (DCF) CSOC is frequent. Executive Staff from each Division have collaborated to make system recommendations for youth with mental illness and/or substance use challenges and families currently served in the CSOC whose youth are emerging adults. Recommendations were made in the form of policies, procedures and protocols that will ensure a seamless transition of youth and their families to all adult mental health services. In addition, several staff from CSOC attend monthly Behavioral Health Planning Council meetings to better coordinate services.

DMHAS provides funding via a Memorandum of Understanding between the SSA and DCF to supplement DCF contracts for women with children under supervision of the Division of Child Protection and Permanency (DCP&P). This specialty funding is for the Substance Abuse Initiative for Substance Abusing Women (SISAW) Initiative. SISAW includes residential (18 beds) and intensive outpatient treatment slots (43) for women and children who reside in three catchment areas; Asbury Park, Jersey City and Newark and are also eligible for Work First.

DMHAS developed a Memorandum of Agreement with DCF to provide services for the Partnership for Success grant that DMHAS was awarded in 2018 but which ended August 2023.

New Jersey Judiciary, Administrative Office of the Courts. A Memorandum of Agreement (MOA) with the Administrative Office of the Courts (AOC) will be maintained to fund a full continuum of treatment services for Recovery Court (RC), previously known as Drug Court, where applicants who are deemed legally and clinically eligible for Recovery Court. State funding appropriated to the AOC for this purpose is transferred to the SSA to implement and manage the statewide network of treatment services in coordination with the AOC and participating Superior Court vicinages. Enhanced services will be maintained as funding permits, including: medication, psychiatric/psychological evaluations, medication monitoring, physical exams, transportation, counselor appearances, partial care, co-occurring integrated services, methadone, and methadone intensive outpatient services. Since January 2018, Medicaid began paying for ambulatory SUD treatment for eligible Recovery Court participants. In July of 2018, short term residential was added and in October of 2018, long term residential and ambulatory withdrawal management.

The Recovery Court Efficiency (RCE) Initiative was established and launched on October 1, 2020 to enable fee- for- service reimbursement through the DMHAS fiscal agent for the specific services not covered by Medicaid, but provided to Recovery Court referred consumers whose SUD treatment is primarily covered by Medicaid. NJSAMS is restructured to allow parallel funding for Recovery Court Medicaid (Medicaid authorizations) and Recovery Court Efficiency Fee for Service (DMHAS-funded) authorizations to occur at the same time.

New Jersey State Parole Board. A Memorandum of Agreement (MOA) will be maintained between the New Jersey State Parole Board (NJSPB) and the SSA to purchase, within a fee-for-service (FFS) network, community-based substance use disorder treatment for NJSPB parolees under the Mutual Agreement Program (MAP). Since October 1, 2017, Medicaid has been introduced to begin paying for ambulatory treatment for eligible parolees. In July of 2018, short term residential was added and in October of 2018, long term residential.

Mutual Agreement Program. The SSA oversees the Mutual Agreement Program (MAP), a Parolee Substance Use Treatment Project implemented through Memoranda of Agreements between the SSA and the New Jersey State Parole Board (NJSPB). This funding is a combination of Medicaid and direct appropriations from DMHAS and funds transferred from NJSPB. These funds support a similar FFS network which offers the full continuum of care including long term and short term residential care, halfway house, partial care, detoxification, outpatient and intensive outpatient treatment, co-occurring services, psychotropic medication reimbursement, and MAT. With the advent of Medicaid reimbursement for treatment services and medication, the use of MAT for parolees has expanded.

On December 21, 2021 an extension and modification MOA between NJSPB and DMHAS to expand Intensive Outpatient Treatment Services (IOTSS) in order to provide rapid access to behavioral health services to parolee clients demonstrably in need of addiction and mental health treatment through the Mutual Agreement Program (MAP). Access to IOTSS is intended to provide an option for Designated Screening Programs and other acute care and hospital referral sources to assure that appropriate, intensive, community based, recovery-oriented outpatient services. Through IOTSS Parolee with an exacerbation of the symptoms of mental illness and/or a co-occurring substance abuse disorder receives comprehensive assessments, Wellness and Recovery Action Plans (WRAPS), Medication Administration and Education, Individual Therapy, Structured Group Therapy, Illness Management and Relapse Prevention Groups.

Department of Corrections. Since 2017, DMHAS has worked with the Department of Corrections to provide Intensive Recovery Treatment Support (IRTS) post-release services to a cohort of eligible offenders with Opioid Use Disorder that receive MAT prior to release from prison, and to another cohort of non-MAT eligible offenders both pre- and post-release into the community. Services are provided by staff from Rutgers University Behavioral Healthcare.

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

IRTS links eligible offenders to recovery services necessary to support wellness and successful community re-integration. It helps offenders address issues such as: health/wellness, treatment adherence, employment, housing, and opportunities and skills to enhance the individual's ability to participate in meaningful life activities. IRTS teams can provide services to a maximum of 840 participants for up to six months prior to release and up to 12 months post release. To date, 4,315 inmates have been referred to the program.

Department of Education. The SSA will continue to coordinate with the Department of Education (DOE) to develop school health goals and priorities. The primary focus of this interdepartmental group is to reduce risky behaviors and promote the adoption of health enhancing behaviors. Additionally, the DOE will continue to participate in DMHAS' State Epidemiological Outcomes Workgroup (SEOW) to review survey instruments that can be jointly used to collect data required by both entities, and to coordinate schedules for administering student surveys so as to minimize duplication of data collection efforts.

State Police. In 2014, the Regional Operations Intelligence Center operated by the New Jersey State Police developed the Drug Monitoring Initiative (DMI), to address the pervasive use of heroin, opiates, and the violent crimes and burglaries that are directly correlated with this nationwide crisis. The DMI is a nationally-recognized program with a robust multi-state drug intelligence capability that collects and analyzes law enforcement and healthcare data in order to help law enforcement and public healthcare experts develop strategies to combat drug activity in their jurisdictions. Some highlights of the initiative are:

- The incorporation of public health guidance into the drug monitoring intelligence process
- The ability to coordinate the collection, analysis, and mapping of drug incidents statewide
- The expedited analysis of drug seizures to better direct criminal investigations and health resources
- Training law enforcement, fire service, and emergency medical service personnel statewide

DMHAS and the DMI continue to be active and committed partners in substance abuse prevention throughout New Jersey. Representatives from the DMI participate in activities of the State Epidemiological Outcomes Workgroup (SEOW) and DMHAS and the DMI frequently share data and other resources.

Department of Health. DMHAS collaborates with its partners at DOH in several areas. DMHAS works with the DOH Division of HIV, STD and TB on a SOR initiative to bring low threshold Buprenorphine to the state's seven Harm Reduction sites. DMHAS works with the Manager of the DOH Office of Primary Care and Rural Health on enhancing integrated care at the state's FQHCs. DMHAS works with the Office of Communicable Disease Services in efforts to address Hepatitis C and other communicative diseases common to those with a SUD and the DOH Office of Certificate of Need and Licensure to streamline and make effective the state's provider licensure requirements.

During calendar years 2020-2022, DMHAS collaborated with DOH on its Opioid Reduction Options in the Emergency Department (ORO) project. The goal of the project was to reduce the number of opioid prescriptions written in the ED and, instead, use alternative non-opioid pharmacological and non-pharmacological (nerve blocks, massage, etc.) approaches to addressing pain. In 2020, DMHAS issued one-year awards to 11 hospitals and in 2022 made four additional awards. DMHAS managed the program, and the DOH developed a learning collaborative in which awardees were required to participate. During 2020-2022, 114,817 patients received the ORO protocol and 1,006 providers were trained May 2021

DMHAS collaborated with DOH on a project with the National Alliance of State and Territorial AIDS Directors (NASTAD) and the JSI Research & Training Institute, Inc. (JSI). They were provided one-time funds to support activities related to the Strengthening Systems of Care for People with HIV and Opioid Use Disorder (SSC) project. Funds were meant to support concrete, time-based activities focused on enhancing systems of care for people with HIV and OUD and in alignment with state technical assistance plans developed for the project. Funding was made available to support technical assistance (TA), training, and capacity development activities of New Jersey, one of the nine states selected to participate. JSI was funded by the Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB) Special Projects of National Significance (SPNS) to work with nine states and provide technical assistance (TA) on strengthening systems of care to address opioid use disorder (OUD) and HIV treatment, care, and recovery needs. DMHAS and DOH were partners in this project and met monthly with the consultants. The SSC conducted their initial site visit in February 2020 and concluded the monthly technical assistance meetings in August 2022. The two Departments worked on a TA plan with JSI and the final sustainability plan containing six goals was completed and provided to DMHAS and DOH in September 2022.

Stigma and its effects contribute to the syndemics of HIV and opioid use disorder (OUD), acting as a barrier to care for people seeking services. An area to be explored will be data sharing among the two Departments to determine the number of individuals in substance use disorder (SUD) treatment who have HIV and the number of individuals who have HIV that are in SUD treatment. The information will be utilized by both Departments to help improve health outcomes for this population by better engaging individuals to seek either HIV or SUD treatment.

As a SAMHSA Prescription Drug Abuse Policy Academy State, in 2014, NJ applied for a unique technical assistance opportunity through the SAMHSA supported NCSACW to address the multi-faceted problems of NAS and SEI. NJ DHS/DMHAS as the lead State agency, partnered with DCF and DOH, and submitted a successful application (no funding attached). The IDTA goal was to develop uniform policies/guidelines that address the entire spectrum of NAS and SEI from pre-pregnancy, prevention, early intervention, assessment and treatment, postpartum and early childhood. The IDTA provided technical assistance to NJ to strengthen collaboration and linkages across multiple systems such as addictions treatment, child welfare, and medical communities to improve services for pregnant women with opioid and other substance use disorders and outcomes for their babies. The Core Team included over 60 individuals representing multiple State Departments and Divisions, community stakeholders, treatment providers, and the medical community. Three goals were established (1) Increase perinatal SEI screening at multiple intervention points (2) Leverage existing programs and policy mechanisms to collaboratively increase the rate at which women screening positive on the 4P's Plus get connected for a comprehensive assessment by establishing formal warm-handoffs and other safety net measures; (3) Leverage existing programs and policy mechanisms to collaboratively increase the rate at which women delivering SEIs and their babies and any other eligible children, receive early support services for which they are eligible. Workgroups were formed.

New Jersey was recently awarded another round of In-Depth Technical Assistance (IDTA) through the National Center on Substance Abuse and Child Welfare's (NCSACW) 2023: "Advancing Collaborative Practice and Policy: Promoting Healthy Development and Family Recovery for

Infants, Children, Parents, and Caregivers Affected by Prenatal Substance Exposure". The Department of Health is the lead State Department and NJ state representatives include the Departments of Children and Families, Human Services, and the Governor's Office. The state team will include an individual with lived experience. The DMHAS Women's Treatment Coordinator represents the Department of Human Services. The overall goal is to increase awareness of pregnant women and SUD, through increased education and maximizing messaging through the perinatal work force; increase awareness and access to treatment, Plans of Safe Care, and improving screenings in hospitals and healthcare providers.

NJ Department of Military and Veterans Affairs. The United States Department of Veterans Affairs (VA) has partnered with the Substance Abuse and Mental Health Services Administration (SAMHSA) to continue the Governor's Challenges to Prevent Suicide Among Service Members, Veterans and Their Families (SMVF). For the *Governor's Challenge*, states are taking part in the challenge and are working to develop and implement state-wide suicide prevention best practices for SMVF, using a public health approach. New Jersey is one of the 8 states that participated in the 2021 Governor's Challenge cohort. With the support of the governor, each state formed an interagency military and civilian team to develop a strategic action plan to advance the National Strategy for Preventing Veteran Suicide. These 8 states joined the 27 inaugural states of 2019 and 2020 in their commitment to implement best practices for preventing suicide among SMVF. Teams are encouraged to include suicide prevention coordinators representing the state public/behavioral health agency, VA, and National Guard. DMHAS is co-leading the challenge along with the NJ Department of Military and Veterans Affairs. A team composition was created consisting of members from the National Guard, VA, Department of Labor, NJ Hospital Association, NJ Gun Violence Research Center, Rutgers University, NY State representatives, and other community agencies. This team will meet to combat three priority areas set forth by SAMHSA and the VA to prevent suicide for SMVF.

New Jersey has participated in various site visits, policy academy meetings, and a Conference in Virginia with other States. The challenge makes up three Priority Area workgroups which are: 1) Identifying SMVF and Screening for Suicide Risk, 2) Promoting Connectedness and Care Transitions, and 3) Lethal Means Safety and Safety Planning.

Department of Health and Division of Medical Assistance and Health Services. DMHAS participates in a multi-department SUD Health Information Technology (HIT) Plan Workgroup that has been formed. To promote interoperability between behavioral health and physical health providers caring for SUD/OUD individuals, the State of New Jersey made available a total of $5.4 million in funding for a milestone-based SUD provider incentive program. The program will now be administered by the Department of Human Services, after execution of an MOA that will transfer the administration from the Department of Health. It is described more fully under system improvements.

Description of Regional, County and Local Entities that Provide SUD Services

In New Jersey, the administration and organization of the substance use disorder (SUD) system is centralized, rather than county or locally based. A broad array of SUD services are offered in the community and the SSA awards funding either through cost-based contracts to 146 SUD treatment

agencies, and fee-for-service contracts to 145 SUD treatment agencies that provide a continuum of treatment. Of these, 47 agencies had both a cost-based and fee-for-service contract. It provides funding to 42 SUD prevention agencies. It also provides awards to the 21 County Governments.

County Government. The SSA collaborates with the 21 counties of New Jersey in a joint state and county comprehensive behavioral health planning process intended to: 1) coordinate system development and service delivery at state and local levels, and 2) unify community-based planning for prevention and treatment. Chapter 51 of the Laws of 1989, C.26:2BB-12 et seq, amended Chapter 531 of the Laws of 1983 that had established the "Alcohol, Education, Rehabilitation and Enforcement Fund" (AEREF) and the county comprehensive planning requirement for participation in the AEREF program. The amended statute established 1) the Governor's Advisory Council on Alcoholism and Drug Abuse, GCADA, and 2) the county Local Advisory Committee on Alcoholism and Drug Abuse, LACADA, known under the 1983 Act simply as the citizen advisory committee. The AEREF is a non-lapsing, revolving trust fund into which approximately $11 million are deposited annually from a tax on the sale of alcoholic beverages. Approximately $10.4 million from the 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 approximately $17.7 million for CY 2023.

Participation requires each county to develop a community-based, comprehensive plan to provide "community services to meet the needs of intoxicated person and alcoholics," and "relate existing services to the needs of alcoholic and drug addicts" across the full continuum of care, including prevention, early intervention, treatment and recovery support. DMHAS quality assurance standards require county plans be based on a scientific planning process that uses quantitative data, outcomes-related service-provider profiles, and community participation to both assess county needs and optimize county service investments. Additionally, counties must match 25% of their respective annual AEREF allocation with a contribution of county revenues and dedicate approximately 11% of their allotment to the implementation of federally-validated prevention education programs. An additional $20,000 is awarded to each county to support its planning operations. The Office of Planning, Research, Evaluation and Prevention is responsible for overseeing the AEREF county comprehensive planning program.

Governor's Council on Alcoholism and Drug Abuse. The SSA works collaboratively with the Governor's Council on Alcoholism and Drug Abuse (GCADA) on various addiction prevention related projects, including participation in the Prevention Collaborative Process. The Prevention Collaborative: 1) helps counties identify and implement a greater number of evidence-based prevention programs, 2) supports counties in the use of environmental approaches to prevention at the county and municipal levels, and 3) encourages counties to develop and operationalize community-based and culturally appropriate recovery support systems of care. The plan also provides direction in the development of future prevention funding opportunities made available by the SSA.

Through the Municipal Alliance Program, the GCADA unites New Jersey's communities in a coordinated and comprehensive grass roots prevention effort. Municipal Alliances are local planning and coordinating bodies established in all 21 counties to assess needs, set priorities, develop plans and implement programs that form the foundation of New Jersey's substance abuse

prevention activities. New Jersey's Municipal Alliances provide over 3,800 prevention programs statewide. GCADA's Municipal Alliance Program provides 320 grants to 425 municipalities throughout New Jersey, with the majority of grants averaging between $5,000 - $10,000. The primary CSAP strategy utilized by the alliances is education, followed by alternatives, which provide social, athletic and recreational activities as an alternative to situations in which alcohol and drug use might occur. The majority of programming is delivered in communities and schools served by the alliances. In 2022, DMHAS awarded $1 million (from the BG Supplement) to GCADA for the development of a statewide Youth Leadership program.

Local Advisory Committee on Alcoholism and Drug Abuse. The SSA works collaboratively with the county Local Advisory Committees on Alcoholism and Drug Abuse (LACADAs) that "assist county government in development of the annual county comprehensive plan" required for participation in the Alcohol, Education, Rehabilitation and Enforcement" fund of 1983 and 1989.

The LACADAs are also required to establish a County Alliance Steering Subcommittee (CASS), which is the county-level planning body for each county's Municipal Alliances (MAs) that are funded and overseen by the Governor's Council on Alcoholism and Drug Abuse (GCADA). The MAs are coalitions of municipal level residents and other stakeholders who volunteer to conduct data analysis and prevention service inventories as the basis for adopting a set of local prevention priorities and recommending these to the LACADAs.

Overview of the State's SUD Prevention, Early Identification, Treatment, and Recovery Support Systems

Primary Prevention (Criterion 2)

The SSA develops and supports community-based prevention education and early intervention services using a three-tiered approach to the promotion of healthy life choices:

1. Universal: where media messages and written information are provided statewide to all citizens;
2. Selective: where programs of information and skill development are provided to groups of individuals at some risk; and
3. Indicated: where programs of information, skill development and behavioral change are promoted to identify individuals most at risk.

Employing the five-step Strategic Prevention Framework (SPF) developed by SAMHSA's Center for Substance Abuse Prevention (CSAP) as well as DMHAS' Addiction Prevention Strategic Planning, the SSA plans prevention and early intervention services in the state, awards funding to providers through RFPs and funds 19 county-based prevention coalitions as well as more than 60 community-based programs that offer a variety of evidence-based prevention curricula for children, adolescents, older adults, and families. The SSA monitors contracts, provides on-going technical assistance to contracted provider agencies, and oversees outcome evaluations for each program. All DMHAS-funded coalitions and programs focus their efforts on addressing the prevention priorities identified in the Prevention Strategic Plan:

- Reduce underage drinking

- Reduce the use of illegal substances – with a special focus on the use of opioids among young adults 18-25 years of age
- Reduce prescription medication misuse across the lifespan
- Reduce the use of new and emerging drugs of abuse

DMHAS funds over 60 curriculum-based prevention programs in community settings throughout the State. DMHAS-funded providers develop an annual work plan for each program they are delivering and submit a quarterly report that provides information about progress towards achieving annual program deliverables. Examples of curriculum-based programs include: Strengthening Families, Botvin's LifeSkills, I Can Problem Solve, and Too Good for Drugs. In SFY22, a little over 100,000 individuals were served through the delivery of individual and family programs.

Providers also use the Prevention Outcomes Management System (POMS), which is the DMHAS' online prevention data reporting system to submit basic socio-demographic information about program participants.

Since 2012, when DMHAS established its system of regional prevention coalitions, increasing emphasis has been placed on the use of environmental strategies in order to effect significant, measurable change at the community level. Additionally, as a result of Partnerships for Success (PFS) funding from CSAP that was awarded in 2013 and 2018, regional coalitions utilize resources to address tobacco prevention. Coalitions also use PFS funds for services to older adults and returning veterans when warranted.

College Campuses. This initiative awards state funds beginning in November 2014 to Rutgers University and The College of New Jersey to provide recovery support and environmental prevention strategies to systematically identify and help students who have a substance use disorder (SUD) diagnosis as well as those who intermittently abuse AODs. Each college or university is required to provide: individual and group substance abuse recovery-oriented programs and services, assessment, academic and personal counseling services, and offer recovery-based housing for students. Environmental Management strategies seek to reduce the supply of and demand for AODs by making them less available and their use less acceptable within the campus environment. With State Opioid Response and BG Supplement funds, additional state colleges and universities have implemented on-campus programs for students in recovery or those who seek a substance-free college experience. The new institutions are: Ocean County Community College, Ramapo College, Rowan University (main campus), and Richard Stockton University. College Recovery Programs have served about 500 students and provided 5,000 events in SFY22.

Student Athletes. A major component of New Jersey's SPF Rx project focuses on young athletes. A toolkit called "Tackling Opioids through Prevention for Athletes" (TOP) was developed by the New Jersey Prevention Network for use by providers. Literature suggests that when young athletes are prescribed opioid pain relievers for sports-related injuries, there is a risk of addiction and medication misuse. The 19 county coalitions that were established by DMHAS use the TOP to provide education regarding this issue to coaches, parents, prescribers, and young athletes. In SFY22 4,384 individuals were served.

Services to Families of Military Veterans. Working with the New Jersey National Guard Family Program and its eight Family Assistance Centers based at armories around the state, the SSA funds the New Jersey Prevention Network to provide programs to serve returning military personnel and their families through two evidence-based programs, Coping with Work and Family Stress and the Strengthening Families Program. Both programs are designed to enhance protective factors to support military members and their families in making responsible parenting and individual choices in regards to drug and alcohol use.

Services to Gay, Lesbian, Bisexual, Transgendered and Questioning Youth. According to a study by University of Pittsburgh researchers published in the April 2008 issue of *Addiction,* the likelihood of substance use by gay, lesbian, bisexual, transgendered and questioning (GLBTQ) youth are on average 190 percent higher than for heterosexual youth. Since 2009, the SSA has funded the North Jersey Community Research Initiative to continue and expand their existing programs for high-risk GLBTQ youth of color by adapting a prevention model developed by the Centers for Disease Control and Prevention, early intervention services, social marketing, and structured recreational activities. A CSAP-sponsored evaluation of the program determined that the program was effective in reducing rates of substance use among participants and that participants were highly satisfied with the services that were provided. In late 2022/early 2023, DMHAS issued an RFP to expand these services. Two awards were made in November 2022 and May 2023 to two SUD prevention agencies to provide these services in the central and southern regions of the state.

Strategic Prevention Enhancement. In 2011, New Jersey received a State Prevention Enhancement (SPE) grant from CSAP. New Jersey's State Prevention Enhancement (SPE) Project served six high-need counties: Bergen, Camden, Hudson, Essex, Middlesex, and Monmouth. The SPE grant provided intensive training and technical assistance on the effective use of the Strategic Prevention Framework (SPF) to agencies and local government in these high-need communities to enable them to identify or collect data regarding substance abuse and its consequences in their communities and develop a local approach to addressing the consequences.

Partnership for Success. In October 2013, DMHAS received a five-year Strategic Prevention Framework - Partnerships for Success (SPF-PFS) cooperative agreement from CSAP. The goals of New Jersey's SPF-PFS initiative were threefold: 1) to strengthen and enhance the work of DMHAS-funded prevention coalitions; 2) to further develop the prevention data infrastructure and information systems capacity at the state level; and 3) in collaboration with state partners and community stakeholders, to continue work in developing a unified statewide prevention planning and service delivery system. Specifically, New Jersey's SPF-PFS sought to 1) reduce underage drinking among persons aged 12 to 20; and 2) reduce prescription drug misuse and abuse among persons aged 12 to 25. As additional components of its PFS programming, New Jersey also focuses on unhealthy drinking patterns and prescription drug abuse among adults age sixty and older; and serves military families with prevention education, addressing military community risk levels, striving to mitigate the risk factors, and enhancing the protective factors to support military members and their families in making responsible parenting and individual choices in regards to drug and alcohol use.

DMHAS was awarded a second PFS grant in 2018. In this project, DMHAS prevention coalitions provided training on the basics of substance abuse prevention, and use of the SPF, to the Children's Inter-Agency Coordinating Councils (CIACC) in each county. The CIACC provides a forum where the system of services for children with special social and emotional needs can be developed, reviewed, revised and/or redirected through a collaborative decision-making process with the New Jersey Department of Children and Families to promote optimal services provided in the least restrictive, but most appropriate setting possible.

DMHAS utilized these SPF-PFS funds for various prevention infrastructure developments and enhancements, some of which are:

- Updating New Jersey's Epidemiological Profile

  The first New Jersey Epidemiological Profile of Substance Abuse was published in May 2008. It included a comprehensive array of substance abuse-related components and indicators and is organized around indicators for mortality, morbidity, crime, consumption and other factors. The updated Profile will include more indicators related to mental health in order to also support mental health prevention efforts and also will address one of the most prominent data gaps – substance use and mental health data for older adults.

- Updating the Prevention Outcomes Management System (POMS)

  Support was requested to modify the existing DMHAS prevention information data collection system known as POMS. An outcomes-module will be designed, and the existing curriculum-based module will be re-designed to make it more user friendly.

- Update of the Statewide Prevention Inventory

  An inventory of all existing substance abuse prevention interventions in NJ was produced under NJ's SPE grant. The goal of this task was to provide information on existing prevention efforts and their focus so that service gaps could be identified, and duplication avoided in ongoing strategic planning efforts.

DMHAS has applied for a third Partnership for Success to begin in October 2023 and is awaiting the outcome. The project aims to: 1) Decrease youth underage drinking, vaping/use of e-cigarettes, and marijuana use and by youth and young adults ages 12-25 throughout NJ; 2) Increase knowledge about the effects of underage drinking, vaping/use of e-cigarettes, and marijuana use among youth and families throughout NJ; 3) Implement programming that addresses misinformation provided by social media about alcohol and drug use; and 4) Initiate or expand prevention programming for the Underserved Populations identified by each county coalition's needs assessment. DMHAS will fund 15 of its 21 County Prevention Coalitions (not awarded the community SPF-PFS grant) to address alcohol and underage drinking, marijuana and vaping in their respective counties: Atlantic, Bergen, Burlington. Camden, Cumberland, Gloucester, Mercer, Middlesex, Monmouth, Passaic, Salem, Somerset, Sussex, Union, and Warren.

Strategic Prevention Framework for Prescription Drugs. In September 2016, NJ was awarded a Strategic Prevention Framework for Prescription Drugs (SPF Rx) grant for $371,616 per year for

five years. The SPF Rx provides an opportunity for states that have completed a Strategic Prevention Framework State Incentive Grant (SPF SIG) to target the priority issue of prescription drug misuse. Called NJAssessRx, the grant expands interagency sharing of the state's prescription drug monitoring program, data and gives DMHAS the capability to use data analytics to identify prescribers, prescriber groups and patients at high risk for inappropriate prescribing and nonmedical use of opioid drugs. Informed by the data, DMHAS and its prevention partners strategically target communities and populations needing services, education or other interventions.

The target population is youth (ages 12-17) and adults (18 years of age and older) who are being prescribed opioid pain medications, controlled drugs, or HGH, and are at risk for their nonmedical use. A major component of New Jersey's SPF Rx project focuses on young athletes. A TOP toolkit entitled "Tackling Opioids through Prevention for Athletes" was developed. Literature suggests that when young athletes are prescribed opioid pain relievers for sports-related injuries, there is a risk of addiction and medication misuse. The 19 county coalitions that were established by DMHAS provide education regarding this issue to coaches, parents, prescribers, and young athletes.

DMHAS conducts epidemiological analysis on NJPMP data and employs geographic information systems (GIS) to identify communities and issues that require targeted interventions and public health initiatives. One of the goals of this project is to build capacity to strategically utilize the PMP to inform our prevention strategies. DMHAS purchased the SAS® Analytics software for Prescription Drug Monitoring data. This product allows us to identify suspicious or problematic patterns and helps us develop targeted prevention strategies. We can use the SAS® Analytics tool for anomaly detection and predictive modeling. This helps us achieve our goal to identify drug misuse trends and develop appropriate prevention strategies. Reports will identify those populations, practice settings and geographic areas, with the highest rates of nonmedical use of opioids and opioid prescriptions.

The reports developed from DMHAS data analysis will be shared with other state agencies and with DMHAS' Prevention Coalitions to inform planning in local communities, which might, for example, target locales for naloxone distribution to prevent drug overdoses. These reports will also be the basis for a public awareness campaign and for training of providers and the health care community on addictions and the risks of opioid prescribing.

In 2021, DMHAS was awarded a second five-year SPF-Rx grant to continue its work with Young Athletes and the other projects described above.

State Targeted Response to the Opioid Crisis. In May 2017, SAMHSA awarded New Jersey $12,995,621 annually for two years for its State Targeted Response to the Opioid Crisis project. As one component of this project, DMHAS awarded funding for prevention services programs to older adults in five counties. Awardees designed and implemented a comprehensive educational program specifically focused on providing older adults with practical information regarding non-pharmacological approaches to dealing with acute and chronic pain. The goal of the project was to reduce the overuse, misuse and abuse of prescription opioid medications within this population.

An additional five programs were added through a No Cost Extension (NCE). Since this grant has ended, these services are being continued through the subsequent SOR grants that were awarded.

State Opioid Response 2018. In September 2018, SAMHSA awarded State Opioid Response (SOR) funds to New Jersey for two years. With these funds, DMHAS developed an additional five Alternative Approaches to Pain Management for Older Adults programs, described above.

State Opioid Response 2020. Using State Opioid Response (SOR) funds, the Alternative Approaches to Pain Management for Older Adults (AAPMOA) programs was further expanded, and now includes 20 of 21 NJ counties, since one county did not apply for this funding.

Program providers have implemented a comprehensive educational program specifically focused on providing older adults with practical information regarding (1) the appropriate use of non-opioid analgesic pain medication and (2) non-pharmacological approaches to dealing with acute and chronic pain. The goal of the project is to reduce the overuse, misuse and abuse of prescription opioid medications within this population. Programs utilize current evidence-based treatment guidelines for non-pharmacological treatment modalities. The "efficacy" of the educational program on participants' knowledge about and understanding of alternative approaches to pain management is assessed by means of a pre and post-test. Most of the providers who are delivering the AAPMOA program use the evidence-based Wellness Initiative for Senior Education (WISE) program. WISE is a wellness and prevention program targeting older adults, which is designed to help them celebrate healthy aging, make healthy lifestyle choices and avoid substance abuse. It provides educational services to older adults on topics including medication management, stress management, depression, and substance misuse. Created by the New Jersey Prevention Network and implemented locally by prevention agencies across the country, WISE promotes health through education concerning high-risk behaviors in older adults. Since the program was launched in 1996, prevention programs presented by WISE facilitators have reached over 40,000 individuals.

Providing information about the risks associated with prescription pain medications is a component of these trainings. However, the primary focus is on providing information and answering questions about proven, non-pharmacological means of addressing pain. Providers do not deliver actual services, but offer information about alternative approaches and information regarding how and where to access such services as: physical therapy, chiropractic care, yoga, massage therapy, etc.

SOR funds have also been used to purchase Deterra Drug Disposal kits and medication lock boxes. These materials are provided to the DMHAS-funded prevention coalitions who, in turn, distribute them throughout their communities. In late 2020. DMHAS purchased 7500 Deterra kits and 2500 lock boxes.

State Opioid Response 2022. The Older Adult program described above continued (using SOR 2 funds). To date, over 10,000 older adults, caregivers, and healthcare professionals have participated in the trainings.

SOR 2 funds were also used to purchase 8,000 Deterra kits to distribute to the DMHAS prevention coalitions. And, DMHAS purchased 28,400 kits for our partners at the NJ Attorney General's Coordinator for Addiction Responses and Enforcement Strategies ("NJ CARES"), and the Division of Consumer Affairs ("DCA"). Eighty (80) hospice and long-term care facilities received drug disposal kits. The bags provide the facilities with a safe and easy way to dispose of leftover medications, preventing opioids from being diverted or misused after they are no longer needed for a patient.

SUPTRS COVID-19 Supplemental FY 2021 Funding. DMHAS was awarded approximately $45M in COVID-19 Supplemental Block Grant funding in March 2021. Funding was allocated to enhance prevention services. It was used to develop Prevention Hubs in each of NJ's 21 counties. The DMHAS-funded system of prevention agencies became Prevention Hubs where individuals, local government entities, community organizations, youth, families and community members can obtain information and resources, get connected to outreach events, and do brief screenings and/or be connected to needed services. The Prevention Hubs' staff were trained to be a warm line to direct people to needed prevention resources and services or other interventions or support, as needed. The 21 Prevention Hubs created a one-stop shop to: (1) promote effective planning, monitoring, and oversight of efforts to deliver substance use disorder (SUD) prevention services; (2) provide support for local entities promotion prevention, including schools, law enforcement, and community-based organizations; (3) maximize efficiency in local prevention efforts by leveraging the current infrastructure and capacity; (4) address prevention funding and support gaps expanded by COVID-19; (5) ensure prevention resources are available in all 21 counties.

DMHAS contracted with the New Jersey Prevention Network to serve as the lead agency across the state and oversee the strategic coordination of Prevention Hub services. This model allows local impacts to be strengthened with the consistent messaging and comprehensive reach to every county. The local Prevention Hub can ensure that the unique communities, cultures and needs of each county are addressed in a culturally, and to the extent possible, linguistically, inclusive way.

To ensure the implementation of evidence-based prevention strategies, interventions and programs, key stakeholders and organizations need a one-stop source that supports needed prevention services to build resiliency, increase protective factors and reduce risk factors related to behavioral health issues. NJ has long-established prevention agencies that serve their communities. These organizations employ expert staff knowledgeable and skilled in the use of the Strategic Prevention Framework and implementation of best practices. Many of these agencies have been de facto Prevention Hubs supporting schools, government, faith-based communities, healthcare setting, and consumers, such as youth adults while also supporting provider organizations in the implementation of policies, practices and programs that focus on reducing the negative impact of substance misuse through the lifespan.

The Prevention Hubs are tasked with additional activities as a result of BG supplemental funding and further incorporate evidence-based tools for screening into their programs. Some of the planned tools involve Universal ACE's (Adverse Childhood Experiences), Social Determinants of Health Screening, and SBIRT screening. In addition, DMHAS makes available a program called PreVenture which is an evidence-based prevention program that uses personality targeted interventions to promote mental health and skill development and delay youth substance use.

PreVenture is designed to help at-risk youth ages 12-17 learn useful coping skills, set long term goals, and channel their personality towards achieving them. It focuses on at-risk youth and introduces motivational pathways and coping skills based on the individual's personality. PreVenture can be implemented in school/non-school and online settings. PreVenture has been shown to reduce drug use, alcohol use and likelihood of binge drinking by 50%, delay initiation and frequency of cannabis use, reduce conduct problems and reduce risks for mental health struggles, such as anxiety and depression. A link for further information about NJ's Prevention Hubs can be found at: https://www.njpreventionhub.org.

New Jersey is expanding web-based/mobile tools for risk messaging for adolescents and young adults and to enhance social media utilization. DMHAS provided funds to the New Jersey Prevention Network to enable them to work with the Public Good Project, which has expertise in health messaging, campaign development and effective use of social media and other technology to reach high risk youth. Messaging will be utilized by the Prevention Hubs to maximize strategic local reach.

The Strengthening Families Program (SFP) is an evidence-based curriculum the state currently utilizes that has been expanded to address the needs of targeted underserved communities within our counties. Once families are engaged they tend to stay connected to larger supports. The connection between families and the community increases the likelihood of positive experiences that can combat ACEs (Adverse Childhood Experiences). Family programming has become an intervention point for marginalized families to engage them in services that foster resilience. Through Strengthening Families, the state makes transportation available, connects individuals to additional financial supports and health resources like COVID Vaccine centers. This program provides families with meals, support and family activities and engagement. This support directly creates better health outcomes for children by addressing four of the Social Determinants of Health: Economic Stability, Education, Food and Community and Prosocial Engagement. The population of focus for this SUPTRS Supplemental-funded delivery of SFP is families that are involved with the justice system.

Using SUPTRS Supplemental funds, DMHAS has enhanced prevention services to other underserved populations as identified by the local prevention coalitions, such as NJ's three Native American tribes. These tribes, while recognized by the state are not federally recognized. This is DMHAS' first collaboration with this important population.

DMHAS also identified a need to increase recovery and prevention programs for colleges and universities in NJ. An RFP was issued in July 2022 to provide supportive, substance-free living environments and services for college students in recovery. Three colleges were awarded a contract in September 2022 to provide individual and group substance abuse recovery-oriented strategies, provide assessment, academic, and relapse prevention services to students, and other appropriate services.

While DMHAS addresses marijuana prevention through our Regional Coalitions, NJ is strengthening underage marijuana use and marijuana abuse with SUPTRS Supplemental resources.

DMHAS (with colleagues from Montclair State University) is creating a coordinated, state-wide, scientifically designed digital data collection tool (survey) for the 18- to 25-year-old population. This is a population for which the state lacks information on drug use behaviors and trends.

DMHAS provided SUPTRS Supplemental funds to the Governor's Council on Alcoholism and Drug Abuse (GCADA) for the development of a statewide Youth Leadership Program. This is a unique partnership opportunity for state government agencies to work collaboratively to service communities across New Jersey, particularly DMHAS and GCADA, the two leading providers of prevention programming and education in the state. Recipients of the Youth Leadership funding are the 21 counties in New Jersey who will then distribute the funding to the Municipal Alliances in their respective counties. The Municipal Alliances are comprised of local volunteers engaged in addressing substance use and misuse through prevention programming in their communities. In Fiscal Year 2021, there were 320 Municipal Alliances in 425 municipalities across all 21 counties. Prevention programming was planned for approximately 1,700,000 participants statewide - over 400,000 youth, 30,000 older Americans, and 1,200,000 community-wide event participants, reaching millions of New Jerseyans. The Municipal Alliance Program is an inextricable part of communities across the state, engaging all parts of the community: families who have lost loved ones, those trying to save them, educators, students, parents, seniors, coaches, athletes, clergy and communities of faith, veterans, law enforcement, chambers of commerce, county officials, and community members.

The programs and services described above can be categorized according to the CSAP Prevention Strategies as such:

- Education: Strengthening Families Program
- Environmental (Policy): Coalitions and prevention agencies guide and influence the development of policies that address underage marijuana use in their communities
- Environmental (Community Norms): Public Good Project
- Information Dissemination: Large-scale public messaging provided by Prevention Hubs
- Alternatives: Substance-free recreational and/or sports activities provided by Prevention Hubs to their communities
- Problem Identification and Referral: The Prevention Hubs will utilize a screening process to determine if an individual's behavior can be modified through SUD primary prevention education activities or services.
- Community-Based Process: Prevention Hubs will promote effective planning, monitoring, and oversight of efforts to deliver substance use disorder (SUD) prevention services, and provide support for local entities promotion prevention, including schools, law enforcement, and community-based organizations.

<u>SUPTRS ARPA 2022</u>. DMHAS was awarded approximately $38.9 million of ARPA funding in May 2021, and will continue many of the programs above, which were described in the previous section. DMHAS will also continue to work with the New Jersey Prevention Network as the lead agency across the state who will oversee the strategic coordination of prevention services. New Jersey will continue web-based/mobile tools for risk messaging for adolescents and young adults and enhance social media utilization. Youth Peer leadership programs will continue. Our Prevention Warm-Line will continue. Marijuana prevention programs will continue.

Prevention activities will continue to address over-the-counter medication use. Social media, such as TikTok, is fueling challenges to use these products. The "Benadryl Challenge" encourages young people to take dangerous amounts of Benadryl in an effort to experience a high or hallucinations. Social media *challenges* and *over-the-counter medications* can lead to deadly overdoses.

Strengthening Families will be expanded for women in our treatment programs and expanded to other marginalized groups in need of such programming.

Coalitions will provide evidence-based or evidence-informed vaping prevention programs to youth in schools or alternative locations.

In terms of the grant management and monitoring of all DMHAS' prevention services, we plan to upgrade our existing Prevention Outcomes Monitoring System (POMS) which was developed in 2008. There have been new developments in prevention that are not being adequately captured in this old system. It needs to be responsive to capturing activity around the Strategic Prevention Framework, environmental strategies and outcomes. It needs to provide a mechanism for providers to electronically submit their required reports.

There is a need for the public to have a better awareness of our prevention services. Individuals are not adequately familiar with the array of prevention and recovery support services that are available. Our plans include creating a "user friendly" website for prevention services which is currently difficult to navigate on our existing website.

<u>Suicide Prevention.</u> DMHAS Suicide Prevention Committee implements the Adult Suicide Prevention Plan in accordance with and guided by the 2012 National Strategy for Suicide Prevention: Goals and Objectives for Action, published by the U.S. Department of Health and Human Service Office of the Surgeon General and National Action Alliance for Suicide Prevention. In addition, the Suicide Prevention Committee used the New Jersey Youth Suicide Prevention Plan and other States' suicide prevention plans as references. The NJ Adult Suicide Prevention Plan contains strategies and actions in addition to crisis responses for specific concerns of adult New Jersey citizens; addressing current NJ needs and activities and linking up-to-date science for prevention with practical application in the field. The plan and the action steps go beyond organizations and agencies and stress the importance of everyone's contribution to keeping all individuals in the state safe, in addition to conveying hope and recovery. Although NJ's rate of suicide has been the lowest or second lowest in the nation, DMHAS believes that every suicide is unacceptable and can potentially be prevented, especially for people under care. The plan recognizes several at-risk populations, such as individuals with mental health and substance abuse, a suicidal and/or trauma history, who are part of the LGBTQ community, or have severe medical conditions/chronic pain, etc., as well as high risk periods, such as transitions of care, especially discharges from EDs and inpatient psychiatric units, and includes programs, policies, and approaches to address these at-risk populations and problems.

Since 2015, DMHAS has initiated and collaboratively developed a Proclamation, signed by the Governor proclaiming September as Suicide Prevention Month (2015) or Week (2016 - 2022), and

in April 2019, DMHAS started a single Suicide Prevention Unit to spearhead multiple suicide prevention initiatives in the State. DMHAS has partnered with the Education Development Center (EDC) to host three Zero Suicide Academies in the Fall of 2020. Zero Suicide is a commitment to suicide prevention in health and behavioral health care systems and is also a specific set of strategies and tools. The foundational belief of Zero Suicide is that suicide deaths for individuals under care within health and behavioral health systems are preventable. Following the three Academies, DMHAS partnered with EDC further to offer nine months of Community of Practice sessions to the participants of the academy for technical assistance and follow-up during their first year of implementation. DMHAS has expanded their partnership with EDC to offer additional academies in the fall of 2023.

During this time, DMHAS partnered with the Rutgers University School of Public Health's Gun Violence Research Center (GVRC) to develop webinars covering a range of suicide prevention topics (e.g. firearm suicide prevention across settings). The intent was to target diverse audiences from health care providers, parents, gun owners, law enforcement, service members and veterans, and adolescents. Webinars represent a quick and scalable intervention that could reach stakeholders both within and beyond New Jersey. Two webinars in total were created, one for healthcare practitioners, and one for the general public which have been put on the DMHAS public website. Most recently, The GVRC has developed a freely available online map of locations across New Jersey willing to consider temporary and legal storage of personal firearms to disseminate the map broadly and to examine the experiences of participating sites in the months following the development and dissemination of the map.

Focusing on attracting the Primary Care community to suicide prevention training because of the statistic that 45% of those who died by suicide saw their primary care provider within a month of their death, DMHAS has also partnered with the NJ Academy of Family Physicians. As the professional association specifically for family physicians in New Jersey, NJAFP represents nearly all family physicians in New Jersey and can directly communicate with 6,500 primary care physicians and residents. This project developed six accredited podcasts to discuss suicide prevention training and resources, support, and electronic health records.

In addition, as of March 2021, DMHAS was awarded a grant to support the implementation of 9-8-8, a national three-digit dialing code for the National Suicide Prevention Lifeline. DMHAS partnered with the five Lifeline call centers in New Jersey and key stakeholders in the state to ensure a smooth transition to the 9-8-8 system in July, 2022. The five Lifeline call centers are funded by DMHAS has responded to up to more than 5,000 callers in distress per month after COVID-19 with referral options when indicated. In July 2022, the month that the Lifeline transitioned to 988, the most number of calls were received at 5,202 and the least in February 2023 with 4,394.

<u>Stigma Reduction.</u> The many New Jersey residents with a substance use disorder, as well as those who are in recovery from this disease, routinely encounter stigma and discrimination. Existing policies, laws, practices and misplaced perceptions undermine acceptance of addiction as a treatable disease and health condition and restrict access to appropriate health care, employment, housing, and public benefits. The New Jersey chapter of The National Center for Advocacy and

Recovery (formerly NCADD-New Jersey) provides extensive education and public information to help reduce the incidence of stigma related to alcoholism or drug addiction.

DMHAS, in partnership with the Department Human Services (DHS), Office of Public Relations, secured a vendor that has been delivering a public awareness campaign to help reduce stigma and discrimination around the use of MAT for Opioid Use Disorder (OUD). The campaign was initially launched in the Spring of 2020 and refreshed its campaign in the Spring of 2021. Various forms of messaging including TV ads, radio commercials, social media and billboards have been utilized.

One mission of the Governor's Council on Alcoholism and Drug Abuse (GCADA) is to reduce stigma related to substance use disorder as a top priority. Through outreach and education, the Council sends a message that addiction stigma must no longer be tolerated. In 2014, GCADA unveiled the Addiction Doesn't Discriminate campaign, which is dedicated to increasing public awareness of substance abuse issues. The awareness campaign represents a partnership between GCADA and the New Jersey Office of the Attorney General, including its Division of Consumer Affairs, Division of Criminal Justice, Office of the Insurance Fraud Prosecutor, and Division of State Police; the New Jersey DHS and its DMHAS; the U.S. Attorney's Office, District of New Jersey; the New Jersey Department of Education; and the Partnership for a Drug-Free New Jersey. The campaign is still in operation.

Drug Free Communities Support Program. The Drug-Free Communities (DFC) Support Program is the nation's leading effort to mobilize communities to prevent and reduce substance use among youth. Created in 1997 by the Drug-Free Communities Act, administered by the White House Office of National Drug Control Policy (ONDCP), and managed through a partnership between ONDCP and CDC, the DFC program provides grants to community coalitions to strengthen the infrastructure among local partners to create and sustain a reduction in local youth substance use.

The DFC program is aimed at mobilizing community leaders to identify and respond to the drug problems unique to their community and change local community environmental conditions tied to substance use. Twenty-nine community coalitions in New Jersey receive funding to strengthen collaboration among local partners and create an infrastructure that reduces youth substance use. Additionally, extensive prevention programming and education is provided by other state agencies such as: the Department of Education's Office of Student Support Services, Department of Children and Families, the Juvenile Justice Commission, Department of Health, the Division of Highway Safety, and law enforcement agencies.

Sober Truth on Preventing Underage Drinking. The purpose of Sober Truth on Preventing Underage Drinking (STOP Act) funding is to prevent and reduce alcohol use among youth and young adults ages 12-20 in communities throughout the United States. The program aims to: (1) address norms regarding alcohol use by youth, (2) reduce opportunities for underage drinking, (3) create changes in underage drinking enforcement efforts, (4) address penalties for underage use, and/or (5) reduce negative consequences associated with underage drinking (e.g., motor vehicle crashes, sexual assaults). In addition, grantees build on strategic plans that were developed under a Drug Free Communities (DFC) award utilizing the strategic prevention framework model which aims to address underage drinking behaviors. New Jersey is home to eight STOP Act grantees.

Policy Academy. In 2014, New Jersey was 1 of 10 states selected by SAMHSA to participate in the Prescription Drug Abuse Policy Academy. The goal of the Academy was to develop and strengthen state strategic plans to address prescription drug abuse. Representatives from DMHAS, along with partners from: the NJ Attorney General's Office, Department of Health, Department of Children and Families, the prevention/treatment provider community, as well as a family member who lost her son to an overdose participated in the academy.

New Jersey's approach to the problem of Prescription Drug Abuse emphasizes that drug overdose deaths are preventable. We chose to focus our efforts on three components that have proven to be essential aspects of an effective approach to combating the issue:

A. Public Awareness involves: 1. Utilizing existing or developing new social marketing and public information campaigns that target the General Public and provides information to address existing obstacles such as stigma and beliefs such as prescription drug abuse only happens in "bad" families, or that, if a physician prescribes a medication, there are no risks involved and misperceptions and, 2. Utilizing existing or developing new social marketing and public information campaigns that target Youth and Young Adults (12-25 year olds) and provides information to address obstacles and misperceptions.
B. Collaboration and Coalition Action: according to Community Anti-Drug Coalitions of America (CADCA), coalitions are by their very nature in the business of strategic social interaction. The central mission of any coalition is to develop a collective understanding across the region of the social issue at hand as well as to envision new ways of living that will yield better outcomes. The work being done by the DMHAS-funded regional coalitions, Municipal Alliances, and Drug-Free Community coalitions around this issue is invaluable and should be coordinated and further enhanced.
C. Surveillance and Ongoing Evaluation of Our Efforts involve 1. Monitoring events and trends related to prescription drug abuse to identify geographic "hot-spots" and/or particular populations at risk and, 2. Evaluating policies and programs that have been implemented to address prescription drug abuse.

The Policy Academy provided an opportunity to refine and enhance the strategies listed above. Additionally, DMHAS developed the Opioid Overdose Recovery Program (OORP) as a result of its participation in the Policy Academy and the information presented there. The intent of the Opioid Overdose Recovery Program (OORP) is to respond to individuals who have been reversed from opioid overdoses (by police, emergency responders, or friends/family) and are subsequently treated at hospital emergency departments as a result of the reversal.

Opioid Overdose Recovery Program. The Opioid Overdose Recovery Program (OORP) responds to individuals reversed from opioid overdoses and treated at hospital emergency departments as a result of the reversal. OORP utilizes Recovery Specialists and Patient Navigators to engage individuals reversed from an opioid overdose to provide non-clinical assistance, recovery supports and appropriate referrals for assessment and substance use disorder treatment. The Recovery Specialists and Patient Navigators maintain follow-up with these individuals for a minimum of 8 weeks after the initial contact. OORP includes linking individuals to appropriate and culturally-specific services and provides support and resources throughout the process. OORP providers are required to have protocols and procedures in place for priority populations that include pregnant

women and parents who have custody of their children and are at risk of child welfare involvement. For pregnant women, OORP provider policies must indicate how they will collaborate with the hospital social worker and/or hospital staff to ensure coordination and access of MAT services. This program was initially implemented in five counties as of January 2015 and is now currently operational in all 21 counties in New Jersey, utilizing state, SUPTRS, and SOR funds. A key goal of OORP is to prevent relapse and future overdose.

DMHAS was able to provide Governor's Initiative funding to 17 OORPs to expand services. The funds enable them to serve individuals who did not experience an overdose, but who present in the emergency department with issues attributable to opioid use disorder. These individuals are also able to receive OORP services as described above. Effective July 2021, expansion services are funded by the SUPTRS.

Opioid Reduction Options in Emergency Departments. Funded through SAMHSA's State Opioid Response grants and Governor Murphy's initiative to address the opioid epidemic in New Jersey, DMHAS issued an RFP to increase awareness and focus on non-opioid pain management strategies, reduce the use of opioids in Emergency Departments (EDs) and the subsequent prescribing of opioids at ED discharge. Funding was available for FFY 2019 and FFY 2020. According to a 2015 study of opioid prescribing in a cross section of U.S. EDs, 17% of discharged patients received an opioid prescription; DMHAS seeks a reduction in opioid prescriptions written in New Jersey's EDs at discharge to 12% or lower.

Though there are numerous pain management programs, most deal with chronic pain, not acute pain, the type of pain that ED physicians treat. In its effort to help stem the over-prescribing of opioids, DMHAS developed an Opioid Reduction Options (ORO) Plan that is geared to assisting health facilities in minimizing the use of opioids as the first line of treatment in New Jersey EDs where clinically indicated. The ORO program promotes the CERTA concept: channels, enzymes, receptors, targeted, analgesia. The CERTA concept optimizes the following medication classes in place of opioids: Cox-1, 2, 3 inhibitors, *N*-methyl-D-aspartate ("NMDA") receptor antagonists, sodium channel blockers, nitrous oxide, inflammatory cytokine inhibitors and *gamma*-Aminobutyric acid ("GABA") agonists/modulators. Specific agents include NSAIDs and acetaminophen, ketamine, lidocaine, nitrous oxide, corticosteroids, benzodiazepines and gabapentin.

Three tiers were established which have different levels of expectation: Gold, Silver, and Bronze. Hospitals could apply for one of the tiers and were required to participate in a Learning Community tailored to the tier. In July 2019, DMHAS granted ORO awards to 11 hospitals, 10 Gold and 1 Silver. A new RFP was released in March 2021. Awards were made in May 2021 to four hospitals, 3 Gold and 1 Silver tier.

Secondary Prevention

Opioid Overdose Prevention Program. As a result of the Opioid Antidote and Overdose Prevention Act passed in May 2013, DMHAS issued contracts to licensed, contracted opioid treatment programs to provide community education and training, to include the distribution of naloxone kits to individuals who attend and complete training. Contracts were awarded to four opioid

treatment programs located in, or adjacent to, five counties which had the highest rates of opiate overdose death reported for the period of January 1, 2013 - June 30, 2014. Efforts to educate and dispense naloxone are focused on individuals who are high risk for opioid overdose and include individuals admitted to opioid treatment programs and other substance abuse treatment programs, as well as those individuals engaged with local syringe access programs. Another priority is educating, training and distributing naloxone to family members, friends and loved ones who are in contact with individuals at risk for an opiate overdose.

When those contracts expired, an RFP was issued in July 2015 to continue this initiative on a statewide basis, known as the Opioid Overdose Prevention Program (OOPP). The RFP established three programs commencing in the fall of 2015 in the following regions.

North:	Bergen, Essex, Hudson, Morris, Passaic, Sussex and Warren Counties
Central:	Hunterdon, Mercer, Middlesex, Monmouth, Somerset, and Union Counties
South:	Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester, Ocean and Salem Counties

The program provides education to individuals at risk for an opioid overdose, their families, friends and loved ones to recognize signs of an opioid overdose and includes the distribution of naloxone kits and information on how to access treatment, including Medication Assisted Treatment, which is the best practice for someone living with an opioid use disorder. Federal funding received through STR and SOR helped to expand these trainings and distribution of kits to populations including, but not limited to residential substance use disorder treatment agencies, schools, jails, prisons, fire departments, homeless shelters, offices of emergency management and HIV clinics. In addition to distributing naloxone, as of August 2022, the OOPPs can now also provide Fentanyl Test Strips (FTS), as a harm reduction strategy, to those who request during the trainings.

<u>Prevent Prescription Drug/Opioid Overdose-Related Deaths (PDO).</u> In September 2016, DMHAS was awarded a PDO grant from SAMHSA for $1 million annually for five years to implement the Opioid Overdose Prevention Network (OOPN) initiative. DMHAS partnered with Rutgers University, Robert Wood Johnson Medical School, for the development and implementation of a comprehensive prescription drug/opioid overdose prevention program for this project which includes Naloxone training and distribution. The project reached over 3,000 individuals through training and distributed a minimum of 2,500 naloxone kits annually. The initiative served programs that served individuals with specialized needs, including: agencies and organizations working with justice-involved populations and offender re-entry programs; healthcare professionals; pharmacists; syringe access programs; community health centers; individuals who underwent an overdose reversal and women's substance use disorder providers.

Our project implemented an Early Warning and Rapid Response System (EWRRS) that allows an extensive network of practitioners and community workers in a variety of healthcare settings (e.g., FQHCs, EDs, hospitals) who will be informed when their communities are affected. The alerts will also mobilize opioid overdose prevention practitioners who can provide emergency response training and distribute naloxone to at-risk individuals and their families, as well as disseminate information about addiction treatment services to the local communities that are affected. This program is in operation through August 30, 2023.

The OOPN program continues with funding from the SUPTRS Supplemental and ARPA funds.

In June 2023, SAMHSA awarded a second five-year PDO grant to DMHAS which will continue the work of the OOPN.

DHS Naloxone Direct Program. Naloxone Direct (formerly called Naloxone Distribution Program) is a DHS naloxone distribution initiative that allows local government agencies, first responders and other eligible entities to place orders for naloxone though an online portal. The purpose of the program is to provide naloxone to first responders and other eligible agencies for the purposes of: general distribution in the community, emergency administration, and to make "leave behind" naloxone available for distribution by first responders for individuals post overdose. Registered agencies are able to log into the portal and request naloxone by the case (each case contains 12 two-dose kits). Orders received through the portal are sent to the manufacturer of Narcan, Emergent BioSolutions, who then ships the medicine directly to the agency. The Naloxone Direct portal was launched in June 2022 and has distributed 102,792 kits statewide during the period of June 1, 2022 – August 14, 2023.

Current Eligible Agencies include: law enforcement, EMS/Fire, county correctional facilities, local health departments, prevention agencies, libraries, shelters, re-entry agencies, harm reduction agencies, institutes of higher education, county prosecutor's offices, family support services, mobile outreach vehicles, mental health agencies, universities, and substance use disorder treatment agencies.

DHS Naloxone 365 Program. Naloxone 365 is a DHS naloxone distribution initiative for individuals in the community. Launched in January 2023, DHS partnered with the NJ Board of Pharmacy and its Medicaid division to develop and implement this unique program. Individuals 14 years or older may obtain naloxone at no-cost to them at participating pharmacies in NJ. Anonymity, easy access, and free naloxone are the three cornerstones of the Naloxone 365 program. Individuals are not required to present a prescription for naloxone, nor are they asked to provide identification, personal information, or their insurance. Simply walk into a participating pharmacy and ask the pharmacist for naloxone and they will receive a package of naloxone 4mg nasal spray (2 doses per package) for free. Pharmacies must complete the NJ Board of Pharmacy's Naloxone Pilot Agreement to participate in the program. Once signed up, participating pharmacies would procure naloxone through their normal network of wholesalers and after dispensing, bill for reimbursement using the NJMMIS/Medicaid billing code by following the instructions in the pilot program agreement. Pharmacy reimbursement for naloxone is at the current Medicaid rate. This program is funded using federal grant dollars. Since the program's launch in January 2023, the number of naloxone kits dispensed is 46,852 kits. To date, there are 636 pharmacies participating in the program.

Early Identification/Intervention

The SSA has initiated several programs to develop and provide early intervention services.

Early Intervention Services. ASAM level .5 services are offered in the SSA's continuum of care. In CY2022 there were 278 admissions for Early Intervention services. This service is most

commonly delivered to clients referred from DMHAS' Driving Under the Influence (DUI) program.

<u>NJ Connect for Recovery Call Line.</u> The NJ Connect for Recovery (NJCR) Call Line was established by the Mental Health Association in New Jersey to support families and friends who are dealing with substance use disorders of their loved ones. The NJCR staff of family peer specialists and Certified Alcohol and Drug Counselors provide peer support, education, information, referral to community recovery support services, and advocacy to family members. This is a safe, confidential, and nonjudgmental service whose goal is to engage families in long term recovery supports for themselves. Services are available at no cost to the caller.

Known at the "Family and Friends" line, NJCR works closely with REACHNJ to support families. The NJCR Call Line hours of operations are Weekdays 8AM to 10PM, Weekends and Holiday 8AM to 10PM. Call 855-652-3737 or go online at www.njconnectforrecovery.org for assistance.

NJCR also provides consultation and training to Substance Use Disorder (SUD) and Co-Occurring Family Support groups across NJ. NJCR services include training in group facilitation, community recovery services and accessing treatment. Utilizing the Community Reinforcement and Family Training (CRAFT) model of family support, NJCR operates one virtual SUD Family Group meetings that provide access to local family counseling and support resources. Both are offered statewide on a weekly basis. In addition, NJCR offers education related to addiction, family strategies and the CRAFT model. CRAFT is a motivational model of family therapy. It is reward-based —that is, based on positive reinforcement. CRAFT is aimed at the families and friends of treatment-refusing individuals who have a substance use disorder. "CRAFT works to affect [influence] the substance users' behavior by changing the way the family interacts with them."

<u>CY 22 Data:</u>
Calls Received: 3,990
Calls from IME (warm handoffs): 877
NJCR Family Support Meetings: 88
NJCR Family Support Participants: 1,219
CRAFT trainings: 3 virtually as part of Family Support meetings (during COVID)

<u>ReachNJ Hotline.</u> In February of 2017, the Governor announced ReachNJ, the Addiction Helpline. The Reach NJ was continued through 2018 and was updated in 2019. ReachNJ provides the same level of service to callers as the Interim Managing Entity (IME). These services include: screening, coordinated referrals, and care coordination. Reach NJ is available to all NJ residents including those with private insurance, those in need of financial assistance, children and young adults. Through this process, ReachNJ facilitates referrals to the agency most appropriate to meet the caller's needs.

NJ has embarked on a marketing campaign to increase awareness of the ReachNJ services. Recent data has demonstrated the effectiveness of the campaign. Some weeks NJ has seen increases in call volume of up to 400%.

988 Suicide and Crisis Lifeline. 988, the new three-digit dialing code for individuals experiencing suicidal, mental health, and/or substance use crisis, was established nationwide in July, 2022. It is part of a larger crisis care continuum being developed in New Jersey known as the 988 system. This system is being set up with the guiding principle that there will always be someone to call, chat, or text; someone to respond; and somewhere to go.

Individuals with SUD are at risk for suicide, which is a finding well documented in research studies. Substance use is a risk factor for both fatal and nonfatal overdoses, suicide attempts, and death by suicide. Compared with the general population, individuals with alcohol dependence and persons who use drugs have a 10–14 times greater risk of death by suicide, respectively, and approximately 22% of deaths by suicide have involved alcohol intoxication. One study found that opiates were present in 20% of suicide deaths, marijuana in 10.2%, cocaine in 4.6%, and amphetamines in 3.4%. Among the reported substances, alcohol and opioids are associated with the greatest risks of suicidal behavior. SUPTRS Supplemental funds are being utilized to support this need.

New Jersey has five crisis call centers that respond to calls, texts and chats for the 988 Suicide and Crisis Lifeline. They are certified by Vibrant Emotional Health (Vibrant) for meeting the minimum clinical, operations and performance standards and together they provide statewide coverage 24 hours a day, every day of the year.

In preparation for the transition to 988, NJ DMHAS was awarded approximately $2.5 million from the SAMHSA 988 Capacity Building Grant. These funds were designed to support Lifeline centers as they prepared for the anticipated increase in call, chat and text volume. Funding from a combination of federal grants totaling $3.7 million was awarded to the five NJ Lifeline centers.

In December 2022, NJ DMHAS was awarded an additional $1 million through the SAMHSA 988 Capacity Building Supplemental Grant. Of this award, approximately $340,000 has been awarded to four of the five 988 Lifeline centers in New Jersey (one center declined additional funding). These awards continue to support centers as they onboard additional staff.

An additional $12.8 million was allocated in the State Fiscal Year 2023 (SFY23) budget toward the expansion of the 988 Lifeline network to handle the increased volume of 988 calls, chats and texts. From these funds Carelon Behavioral Health was awarded a contract to act as the Managing Entity (ME) for the New Jersey 988 Suicide and Crisis Lifeline system. Among the ME's responsibilities will be to collect and report 988 Lifeline center data, establish and maintain a comprehensive resource and referral database, and to dispatch Mobile Crisis Outreach Teams (MCORTs) once they are operational.

The remaining $10 million will go toward the expansion of 988 Lifeline center operations (for current and/or additional centers). This expansion will add capacity to the NJ 988 Lifeline system and allow a higher rate of response to calls, chats and texts originating in New Jersey. Funding was allocated from the SUPTRS for implementation of the 988 Lifeline. Individuals with an SUD are susceptible to suicide and suicide attempts. Suicide is a leading cause of death among those that misuse substances (SAMHSA 2008). Deaths due to alcohol, drugs, and suicide have been on

the rise for over the last two decades, doubling from 104,379 deaths in 2011 to 209,225 deaths in 2021 (Trust for America's Health 2023).

The goal is to reach a minimum 90% in-state answer rate with a maximum of 10% of calls being routed to the national backup system. Data provided by Vibrant for the month of June 2023 shows that NJ had an in-state answer rate of 83%. NJ 988 Lifeline centers continue to recruit and onboard staff to expand the capacity for responding to calls, chats and texts. However, future funding opportunities and ongoing funding streams are vital to reaching and maintaining this goal.

The next step for the 988 system will be to develop a Mobile Crisis Outreach Response system with teams of trained professionals who will meet with people in crisis in the community. Mobile Crisis Outreach Response Teams (MCORTs) will be established as the "Someone to Respond" for the NJ 988 system. The SFY23 budget includes $16 million for the establishment of statewide MCORTs. These teams are designed to respond 24 hours a day, every day of the year, to non-life-threatening mental health, substance use or suicidal crises in the community. Ongoing funding for this program will be critical to maintaining this community-based, lifesaving service.

Crisis Receiving and Stabilization Centers (CRSCs). This program will provide services to those in need of immediate in-person crisis intervention and stabilization for a behavioral health crisis. The decision was made to combine both mental health (MH) and substance use disorder (SUD). CRSC offers a no-wrong-door access to crisis stabilization, operating much like a hospital emergency department (ED) that accepts all walk-ins, law enforcement drop offs, and fire department drop offs. The individuals served in the program will receive community-based treatment and supportive services 24 hours a day, 7 days a week, 365 days per year, with the goal of mitigating the need to use the ED to access community-based services and preventing unnecessary or inappropriate hospitalization and provide short-term (less than 24 hour) community-based services to individuals experiencing a suicidal, mental health or substance use crisis. Individuals will be available to walk-in for immediate crisis response services. The program will also result in cost savings through the reduction in avoidable ED visits, inpatient admissions, police engagement, arrests, incarcerations and 911 calls. In 2021 there were 49,219 visits to EDs related to alcohol use disorder (AUD) with about 55 in 10,000 individuals visiting EDs for AUD. There were 110,386 visits for drug related issues with about 124 individuals per 10,000 using the ED for a drug issue. Currently, there is no alternative to EDs for individuals who are in crisis due to a SUD.

These facilities will be staffed by health and behavioral health professionals, including professionals with prescribing authority and trained peer professionals. Once a crisis is de-escalated, individuals will be linked to aftercare services and offered follow-up support.

Screening, Brief Intervention and Referral to Treatment (SBIRT). SBIRT was initially implemented by DMHAS in 2013 at the Henry J. Austin Health Center (HJAHC), a federally-qualified health center (FQHC) with several locations throughout Trenton. HJAHC then expanded services to two partner emergency departments (EDs) in 2014. Services were further expanded to five additional NJ counties in 2016 through partnerships with Rutgers Robert Wood Johnson Medical Group and Rowan School of Osteopathic Medicine, Department of Family Medicine. SBIRT was delivered in diverse healthcare settings including primary care clinics, federally-

qualified health centers, emergency departments, dental clinics, and a student wellness center. The project was in operation between 2013-2017 and a total of 55,990 unique individuals were pre-screened. SBIRT interventions were provided for more than 1,750 of these individuals.

In November 2021, a Memorandum of Agreement with the Rowan University, School of Osteopathic Medicine (SOM) was developed for Screening, Brief Intervention and Referral to Treatment (SBIRT) for persons receiving services at their internal medicine, family care, OB/GYN clinics, and the Rowan University Student Health Center. Utilizing national best-practice standards for substance use screening, Rowan SOM has developed and implemented a fully sustainable, integrated SBIRT model as part of routine medical care. Additionally, Rowan SOM will implement annual, universal screening protocol, and office-based risk interventions, as part of patient intake services in all OB/GYN clinical settings.

In the fall of 2023, DMHAS will issue a Request for Proposals to identify hospital systems to provide SBIRT services in hospital emergency departments in New Jersey.

Shatterproof. Shatterproof is a national nonprofit organization dedicated to reversing the addiction crisis in the United States. Shatterproof partnered with key thought leaders and subject matter experts in addiction treatment to create ATLAS. The platform is based on quality measurement system best practices. ATLAS identifies addiction treatment providers' use of evidence-based best practices, and publicly displays this information to support those in need and their loved ones in navigating to appropriate, quality care. Individuals can search for and compare treatment options using criteria that are important to them – such as location, particular services offered, and insurance accepted. ATLAS is currently available in 11 states which includes New Jersey. It is being funded for its first year in New Jersey by Horizon, and then the SUPTRS.

Internet Gambling. In 2014, the New Jersey Legislature enacted legislation directing that $250,000 be collected from each casino located in Atlantic City or their internet gaming affiliate(s) that were issued a permit to conduct internet gaming. The purpose of the legislation is to increase/enhance the scope of disordered gambling treatment services in New Jersey.

With the funds described above, DMHAS developed a Memorandum of Agreement with the Rutgers University Center for Gambling Studies (CGS). The CGS conducted a needs assessment of agencies who serve as our state-approved field sites for students pursuing their LCADC license. Supervisors were contacted in person and/or by phone and email and asked a series of questions to gauge their: 1) knowledge of gambling problems and gambling treatment and screening needs; 2) willingness to participate in a pilot project to develop a gambling SBIRT; and 3) interest in attending a 30-hour gambling training either in person or online.

CGS also reviewed all the existing literature on SBIRT protocols for substance use as well as a gambling SBIRT that was designed in Maryland. Based on their review, CGS designed a small pilot study to test the GAM-SBIRT, including validated screening instruments and feedback from participants. The study will be implemented in selected substance abuse treatment agencies in NJ.

Sports Betting. With the introduction of legalized sports betting in 2018, DMHAS now receives $50,000 as a portion of the licensing fee each gaming establishment is required to pay. These

funds are also directed to the further development or enhancement of prevention programs or treatment services for gambling disorder.

Compulsive Gambling. This contract provides statewide assessment, treatment, prevention, and helpline services through the Council on Compulsive Gambling of New Jersey. The Council offers counseling by certified treatment providers; a helpline (1-800-GAMBLER) that provides information on problem gambling and connects callers to treatment programs and Gamblers Anonymous/Gam-Anon meetings; ongoing public awareness activities; and educational materials for compulsive gamblers, families, and others affected by gambling problems. The Council also conducts outreach to at-risk populations such as older adults, adolescents, criminal offenders, and alcohol/drug dependent persons. Advanced professional training workshops and program development assistance are offered throughout the year. The Council's annual statewide conference focuses on promising approaches to assessment, prevention and treatment of compulsive gambling.

Conduct Disorder. Through the fall of 2021, DMHAS collaborated with University Behavioral Health Care (UBHC) at Rutgers University who implemented a substance abuse prevention study/intervention for children age 8-11 who display behaviors consistent with or meet diagnostic criteria for one of the diagnoses included in the definition of Conduct Disorders. Conduct disorders in youth are a significant predictor of the development of substance use disorders in adolescence and adulthood. DMHAS recognizes the need to identify, create and deliver innovative, quality outpatient services to those children at increased risk for the development of substance use disorders with the hope that these interventions will forestall or prevent their development. The project included an intensive clinical component in combination with the 14-week Strengthening Families Program. The study identified factors that were associated with the development of conduct disorders within the study population and suggested approaches and interventions that can minimize the likelihood of a young person developing a conduct disorder.

Treatment

Interim Managing Entity. DMHAS partnered with DMAHS and Rutgers University Behavioral Healthcare (UBHC) to implement an Interim Managing Entity (IME) to allow a single point of entry into substance use disorder treatment throughout the state. Launched in July 1, 2015, the IME has coordinated the addiction services for individuals, insuring that it is delivered at the appropriate level for the applicable time required. Clients can either call the IME directly to be screened and receive a warm handoff to a provider, or they can go to/call a provider directly to be screened and continue services. If callers to the IME are amenable, the IME completes a full screen, both clinical and fiscal, and uses this information to make a referral to an SUD treatment agency with the funding and capacity to meet the caller's needs. The IME holds Affiliation Agreements with all of SUD treatment providers who receive state funding, federal funding and/or Medicaid. These agreements allow for coordination between the provider and the IME to increase caller engagement in care. This has allowed NJ to manage its resources across the continuum of care. The IME care coordination center's phone number is publicized as the addiction services hotline. The IME is publicized as ReachNJ in an on-going media campaign.

In 2020 New Jersey launched a real time bed management system in the NJSAMS. That system allows the IME to more accurately determine capacity and target referrals for residential providers. That real time system also became available to the general public through the NJSAMS directory in June 2021.

The IME also provides provider training, care coordination to callers and utilization management (UM) activities. UM activities assure that individuals are provided with the correct level of care for their needs.

Between the SUPTRS Block Grant and other state resources, the SSA supports the following levels of care for substance abuse treatment, which comport with SSA regulations and The ASAM Criteria standards.

Residential. New Jersey's system of care for residential treatment services is comprised of five levels:

1) Level 3.7 WM Medically Monitored Inpatient Withdrawal Management
2) Short-term residential treatment which approximates Medically Monitored Intensive Inpatient Services Level 3.7,
3) Long-term residential treatment which approximates Clinically Managed High-Intensity Residential Services Level 3.5, and
4) Halfway house services which approximates Clinically Managed Low Intensity Residential Services Level 3.1.

Medication Assisted Treatment, including Methadone, Buprenorphine and Naltrexone are available at most residential facilities either through an affiliation with an Opioid Treatment Program or provided by the residential provider directly.

Specified providers offer specialized programs for women, women with dependent children, children and adolescents, which are consistent with the level of care classification but include services appropriate to these populations. Enhanced co-occurring services are also available. Services provided at each level of care will meet or exceed current New Jersey licensure standards.

Outpatient. New Jersey's level of care for outpatient treatment services is comprised of six levels:

1) Early intervention Level .5,
2) Outpatient Level 1.0,
3) Intensive outpatient (IOP) Level 2.1,
4) Partial care Level 2.5,
5) Level 2-WM Ambulatory Withdrawal Management with Extended On-Site Monitoring, and
6) Medication Assisted treatment delivered in an Opioid Treatment Program (OTP). Services are offered on site as well as at some mobile medication sites.

Services provided at each level of care will meet or exceed current New Jersey licensure standards.

The following is a brief description of the various substance abuse treatment initiatives funded through SAPT and state funds.

Interim Services. Interim Services have been a requirement of provider contracts, but an initiative launched in October 2019 allows DMHAS to pay for these services through a fee-for-service (FFS) mechanism. The Interim Services initiative provides funding to agencies to support individuals awaiting admission to treatment following an SUD assessment, as well as those individuals who are waiting to be assessed for services. Interim Services are an engagement level of service intended to link individuals to services they may not be able to access due to lack of provider capacity. This service is designed to be provided by agencies contracted for any licensed ASAM level of care. Interim services will be made available to any individual eligible for treatment within the public system who cannot be admitted for the assessed level of care within 72 hours. Funding for Interim Services is open to all contracted FFS providers.

Prior to this initiative, agencies enrolled in the Block Grant initiatives were required to provide this service. In 2019 NJ DMHAS added language to Fee for Service (FFS) Network Annex A's to ensure all FFS funded treatment agencies provide Interim Services as an engagement service at all levels of care to ensure priority Pregnant and Parenting Women (PPW) consumers awaiting admission to their assessed level of care anywhere in the state could receive interim services within 48 hours at facilities closer to home. Interim services for PPW consumers is designed to reduce the adverse health effects of substance use, promote individual health, and reduce the risk of transmitting disease to sexual partners and their infants by providing individualized education, case management, referrals and MAT if needed, while awaiting admission. Statewide technical assistance on interim services was provided to all contracted providers.

SUPTRS Women's Set-Aside (PWWDC Criterion 3). The SSA provides funding through the women's set aside federal block grant to a statewide network of licensed substance abuse treatment providers in all modalities of care: outpatient, methadone outpatient, short-term and long-term residential for substance abuse treatment to pregnant women and parenting women. The women's programs are designed to meet the specific needs of women such as gender specific substance abuse treatment and other therapeutic interventions for their children. Gender responsive treatment is trauma informed and trauma specific, strengths-based and relational. Gender specific treatment includes gender specific therapies with family focused services, such as individual and group sessions, child care, transportation, services for children, parenting, linkages and recovery supports. As per contract language, providers are required to develop Plans of Safe Care. If a woman is pregnant, the Plan shall be developed prior to the birth event whenever possible and in collaboration with treatment providers, health care providers, early childhood service providers and other members of the multidisciplinary team as appropriate. Plans of Safe Care will address the needs of the mother, infant and family to ensure coordination of, access to, and engagement in services.

Integrated Opioid Treatment Services and Substance Exposed Infants (IOT-SEI). In December 2017, the Department of Health (DOH) awarded funding through a Request for Applications (RFA) for the expansion of integrated opioid treatment services and substance exposed infants (IOT-SEI). DMHAS manages the IOT-SEI Initiative. The IOT-SEI initiative focuses on three of the five major timeframes when intervention in the life of a SEI can reduce potential harm of

prenatal substance exposure: the prenatal phase, the birth event, and neonatal phase. IOT-SEI provides an array of services for opioid dependent pregnant women, their infants and family ranging from substance use disorder treatment, prenatal and postpartum medical/obstetric services, care coordination, recovery-based living arrangements, wraparound services such as intensive case management and recovery supports. Providers are required to develop Plans of Safe Care. The overall goal is intended to improve outcomes for pregnant women with opioid use disorder, their infant and families. This initiative promotes maternal health, improve birth outcomes and reduce the risks and adverse consequences of prenatal substance exposure. Five agencies across the State are contracted to participate in this initiative. In SFY 2021, one of the awardees located in the Northern counties chose not to renew their contract. DMHAS rebid these services in SFY2022 and awarded a provider in one of the northern counties.

Recovery Court. Recovery Court is a cooperative initiative between the Administrative Office of the Courts (AOC) and the SSA which commenced in 2002. This agreement allows the AOC to transfer treatment funding to the SSA who then secures and makes available, based upon clinical need, a complete continuum of care for Recovery Court offenders sentenced in New Jersey Superior Court. Recovery Court participation has been voluntary. There are fifteen (15) vicinages serving all twenty-one (21) counties Recovery Courts function within the existing Superior Court structure to provide treatment along the full continuum of care and diversion opportunities for non-violent offenders who otherwise may be incarcerated in state prisons for drug related offenses. Since 2012, Recovery Court has expanded the criteria for participation; legal eligibility now includes second degree burglary and robbery and also mandatory sentencing to Recovery Court. As with the State Parole Board, Recovery Court agreed to begin using Medicaid to pay for treatment services beginning in January of 2017 for ambulatory services and in July 2018, residential services were added. As the result of legislation allowing for the use of medication assisted treatment (MAT), Recovery Court has had a six-fold increase in the number of participants using some form of MAT. This trend is expected to continue.

The success of NJ's statewide Recovery Court program has diverted a sizable number of non-violent, low security offenders whose crime resulted from their addiction have been diverted from the prison system. The Department of Corrections (DOC) has shifted its in-prison focus to medium security offenders in need of SUD treatment. In April of 2017 Mid-State Correctional facility, became the state's first fully-dedicated, licensed drug treatment center for male and Edna Mahan for female inmates. In collaboration with the DHS and DMHAS, both facilities were licensed to provide the ASAM levels of care for short-term and long-term residential services as well as intensive outpatient and outpatient levels of care. An MOU with Rutgers UBHC signed in November of 2016 enables inmates from all DOC facilities being released to either parole or the community to request the full array of ASAM SUD treatment services through the Interim Managing Entity.

Mutual Agreement Program. The SSA oversees the Mutual Agreement Program (MAP), a Parolee Substance Use Treatment Project implemented through Memoranda of Agreements between the SSA and the New Jersey State Parole Board (NJSPB). This funding is a combination of Medicaid and direct appropriations from DMHAS and funds transferred from NJSPB. These funds support a similar FFS network which offers the full continuum of care including long term and short term residential care, halfway house, partial care, detoxification, outpatient and intensive outpatient

treatment, co-occurring services, psychotropic medication reimbursement, and MAT. With the advent of Medicaid reimbursement for treatment services and medication, the use of MAT for parolees has expanded.

South Jersey Initiative. This state funded fee-for-service initiative targets young adults (ages 18-24) from eight counties (Ocean, Atlantic, Burlington, Camden, Gloucester, Cape May, Salem and Cumberland). SFY23, the SJI eligibility criteria was expanded to include young adults ages 25 to 30 years old. This criteria change provides the opportunity to reach more young adults over the age of 24, and those who age out from their parents' insurance coverage who are in need of substance use disorder treatment (SUD). The SJI provides a continuum of care that includes methadone maintenance, detoxification, residential, halfway house, and outpatient treatment services.

Driving Under the Influence Initiative. New Jersey set aside $7.5 million in state funds beginning in November 2005 to support the substance use disorder treatment needs for financially indigent residents of New Jersey who have been convicted of intoxicated driving and related offenses including driving under the influence (DUI). Convicted DUI Offenders who are financially indigent (less than 350% of the FPL) can receive all appropriate levels of care for the length of substance use disorder treatment documented by medical necessity. The intent is to ensure NJ residents in need of substance use disorder treatment receive the necessary interventions, and to reduce the incidence of recidivism and ultimately creating safer roads and waterways. There are over 200 licensed sites in the Driving Under the Influence Initiative (DUII) fee-for-service network providing all levels of substance use disorder treatment services.

The New Jersey Statewide Initiative. The New Jersey Statewide Initiative (NJSI) began on July 1, 2016 when providers with slot-based contracts transitioned to fee-for-service (FFS). Initially NJSI included only ambulatory services – intensive outpatient (IOP ASAM level 2.1) and outpatient (OP level 1) levels of care, and only two of the eight providers that converted to FFS were funded by Block Grant dollars for outpatient substance abuse treatment services (ASAM level 1). In February 2016, residential substance abuse treatment services were also added, including Halfway House (HWH level 3.1), Long-term residential treatment (LTR level 3.5), and Short-term residential (STR level 3.7). LTR and STR services are Block Grant funded and the network has been expanded to new providers and new sites for existing providers. Services also include Assessment and Enhancements such as a psychiatric evaluation and medication monitoring, urine drug screens, as well as an enhancement for Buprenorphine and Vivitrol, and recovery supports.

The Substance Abuse Prevention and Treatment Initiative. As of July 1, 2016, the contracted methadone outpatient, intensive outpatient and residential services reimbursed by SUPTRS Block Grant funds transitioned to Fee-for-Service. On April 11, 2017 IWM was added.

Vivitrol Enhancement Network. Authorization to provide Vivitrol (injectable naltrexone) and related enhancement services in both residential and ambulatory settings through DMHAS Fee-for-Service (FFS) Network is predicated on licensing approval by the Department of Health, Certificate of Need and Licensing (CN&L). Those agencies contracted to provide Vivitrol must agree that the prescription and administration of the medication will be conducted by the

appropriate medical personnel (Medical Director, Nurse Practitioner, Physician Assistant, Advanced Practice Nurse, or Registered Nurse) and that all counseling services will be provided in accordance with DOH and DCA regulation.

Agencies will ensure, and comply with, consumer choice and consent for this course of treatment. Staff shall provide the appropriate education regarding this medication and also discuss the options available for individuals with either an alcohol or opioid use disorder. A consumer information packet that is specific to injectable naltrexone pharmacology and developed by agency medical personnel shall be provided to the consumer by their counselor and verbally reviewed with the consumer at each level of care. The information packet shall include the benefits and the risks of the medication.

Buprenorphine Enhancement Network. DMHAS will continue the Buprenorphine Enhancement, similar to the one created for Vivitrol, that reimburses FFS Network providers for the provision of buprenorphine at their agencies. The Buprenorphine Enhancement Network was expanded in November 2022 to allow licensed SUD agencies to participate in the enhancement network with proper approval (MAT Waiver) issued by CN&L, depending on Level of Care (LOC).

SOR Grant. SAMHSA released a second iteration of the State Opioid Response (SOR) grant for states and territories in March 2020. New Jersey was awarded funding in September 2020. The goals of the SOR are to address the opioid crisis by increasing access to medication-assisted treatment using the three FDA-approved medications for the treatment of opioid use disorder, reducing unmet treatment need, and reducing opioid overdose related deaths through the provision of prevention, treatment and recovery activities for opioid use disorder (OUD) (including illicit use of prescription opioids, heroin, and fentanyl and fentanyl analogs). This grant opportunity also supports evidence-based prevention, treatment and recovery support services to address stimulant misuse and use disorders, including for cocaine and methamphetamine.

DMHAS utilized funding to continue low-threshold buprenorphine induction programming at all seven statewide Harm Reduction Centers (HRCs). Two HRCs began providing this service in December 2019 through the first iteration of SOR funding.

Another initiative to promote low induction medication was through a mobile service and contracts with two programs to facilitate low induction medication, case management and other ancillary services for individuals with an OUD in counties with low access to MAT as well as areas of the State with individuals who are homeless or at higher risk for homelessness. A third contract for this service is being planned with hopes to begin service in FFY 2024.

DMHAS will provide funding to increase paramedic OUD education, provide patients who have been reversed from an opioid overdose with a harm-reduction package that includes emergency naloxone, develop protocols allowing paramedics to administer buprenorphine for opioid withdrawal symptoms, and provide next-day linkage to care. This program will be coordinated through Cooper Hospital at Rowan University who has already been able to implement a pilot program in the City of Camden. This funding will help expand this program to a few other locations throughout the State.

In April 2021, DMHAS launched an Expanded Hour Same Day Service initiative to increase access to MAT through expanding the hours at Opioid Treatment Programs (OTPs). The intent of the program is to provide low barrier, on-demand MAT, specifically methadone, followed by treatment or referral to ongoing care for individuals with an OUD. This program is operational at six (6) OTPs.

DMHAS partnered with both Rutgers University and Rowan University (the two State Centers of Excellence) to ensure funding is available to support individuals at clinics who are indigent with an opioid use disorder, so they can be inducted and/or maintained on medications to treat opioid use disorder. Services for these individuals include other ancillary services such as care coordination, peer services and medications to assist individuals who have a co-occurring mental health or other SUD, for example tobacco use disorder.

In addition, DMHAS continues to assist all county correctional facilities establish MAT programs or enhance existing MAT services for inmates with an OUD as well as provide care management services. Funding has been made available to promote clinical stability and effective recovery processes for inmates prior to release from incarceration. DMHAS also provides funding to the Northern and Southern Center of Excellence to provide technical assistance to all county jails participating in this program. Technical Assistance is specific to assist jails in the provision of MAT and proper medication protocols for inmates.

The Department of Human Services launched a statewide advertising campaign in 2020, through a contract with a marketing agency, centered around opioid use and bringing public awareness that medication can support recovery and encourages viewers of the advertisements to call ReachNJ, the 24/7 Addiction Hotline in New Jersey. Messaging targets multiple resident groups, such as student-athletes, pregnant women, older adults and prescribers. NJ saw a significant increase in call volume at ReachNJ, as the campaign has existed in both physical and digital platforms across the State.

Finally, DMHAS implemented a pilot program addressing the use of methamphetamine and cocaine use disorder utilizing contingency management at several licensed SUD programs. Currently, DMHAS has five contracted programs and looks to expand to another five in FFY 2024.

A third iteration of SOR was released in May 2022. The State of New Jersey received $66.7M as an annual award beginning September 2022 (expected to be a two-year grant) with an ongoing goal to address the opioid overdose crisis by continuing to increase access to FDA-approved medications for the treatment of opioid use disorder (MOUD), support the continuum of prevention, harm reduction, treatment, and recovery support services for opioid use disorder (OUD) and other concurrent substance use disorders. The SOR grant will also continue to support the continuum of care for stimulant misuse and use disorders. Most prevention, treatment, recovery support and training activities will continue that were commenced under earlier iterations of the same titled grant. Some noteworthy initiatives from the grant are listed below.

Programs include the Expanded Hours/Same Day Service Opioid Treatment Programs (OTPs) that provide same-day access to low barrier /on demand MOUD, the Mobile Van Pilot program that facilitates low induction medication in communities with low access to MOUD and high rates of

homelessness, and the Low Threshold Buprenorphine Induction initiative that implements "low threshold" buprenorphine induction and stabilization programs at statewide harm reduction centers (HRCs).

Additionally, a program was funded to enhance overall recovery in stimulant use disorders utilizing contingency management. A public information campaign was funded to reduce discrimination and promote MOUD as the evidence-based practice for OUD. Also, training opportunities continued for OUD treatment professionals and recovery service workers. Prevention efforts included expanding target groups that receive naloxone training and kits and expanded the availability of naloxone kits through a portal developed for entities including: HRCs, county correctional facilities, EMS, law enforcement, shelters and treatment facilities. The Opioid Overdose Recovery Program and Public Education for Older Adults prevention programs also were continued. Recovery activities included the continuation of the Community Peer Recovery and Family Support Centers; and programs that provide case management and support services for individuals with an OUD such as the Support Team for Addiction Recovery and the Nurse Care Manager initiatives.

Anticipated outcomes of the grant include: reduction/abstinence from drugs and alcohol, increases in employment, reduced criminal justice involvement, increased social connectedness, and increased percentage of individuals completing treatment at the recommended level of care. Additional outcomes include: reducing opioid overdoses, increasing retention in treatment, reducing the length of time to relapse and prolonging recovery, and increasing number of individuals receiving medications to support their recovery.

Recovery Support Care Management (RSCM). RSCM was established and effective on March 7, 2023 and is a behavioral health service intended to support consumers who have a SUD with complex physical and/or psychosocial needs. RSCM provides direct and comprehensive assistance to consumers to ensure access to the necessary treatment, rehabilitative and recovery services with the intent of reducing psychiatric and addiction symptoms, connect consumers with services, improve transitions between levels of care, implement strategies to address their unique needs, reduce opioid related deaths and sustain recovery in the community while supporting the consumers' continued stability and recovery throughout the continuum of care. This service is available as an enhancement in all levels of care. This service may be provided face-to-face or via a telehealth platform. Since Medicaid offers Care Management in outpatient, RSCM is excluded from reimbursement for consumers admitted into Ambulatory LOCs in Recovery Care Efficiency (RCE). RSCM is being funded with SUPTRS COVID-19 Supplemental and will continue with ARPA funding. As of August 16, 2023, there were 1,405 unduplicated clients who received this service.

Expanded Outpatient Hours. An RFP was issued in August 2022 to expand outpatient treatment services and enhance access to treatment by removing barriers such as traditional service hours. Ten SUD outpatient treatment providers were awarded a contract to provide these services in October 2022. These expanded hours will provide increased access to outpatient treatment for individuals with an SUD. The purpose of this expansion for outpatient services is to support, enhance and encourage the emotional development and the development of consumer's life skills in order to maximize their individual functioning during alternate times from standard business

hours (after hours and weekends). Providers are required to expand their hours at a minimum of six (6) days per week with the goal of extending hours into the evening and admitting new consumers for these services during these times. This program is funded with ARPA.

Underserved Populations. An RFP was issued in August 2022 for providers to identify an underserved special population(s) to whom they would provide direct services. Ten SUD treatment providers were awarded a contract in November 2022. The services are intended to assist those who have experienced difficulties and challenges accessing SUD services. Providers were required to show the specific detail on how they identified their underserved population. These targeted services should be consumer-driven and planned with the specific needs of the individual and their special population in mind. Groups that will be served include: veterans and their families, older adults, LGBTQIA+, homeless Black and Indigenous, and People of Color (BIPOC), Latinos, and Spanish speaking individuals. This program is being funded with SUPTRS COVID-19 Supplemental and will continue with ARPA funding.

Internet Gambling. In 2014, the New Jersey Legislature enacted legislation directing that $250,000 be collected from each casino located in Atlantic City or their internet gaming affiliate(s) that were issued a permit to conduct internet gaming. The purpose of the legislation is to increase/enhance the scope of disordered gambling treatment services in New Jersey.

Utilizing monies appropriated through this legislation, in early 2018, DMHAS awarded funding (by means of a competitive RFP process) to the Council on Compulsive Gambling of New Jersey to expand outpatient and short-term residential treatment services for Gambling Disorder. The Council's responsibilities include overseeing the provision of treatment, monitoring all aspects of service delivery, credentialing service providers, processing service authorizations and claims, and reporting to DMHAS.

Sports Betting. With the introduction of legalized sports betting in 2018, DMHAS now receives $50,000 as a portion of the licensing fee each gaming establishment is required to pay. These funds are also directed to the further development or enhancement of prevention programs or treatment services for gambling disorder.

In August 2021, DMHAS issued two gambling disorder RFPs funded by New Jersey State Gambling appropriations. One RFP is for gambling disorder clinician services. DMHAS made 10 awards to providers licensed as SUD providers to treat individuals with a gambling disorder. Awarded providers will hire, at minimum, 1 FTE equivalent Gambling Disorder Clinician and provide case management services provided by the clinician or additional staffing. The awards will be chosen regionally and based on need in order to offer statewide gambling disorder services.

The second RFP was for the development of a Provider Gambling Training and Technical Assistance Initiative. This RFP was for one award for $1 million in one-time funding. Through this initiative, the successful bidder, Rutgers University School of Social Work Gambling Program provided robust training and consultation services with the goal of full implementation of gambling counseling practices within agencies across New Jersey that offer substance use disorder services. Clinicians who participate in the training do not have to be employed in a DMHAS contracted agency.

In January 2023, DMHAS issued a second Gambling Disorder RFP, funded by New Jersey State Gambling appropriations for 5 more providers including a Mental Health provider. A total of 15 provider sites now comprise the Gambling Disorder Treatment network.

Recovery Support

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

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

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

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

Bringing Recovery Supports to Scale – Technical Assistance Center Strategy. In recent years, New Jersey has greatly expanded, particularly for substance abuse treatment consumers, opportunities to provide peer-delivered services. Accordingly, the number of peers providing these services has also increased. Most of the positions held by peers, however, are part-time or casual in nature. There is a widely-acknowledged understanding, supported by scientific evidence, that peer-delivered services complement and enhance behavioral health care by creating the emotional,

social and practical assistance necessary that enables the client/patient to manage their illness and stay healthy.

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

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

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

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

Peer workers assist recoverees with accessing External and Internal Recovery Capital, and Family and/or Social Recovery Capital. External Recovery Capital includes, but is not limited to, financial assets, health insurance, safe and recovery-conducive shelter, clothing, food, and access to transportation. Internal Recovery Capital includes, but is not limited to, values, knowledge, educational/vocational skills and credentials, self-awareness, self-esteem, self-efficacy, hopefulness/optimism, perception of one's past/present/future, sense of wholeness and healing. Family and/or Social Recovery Capital includes, but is not limited to, intimate relationships, family

and kinship relationships (defined here non-traditionally, i.e., family of choice), and social relationships that are supportive of recovery efforts. Recovery specialists encourage families (biological, nuclear or self-chosen) to become willing to participate in their loved one's treatment and recovery. The presence of others in recovery within the family and social network can help access sober outlets for sobriety-based fellowship/leisure and relational connections to conventional institutions (school, workplace, church, and other mainstream community organizations).

The Division supports the role of peers through several individual and family-based initiatives. These programs assist individuals with Opioid Use Disorders or those who are at risk of an opioid overdose through supportive services, case management, education, resources, and advocacy for families and individuals. For example, the Opioid Overdose Recovery Program (OORP), which operates in all 21 counties, provides support services to individuals reversed from opioid overdose treated at hospital emergency departments. Peers employed within the OORP program are instrumental in engaging recoverees by sharing stories of hope and recovery, meeting individuals where they are, and emphasizing that recovery occurs via many pathways.

Other DMHAS peer recovery-based programs include, the Support Team for Addiction Recovery (STAR) initiative, which operates in all 21 counties, and is comprised of 12 teams, each consisting of a program supervisor, two case managers, and two peer recovery specialists. STAR focuses on promoting self-determination and helps recoverees connect to housing, employment, health, and social services, etc. The STAR team maintains contact with individuals to support their recovery and lead a productive life.

The Maternal Wraparound Program (M-WRAP) combines intensive case management, wraparound services, and recovery supports for pregnant/postpartum women who have a substance use disorder during pregnancy and up to one year after birth. The M-WRAP model is intended to promote maternal health, improve birth outcomes, and reduce the risks and adverse consequences of prenatal substance exposure.

Family Support Centers offered direct family support, education, resources, and advocacy in a safe and non-stigmatizing environment. Each regional center is staffed with Family Support Coordinators with lived experiences who are specially trained in the Community Reinforcement and Family Training (CRAFT) Model. This model teaches families self-protection and non-confrontational skills to help empower their loved one to seek treatment. It also helps each family member develop and work on their own Individualized Wellness Recovery Plan.

Community Peer Recovery Centers (CPRCs) are places where individuals can access peer support, information about substance use disorder treatment, recovery support services, and information about other community resources in a supportive substance free environment. All CPRC services and activities are led and driven by peers who have experienced addiction and recovery, either directly or indirectly as a family member or friend. The overall goal of the CPRC is to provide a safe place for recovering individuals to gather in support of one another and experience recovery-oriented living in a community setting.

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

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

Peer Roster. In order to accurately capture recovery program demographic data, DMHAS developed a Peer and Recovery Roster system. Staff working in DMHAS recovery programs are required to enter information into the Roster via an online Qualtrics survey link. Program staff input information on their position, agency, supervisor, educational level, certification, credentialing, and training record. DMHAS staff are able to use Roster data to accurately identify the number of peers working in DMHAS programs, follow trends, and assess program and workforce needs.

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

DMHAS has worked with DMAHS to develop a bundled reimbursement rate for the Opioid Overdose Recovery Program (OORP). The New Jersey 1115 Substance Use Disorder (SUD) Demonstration included implementation of an Opioid Overdose Recovery Program (OORP). The Division of Mental Health and Addiction Services (DMHAS) initiated the program based on a recovery model to link individuals recovered from an opioid overdose and transported to an

Emergency Department (ED) with appropriate addiction treatment and recovery support services. The Division of Medical Assistance and Health Services (DMAHS) began coverage of OORP services provided by DMHAS-contracted OORP providers effective January 2022.

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

Peer Recovery Support Summit. DMHAS held a virtual Peer Recovery Support Summit in collaboration with NJPN on September 1, 2022 entitled, Advance-Connect-Transform, The Future of Peer Recovery Support. This event equipped 708 attendees with strategies in providing recovery support services across the continuum of care with 2 keynote speakers and 19 workshop sessions, featuring a total of 35 multidisciplinary expert speakers. All workshops were intentionally coordinated based on best practices that are relevant to the addiction/recovery field, cultural humility, current events, and opioid use disorders.

Opioid Overdose Recovery Program. A Request for Proposals (RFP) was issued in June 2015 to develop an Opioid Overdose Recovery Program (OORP) to respond to individuals reversed from opioid overdoses and treated at hospital emergency departments as a result of the reversal. This new two-year initiative funded by DMHAS, the Governor's Council on Alcoholism and Drug Abuse (GCADA) and the Department of Children and Families (DCF) funded programs in Atlantic, Camden, Essex, Monmouth and Ocean Counties. Since then, using monies appropriated by the Governor, as well as STR and SOR funds, the program is now provided in all 21 NJ counties – and in 73 percent of hospital EDs throughout the state. The Opioid Overdose Recovery Program utilizes recovery specialists and patient navigators to engage individuals reversed from an opioid overdose to provide non-clinical assistance, recovery supports and appropriate referrals for assessment and substance use disorder treatment. The recovery specialists and patient navigators also maintain follow-up with these individuals. It is expected that, at minimum, recovery specialists will be accessible and on-call from Thursday evenings through Monday mornings. This new initiative commenced in the fall of 2015. Additional OORP RFPs were released. As of March 31, 2023, 25,072 individuals have been served by the OORP. While overdose and relapse prevention are key goals, the program is also intended to help individuals move into recovery.

Support Team for Addiction Recovery. Support Teams for Addiction Recovery (STAR) provide case management and recovery support services for individuals with opioid use disorders (OUD). The STAR initiative is comprised teams, with each team consisting of a program supervisor, two case managers and two recovery specialists. The team maintains a caseload of 40 individuals. STAR case managers work with individuals to assist with issues that often occur concurrently with

an OUD, such as homelessness, incarceration, legal issues, employment, education, transportation, need for social services, health care, child welfare involvement, child care, health insurance, documentation, etc. The STAR recovery specialists provide non-clinical assistance and recovery support services. The overall goal of STAR is to help individuals with an OUD achieve and maintain recovery, help reduce the risk of recurring episodes of opioid related problems, and prevent future overdose. STAR programs in all 21 NJ counties are funded by the SOR grant. In early 2020, services were expanded in 10 counties to enable STAR to serve individuals newly-released from county correctional facilities.

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

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

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

To ensure that the needs of the mother, infant and family receive coordination, access to and engagement in services, providers are required to develop Plans of Safe Care. The plan shall be developed prior to the birth event whenever possible and in collaboration with treatment providers, health care providers, early childhood service providers and other members of the multidisciplinary team as appropriate. The M-WRAP model is intended to promote maternal health, improve birth outcomes for women, their infants and families, and reduce the risks and adverse consequences of prenatal substance exposure.

The onset of the COVID-19 pandemic resulted in many significant safety precautions at the national and state level. The stay-at-home orders, such as closures of businesses, schools, restrictions in gatherings has had an impact on the social determinants of health (food, security, employment, income, access to medical care, etc.). Pregnant and parenting women with a history of substance use disorder (SUD) could be at risk for increase in substance use or experience relapse due to feelings of isolation, lack of family supports, or social support systems. Their mental health could be adversely affected exhibiting depression during pregnancy and postpartum July, 2021 the

M-WRAP statewide initiative eligibility criteria will be expanded to include pregnant women with substance use disorder, not exclusive to opioid dependency.

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

Collegiate Recovery. Six public colleges and universities (Rutgers University at New Brunswick and Newark, The College of New Jersey, Ramapo College, Rowan University, Richard Stockton University, and Ocean County Community College) receive state funds to support students in recovery. Recovery supports include screening and intervention services for at risk students; dedicated recovery housing; self-help, mentoring, peer and academic support; crisis management and relapse prevention; community education; and alcohol-free/alternative programming and community service opportunities.

In State Fiscal Years 2019-20, capital agreements were established with The College of New Jersey and Ramapo College of New Jersey to develop and designate recovery housing for students and/or enhance existing recovery communities on campus. Capital improvements include: the re-purposing of a student recreation facility into a health and wellness center, creating a recovery lounge, renovating a single family dwelling into recovery housing, and upgrading an existing residential building with new kitchen and lounge areas for students in recovery.

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

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

- Reduce a loved one's harmful substance use
- Influence a loved one to seek substance use treatment and recovery

• Improve the functioning of family members by making positive life changes

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

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

In 2021, each regional FSC expanded due to the increased numbers of referrals coming from OORPs, STARs, ReachNJ, Connect4Recovery Call Center, Division of Children and Families, and Families, Drug Court, Probation, and Treatment Providers to assist family members of loved ones with a OUD/stimulant use disorder, and some families without. Each FSC Region now provides family support services for at least 150 families in their region.

<u>Telephone Recovery Support</u>. The Telephone Recovery Support (TRS) program is intended for individuals discharged from substance use disorder treatment with an opioid use disorder, as well as those who are trying to maintain recovery from an opioid use disorder. Weekly phone calls are made by trained staff and volunteers who provide support, encouragement and information concerning recovery resources. TRS is a peer-to-peer check-in type service where the staff and volunteers will help provide local recovery supports, including information about local resources such as self-help meetings, food pantries, recovery houses and detox, if needed. Also included in TRS is the incorporation of text messaging and other types of social media in order to appeal to the younger population who rely on cell phones and social media to communicate. Through May 2021, 1,026 individuals have been served by TRS.

<u>Screening, Brief Intervention and Referral to Treatment (SBIRT).</u> A Memorandum of Agreement with the Rowan University, School of Osteopathic Medicine (SOM) was developed for Screening, Brief Intervention and Referral to Treatment (SBIRT) services for persons receiving services at their OB/GYN clinics. Utilizing national best-practice standards for substance use screening, Rowan SOM shall develop and implement a fully sustainable, integrated SBIRT model as part of routine medical care. Rowan SOM will implement annual, universal screening protocol, and office-based risk interventions, as part of patient intake services in all OB/GYN clinical settings.

<u>Prison Intensive Recovery Treatment Support</u>. Since 2017, DMHAS has worked with the Department of Corrections to provide Intensive Recovery Treatment Supports (IRTS) post-release services to a cohort of eligible offenders (n=200) with Opioid Use Disorder that receive MAT prior

to release from prison, and to another cohort of non-MAT eligible offenders (n=400) both pre- and post-release into the community.

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

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

In a subsample of IRTS (N = 334), the percentage who reported being housed increased from 74% in the first month after release to 84.7% in the fifth month, while the percentage who reported employment increased from 27% to 73%. The self-reported percentage using MOUD decreased modestly over this period but remained relatively high at 63.4% after five months. Self-reported alcohol and drug use increased over this time but remained below 30%. Among participants, on a monthly basis, 0.8% and 2.4% of active participants in the community experienced overdose or return to prison, respectively. Of 1,364 participants in the program, 4.4% were known to experience an overdose at any time while in the program.

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

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

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

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

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

Community Peer Recovery Centers (CPRC). DMHAS has expanded Recovery Centers through the SOR funding. Funding was issued in 2019 through a Request for Proposals (RFP) to develop three Community Peer Recovery Centers (CPRC) where individuals can access peer support, information about substance use disorder treatment, recovery support services, and information about other community resources in a supportive substance free environment. DMHAS initially awarded three providers in the amount of $100,000 each for start-up small-scale Recovery Centers to provide peer-to-peer recovery support services to prevent recurrent of substance use and promote sustained recovery. DMHAS issued another RFP in 2020 with SOR funding to expand the CPRCs. DMHAS awarded seven additional providers for peer-to-peer recovery support services that are responsive to community needs. All activities and services through the CPRCs are led and driven by "peers", individuals who have experienced addiction and recovery, either directly or indirectly as a family member or friend. The overall goal of the CPRC is to provide a safe place for recovering individuals to gather in support of one another and experience recovery-

oriented living in a community setting. The CPRC is a place where those in recovery can have the opportunity to give back to their community thereby fostering senses of empowerment and independence. In March 2020, CPRCs have followed CDC and NJ DHS Guidelines due to the COVID Epidemic in providing Virtual Community Support Services (via phone and secure online services), and limited safe distancing in person recovery support services. All the CPRCs have now reopened their centers to in person as well as hybrid and virtual services. CPRCs found that one of the keys to building a recovery community is embracing the many pathways to recovery, as well as ensuring meeting individuals where they are at. CPRCs have been able to share information regarding Recovery, Treatment, and Harm Reduction at their centers, including distributing Naloxone Training and Kits. DMHAS issued additional RFPs in SFY 2022-23 using SOR funds to expand to the 11 remaining New Jersey counties.

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

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

<u>Grassroots Recovery Organizations and Centers.</u> The Recovery Movement is well established in New Jersey. In terms of social media, there are numerous NJ Recovery Support pages on Facebook, Instagram and Twitter – ranging from parent to parent support groups sprung from the loss of their own children, to groups advocating for more treatment and recovery options for those suffering from a substance use disorder. At the community level, New Jersey has seen tremendous efforts in advocacy and recovery support. The New Jersey affiliate of the National Center for Advocacy and Recovery for Behavioral Health (NCAAR-BH – formerly NCADD-New Jersey) developed a "Recovery Advocates" program with graduates being divided into regional teams across the state. These Advocacy Leaders are trained on how to provide testimony to the New Jersey Assembly as well to develop regional events to educate the community about recovery and reduce stigma regarding addiction.

There are eight grassroots recovery organizations in NJ: Addictions Victorious (Gloucester County), A Change for Nick (Passaic County), CARES- Center for Addiction Recovery, Education and Success (Morris County), CARES (Warren County), City of Angels (Mercer County), CFC Loud and Clear (Monmouth County), Help Not Handcuffs (Monmouth County), Hope Sheds Light Foundation (Ocean County) and Recovery Advocates of America (Mercer County). Some of these organizations operate their own peer designed and run Recovery Centers independent of DMHAS funding: City of Angels, CARES- The Center for Addiction Recovery, Education and Success in Morris and Warren Counties, CFC Loud and Clear, Recovery Advocates of America and A

Change for Nick. All of these centers train their peer recovery staff and volunteers using the Connecticut Community for Addiction Recovery (CCAR) model. These organizations are community-based and help individuals access treatment, provide support throughout their treatment experience and provide aftercare/relapse prevention supports and services after discharge. These are peer-designed, non-12 step affiliated groups, although 12 step meetings are often held on site.

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

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

Group Homes for Persons in Recovery (Criterion 7). Funding is provided to Oxford Houses to provide administrative and programmatic oversight of the statewide network of peer-led group recovery homes in New Jersey. The Oxford House model offers recovery-oriented living as a choice in a person's continuum of care. Recovery is an individualized process for individuals with substance use disorders. As of March 2023, New Jersey has approximately 146 Oxford Houses (107 male houses, 31 women houses, and 8 women with children houses); total beds are 1,164 with 858 male and 306 female beds. The Revolving Loan Fund is administered by Oxford House annually to establish new homes, with additional funding from the Administrative Office of the Courts and DMHAS treatment contracts. This funding supports Oxford House, Inc.

Outreach staff to establish homes exclusive for the Drug Court population and women with children homes.

Federal funding for the State Opioid Response (SOR) allowed for expansion of the Oxford House contract for three full-time Outreach staff employed by Oxford House, Inc. to establish 10 new homes per year. DMHAS expanded the Oxford House contract in State Fiscal Year 2022 with SA Block Grant Funds for two additional full-time Outreach staff employed by Oxford House, Inc., and to support separate start-up funds to cover additional costs associated with the development and opening of houses for specialized populations. The special populations include the following: women with children and men with children, individuals re-entering from incarceration and individuals with a history of opioid use who are at high risk for an overdose death.

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

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

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

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

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

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

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

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

Sober Housing. Contracts were awarded in 2019 for three pilot recovery-based housing residences (a minimum of five individuals in each residence), one in each region (North, Central and South),

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

Interim Housing. As part of ARPA funding, SAMHSA approved a plan to develop an Interim Housing program for individuals with an SUD who are homeless. This initiative will allow homeless consumers with an SUD to be placed in a safe and sober housing environment for a maximum of two months. Cases requiring more than two months of housing will be reviewed on a case-by-case basis. The current funding for Interim Housing will allow for 20 beds to be available through an RFP process that would allow for a total of 60 SUD consumers to be housed with the ARPA funds. The sober housing initiative must use a SAMHSA approved EBR or NARR standard; support an environment that is conducive to a sober life style by living with others in recovery. Housing for men and women are separated and are distinct housing units.

Services to Special/Target Populations

Pregnant Women and Women with Dependent Children (Criterion 3). In 2014 as a SAMHSA Prescription Drug Abuse Policy Academy State, New Jersey was eligible to apply for a unique technical assistance opportunity through the SAMHSA supported National Center on Substance Abuse and Child Welfare (NCSACW) to address the multi-faceted problems of Substance Exposed Infants (SEI) and Neonatal Abstinence Syndrome (NAS). New Jersey DHS/DMHAS as the lead State agency partnered with DCF and Department of Health (DOH) and submitted a successful application for In-Depth Technical Assistance (IDTA) (no funding attached). The IDTA goal was to develop uniform policies/guidelines that address the entire spectrum of NAS and SEI from pre-pregnancy, prevention, early intervention, assessment and treatment, postpartum and early childhood. The IDTA would also provide assistance to New Jersey to strengthen collaboration and linkages across multiple systems such as addictions treatment, child welfare, and medical communities to improve services for pregnant women with opioid and other substance use disorders and outcomes for their babies. The New Jersey IDTA Core Team included over 60 individuals representing multiple State Departments and Divisions, community stakeholders, treatment providers, and the medical community.

The IDTA established three goals: (1) Increase perinatal SEI screening at multiple intervention points (Health system, SUD/MH system); (2) Leverage existing programs and policy mechanisms to collaboratively increase the rate at which women screening positive on the 4P's Plus get connected for a comprehensive assessment by establishing formal warm-handoffs and other safety net measures; (3) Leverage existing programs and policy mechanisms to collaboratively increase

the rate at which women delivering SEIs and their babies and any other eligible children, receive early support services for which they are eligible.

Three workgroups were convened:

(1) *Data Workgroup* looked at statewide data systems (Medicaid ICD codes and DOH) that capture prenatal screening, linkage to treatment services, follow-up for parenting women, prevalence of NAS and associated costs. During the initiative, the team analyzed 2013 and 2014 Medicaid data to establish prevalence and costs of treatment NAS.

(2) *Prenatal Screening, Early Identification of Infants & Referral to Service Workgroup* focused on how to increase connections to appropriate treatment and supportive services such as Central Intake and Perinatal Cooperatives, by mapping out current screening and referral practices across the state using Pregnancy Risk Assessment (PRA) data; New Jersey implemented the 4Ps+ (Parents, Partner, Past, Pregnancy Substance Use Disorder Screening Tool) across the State and embedded the tool within the PRA. The workgroup found high utilization (over 80%) of 4Ps+ within doctors serving pregnant women on Medicaid. The mapping allowed the team to target low utilization areas to increase the prevalence of prenatal screening.

(3) *Labor, Delivery and Engagement (Infants) Workgroup* developed a comprehensive survey with input from the medical community and perinatal cooperatives. The Hospital Birth Survey was disseminated statewide March 2017 to the labor and delivery hospitals. The survey sought to understand how pregnant women with SUD and substance-exposed infants are identified, treated, and triaged with partners at discharge, and if treatment for NAS was explored. The Hospital Birth Survey results was intended to guide Departments in establishing statewide guidelines for best practice; aid in the development of cross system models to ensure families get access to services; establish education needs on issues of SEI/NAS and identify high risk areas.

DMHAS as the IDTA lead state agency, requested modified technical assistance from the NCSACW to support New Jersey to interpret the key findings from the *Birthing Hospital Survey*, and apply these findings to the Project ECHO (Extension for Community Outcomes) program design. Robert Wood Johnson and the Nicholson Foundation, in partnership with the three Departments (Health, Human Services, and Children and Families) and other stakeholders began planning to launch Project ECHO for SEIs. The New Jersey Project ECHO is aimed at Statewide adoption of best practice clinical care and community-based interventions to support SEIs and their parents to support recovery, family formation, and child development through a multidisciplinary case-based learning platform. Project ECHO for SEI and parents focuses on prevention, birth, and the infant's first year of life.

In 2020, DMHAS collaborated with Rutgers/Robert Wood Johnson Medical School to implement Project ECHO for Maternal Child Health, Pregnant and Parenting Women with Opioid Use Disorder (MCH PPW OUD). This ECHO provides education and training to primary care practitioners, SUD treatment providers, behavioral health practitioners, and other stakeholders in multiple clinic settings and at home, utilizing a web-based video collaboration between a multi-disciplinary team of specialists and primary care practitioners on best practices for the assessment, case management, intervention, treatment and recovery support services for PPW with an OUD.

The ECHO's goal was to increase the capacity and competency of providers, community support organizations and clinical teams to support prevention, treatment and recovery of PPW with OUD. ECHO continues to position communities to reduce the NAS birth rates, improve use of medication assisted treatment, family formation and early infant development; improve access to physical and mental health care by educating more providers, midwives, doulas, and other health care professionals on best practices during prenatal and perinatal periods and inform the ECHO participants on Plans of Safe Care.

The anticipated start date for the Program was set for March 2020. However, with the advent of the global COVID-19 pandemic, and the national and state orders to shelter in place effective late March 2020, limitations on who could go to the hospital added a level of complexity to care for those mothers expecting to give birth during this time or in recovery at home. These events required an immediate response to address the public health emergency. In late March, 2020 the DMHAS agreed to postpone the traditional MCH PPW-OUD ECHO Series until such time that the providers could return to a focus on pregnant and parenting women with an OUD. The ECHO team (DMHAS, Rutgers/RWJ and Hub members) refocused resources to provide COVID-19 MCH and OUD ECHO sessions. This temporary change in scope enabled the MCH PPW-OUD ECHO team to address treatment issues, access to healthcare services and how to meet the needs of specific populations of women during this crisis. The MCH PPW-OUD Hub team completed a 7 COVID-19 maternal child health and OUD sessions between April and the first week of June 2020. The MCH PPW-OUD ECHO with COVID-19 (included as a discussion topic) will reconvened 2021 for two series of 12 bi-weekly sessions.

DMHAS extended the MCH PPW-OUD ECHO through SFY24 for two educational/training (series 3 and series 4) commencing March 2023. Series 3 included eight sessions held in the evening time for practitioners to learn and discuss the latest FDA approved techniques for MAT, integrated care and wraparound services. Series 4 will include 10 sessions with a curriculum that focuses on areas such as reducing stigma of mental health and substance use, screening protocols, improving access to substance use treatment, Plans of Safe Care, coordination of care for pregnant women with OUD and their newborns, MAT, etc.

The New Jersey Department of Health successfully applied for the 2023 In-Depth Technical Assistance (IDTA) through SAMHSA's National Center on Substance Abuse and Child Welfare: *Advancing Collaborative Practice and Policy: Promoting Healthy Development and Family Recovery for Infants, Children, Parents, and Caregivers Affected by Prenatal Substance Exposure.* The Departments of Health, Children and Families, and Human Services, DMHAS, representative from the Governor's Office and an individual with lived experience comprise the State team. This new round of IDTA will build on the previous IDTA. Several goals have been established: conduct a statewide landscape analysis of resources targeted at individuals and the families of individuals with SUD: establish a comprehensive and seamless system of care among state agencies, healthcare providers, and community level and non-profit organizations to address SUD during and after pregnancy; increase the percentage of prenatal Plans of Safe Care that community partners develop; and develop and update protocols and policies that aim to prevent NAS, SEI and SUD to implement care coordination through the NJ Plans of Safe Care model.

Child Welfare/Parents with Dependent Children Programs (PWWDC Criterion 3). July 1, 2015, the treatment contracts for parents with substance use disorders via a Memorandum of Understanding between the SSA and DCF Division of Child Protection & Permanency (DCP&P) transitioned over to DCF.

DCF is the lead State agency on Plans of Safe Care for SEI, mothers and their families and has developed protocols for integrating Plans of Safe Care into child protection services and child welfare and child welfare assessments. DCF and DMHAS collaborate on multiple initiatives targeted to pregnant and parenting women with substance use disorders. This partnership focuses on a coordinated multisystem approach to enhance and integrate service delivery that will ultimately improve the outcomes for the women, their infants and families. This cross-system collaboration ensures that services are coordinated, and information is shared appropriately to facilitate better communication, maximize resources and address barriers.

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

Persons Who Inject Drugs Services (Criterion 4). The SSA will continue to require all substance use disorder treatment agencies providing treatment to persons who inject drugs (PWID) to provide outreach activities to encourage PWID clients to seek and undergo treatment. The SSA will continue to incorporate a provision within the requirements section of each contract with the agencies providing treatment to PWID to ensure that these entities: 1) admit all individuals who request and are determined to be in need of treatment for intravenous drug use within 14 days of their request; or 2) make interim services available to the individuals within 48 hours of the request, and should the individual actively remain on the waiting list, admit the clients within 120 days. Each program will be notified that the following information about each client, who cannot be admitted to treatment within 14 days, shall be documented on the provider's standard waiting list: 1) date of placement on the waiting list; 2) unique client identifying number; 3) categorical priority status for admission; 4) record of provision of interim services by type and date; 5) record of weekly contact between client and entity; and 6) date and reason for removal from the waiting list. DMHAS will continue to utilize funding to support individuals requiring interim services through its Fee-for-Service (FFS) initiatives.

CY 2022 data indicated that the mean waiting time for the various levels of treatment ranged from .1 days (residential detox) to 4.5 days (halfway house). Opioid maintenance programs had a wait time of .4 days.

Tuberculosis Services (Criterion 5). In New Jersey, all substance use disorder treatment facilities receiving contracts are required to conduct TB testing as part of the patients' admissions process. A provision of the guidelines require that patients with TB, who were not admitted for treatment because the funded capacity at that facility had been exceeded, would be referred to another treatment provider for services. DMHAS will continue to have discussions with the NJ Department of Health, Division of HIV/AIDS, STDs and Tuberculosis Services (DHSTS) to consider the latest best practices for this effort.

HIV Services (Criterion 6). New Jersey is no longer classified as a designated HIV Block Grant State. However, licensed substance use disorder treatment programs continue to be required by licensure standards to either provide HIV testing/screening on-site or refer out to a Division of HIV/AIDS, STDs and Tuberculosis Services (DHSTS) funded site location. DMHAS continues its collaboration with DHSTS to ensure an integrated approach to SUD treatment and HIV care.

Recovery Court. Recovery Court is a cooperative initiative between the Administrative Office of the Courts (AOC) and the SSA which commenced in 2002. This agreement allows the AOC to transfer treatment funding to the SSA who then secures and makes available, based upon clinical need, a complete continuum of care for Recovery Court offenders sentenced in New Jersey Superior Court. Fifteen vicinages serving all 21 counties. Recovery Courts function within the existing Superior Court structure to provide treatment along the full continuum of care and diversion opportunities for non-violent offenders who otherwise may be incarcerated in state prisons for drug related offenses. Recovery Court participation had been voluntary. In July 2012 legislation was signed into law that stipulated a two-phase Recovery Court expansion: broaden the legal eligibility to include second degree burglary and robbery and require mandatory sentencing to Recovery Court. These were both accomplished by the court by July 2017.

Mutual Agreement Program. The SSA oversees the Mutual Agreement Program (MAP), a Parolee Substance Use Treatment Project implemented through Memoranda of Agreements between the SSA and the New Jersey State Parole Board (NJSPB). This funding is a combination of direct appropriations from DMHAS and funds transferred from NJSPB. For the NJSPB, these funds support a similar FFS network which offers the full continuum of care including long term and short term residential care, halfway house, partial care, detoxification, outpatient and intensive outpatient treatment, co-occurring services, psychotropic medication reimbursement, and medication assisted treatment.

Prison Inmates. Since 2017, DMHAS has worked with the Department of Corrections to provide Intensive Recovery Treatment Supports (IRTS) post-release services to a cohort of eligible offenders (n=200) with Opioid Use Disorder that receive MAT prior to release from prison, and to another cohort of non-MAT eligible offenders (n=400) both pre- and post-release into the community.

In October 2020, NJ Governor Phil Murphy signed legislation for the reduction of sentences and early release of certain NJ state prison inmates incarcerated for non-violent offences. The law was effective in early November 2020. Through January 2021, almost 3,000 inmates were released.

Approximately 800 of these individuals had an OUD diagnosis and 364 enrolled in the IRTS program. Two additional IRTS teams were developed to serve them.

IRTS links eligible offenders to recovery services necessary to support wellness and successful community re-integration. It helps offenders address issues such as: health/wellness, treatment adherence, employment, housing, and opportunities and skills to enhance the individual's ability to participate in meaningful life activities.

There are five IRTS teams providing services for up to six months prior to release and up to 12 months post release.

Jail Inmates. The New Jersey Department of Human Services' Division of Mental Health and Addiction Services (DMHAS), in collaboration with the Department of Corrections (DOC), Department of Health (DOH) and our community partners to coordinate and deliver medication-assisted treatment (MAT) for opioid addiction to individuals serving within county based correctional facilities. This partnership will help facilitate the connections individuals will need in order to sustain treatment services upon release.

This funding is being made available as part of Governor Murphy's initiative to combat the opioid epidemic in New Jersey and designed to encourage the use of or increase use of MAT in county correctional facilities for individuals with an opioid use disorder (OUD). Nationally, 75 percent of inmates with opioid use disorder are reported to have relapsed within three months of release and only 8 percent enter treatment after incarceration. (Fox et al., 20151) Few inmates receive MAT during incarceration despite MAT being the clinical standard for OUD treatment.

In New Jersey, a recent survey conducted by the DMHAS in collaboration with the County Jail Wardens' Association indicate that an average of 17 percent of jail detainees screen positive for a substance use disorder with a range of 10 percent - 69 percent among the jails reporting. (DMHAS/CJWA, 2018). Of particular concern are the rates of opioid overdose immediately following release from incarceration. In response to overdose deaths among its prison/jail population, the Rhode Island Department of Corrections initiated a model to screen and treat with MAT and sustain MAT post release through a community provider network. Results published in JAMA Psychiatry, researchers compared the pre- and post-intervention periods and found that "In the 2016 period, 26 of 179 individuals (14.5%) who died of an overdose were recently incarcerated compared with 9 of 157 individuals (5.7%) in the 2017 period, representing a 60.5% reduction in mortality."(Green et al, JAMA Psychiatry, April 2018)

With the arrival of criminal justice reform in New Jersey, jail/prison wardens are seeing more rapid return of individuals to their communities, often within 24 - 48 hours. Therefore, individuals are more likely to be released prior to or while experiencing the onset of opioid withdrawal symptoms. This can put individuals at an increased risk for overdose. Nevertheless, MAT being introduced pre-release has been shown to improve the likelihood of recovery sustainability post-release and can mitigate the risk associated with shorter jail stays. This initiative seeks to support wardens in building the capacity to deliver and sustain MAT for the impacted population.

Co-Occurring Services. Beginning in SFY 2010, the SSA established a Co-Occurring Services Network (COSN), comprised of 53 substance use disorder licensed treatment providers to provide treatment to clients with co-occurring disorders on a Fee for Service (FSS) basis. Agencies eligible to join the SUD FFS Initiatives Network as a Co-Occurring Provider must meet New Jersey Department of Health (DOH) Office of Certificate of Need Licensing (CN&L) requirements for co-occurring licensing approval. Currently, there are 140 agencies in the COSN. These agencies represent 252 individually licensed sites with COSN approval. Authorization to provide co-occurring services is predicated on agency's co-occurring licensing approval.

Those agencies contracted for the South Jersey Initiative (SJI), Driving Under the Influence Initiative (DUII), New Jersey Statewide Initiative (NJSI), Medication Assisted Treatment Initiative (MATI), Substance Abuse Prevention & Treatment Initiatives (SAPTI), and State Hospital Access to Rehabilitation and Education (SHARE) FFS Initiatives must also participate in the Co-Occurring Services Network and have demonstrated readiness to provide integrated care for dually diagnosed clients. The contractee shall be co-occurring capable and provide at a minimum, assessments and treatment, or must be able to screen, refer and provide linkages to a co-occurring capable agency. The contractee shall ensure that clients screened as "at risk" for co-occurring disorders (COD) shall receive a complete mental health assessment. If the screening contractee is not qualified to provide COD services, it is the contractee's responsibility to facilitate a referral for this service and coordinate ongoing care.

Services to Families of Military Veterans. Working with the New Jersey National Guard Family Program and its eight Family Assistance Centers based at armories around the state, the SSA funds the New Jersey Prevention Network to provide programs to serve returning military personnel and their families through two evidence-based programs, Coping with Work and Family Stress and the Strengthening Families Program. Both programs are designed to enhance protective factors to support military members and their families in making responsible parenting and individual choices in regards to drug and alcohol use.

New Jersey is focused on returning Veterans as a priority population by delivering Block Grant funded initiatives. This is another population for which there is limited information. DMHAS has reached out to New Jersey Department of Military and Veteran's Affairs as well as the New Jersey National Guard to solicit their active participation on the SEOW and Advisory Council in light of this priority.

Driving Under the Influence Offenders. New Jersey set aside $7.5 million in state funds beginning in November 2005 to support the substance use disorder treatment needs for financially indigent residents of New Jersey who have been convicted of intoxicated driving and related offenses including driving under the influence (DUI). Convicted DUI Offenders who are financially indigent (less than 350% of the FPL) can receive and all appropriate levels of care for the length of substance use disorder treatment documented by medical necessity. The intent is to ensure NJ residents in need of substance use disorder treatment receive the necessary interventions, and to reduce the incidence of recidivism and ultimately creating safer roads and waterways. There are over 200 licensed sites in the Driving Under the Influence Initiative (DUII) fee-for-service network providing all levels of substance use disorder treatment services.

Older Adults. Based upon results from the New Jersey Older Adult Survey on Drug Use and Health, DMHAS identified unhealthy drinking patterns and prescription drug misuse among adults age sixty and older as an issue. Data from the Older Adult Survey indicated, that in terms of illicit drug use, respondents were more likely to use tranquilizers, sedatives, and opiates when compared with older adults who responded to the New Jersey Household Survey. Data also showed evidence of possible misuse of prescription drugs and alcohol, particularly among male respondents. New Jersey's 19 DMHAS-funded prevention coalitions are addressing issues regarding the misuse of alcohol or prescription drugs among older adults through the use of appropriate environmental programs and strategies.

Nearly one in every four people residing in New Jersey (23.7% of New Jersey's population) is aged 55 or older. Also, compared to national statistics, New Jersey is expected to witness more significant decreases in two population groups: those under the age of 25 and those between the ages of 35-44 years. In addition, the New Jersey population will age more rapidly than the country as a whole. That is, since 2006, New Jersey has experienced a higher percentage point change in the 75 and older age group.

In 2017, DMHAS utilized STR funds to develop the Alternative Approaches to Pain Management program for older adults. The programs provide information about managing acute and chronic pain with means other than opioid analgesics: NSAIDs, massage, yoga, nerve blocks, etc. The program is currently funded by SOR and is provided in 20 of 21 NJ counties.

Student Athletes. A major component of New Jersey's SPF Rx project focuses on young athletes. A toolkit called "Tackling Opioids through Prevention for Athletes" (TOP) was developed by the New Jersey Prevention Network for use by providers. Literature suggests that when young athletes are prescribed opioid pain relievers for sports-related injuries, there is a risk of addiction and medication misuse. The 19 county coalitions that were established by DMHAS use the TOP to provide education regarding this issue to coaches, parents, prescribers, and young athletes.

Deaf and Hard of Hearing. The Alcohol and Drug Abuse Program for the Deaf, Hard of Hearing and Disabled and a Program Advisory Committee were established pursuant to PL 1995, c.318 (NJSA 26:2B-36 to 39) and continue to meet on a quarterly basis to ensure quality substance abuse treatment services are provided to individuals who identify as being Deaf, Hard of Hearing or disabled in the community. Annualized funding of $350,000 is provided for prevention, education, treatment, intervention, communication accessibility, and advocacy services for the population of individuals who are deaf, hard of hearing, and/or disabled. Communication accessibility is coordinated to provide sign language interpreters or Computer Assisted Real-Time Translation (CART) for individuals who are identified as deaf or hard of hearing seeking substance abuse treatment at any level of care.

Gay, Lesbian, Bisexual, Transgendered, and Questioning. The SSA provides prevention services to Gay, Lesbian, Bisexual, Transgendered, and Questioning (LGBTQ) youth. The SSA awarded funding to the North Jersey Community Research Initiative (NJCRI) to expand their existing programs for high-risk LGBT youth of color by using a "Street Smart" prevention model developed by the Centers for Disease Control and Prevention, as well as early intervention services, social marketing, and structured recreational activities. NJCRI provides services

covering the northern NJ counties. In the spring of 2023, DMHAS (by means of a competitive RFP process) identified two additional organizations to provide services to LGBTQ persons in their communities: Prevention Resources in Central NJ and the Robert Wood Johnson-Barnabas Health Institute for Prevention and Recovery, in the south.

Tribal Community. In 2023 DMHAS developed a Memorandum of Agreement (MOA) with the New Jersey Commission on American Indian Affairs, within the New Jersey Department of State. New Jersey is home to three state (not federally) recognized tribes: Nanticoke Lenni-Lenape Indians, Powhatan Renape Indians, and the Ramapough Lenape Indian Nation.

To date, DMHAS has not collaborated with the Commission on Indian Affairs. But, under this MOA, DMHAS will provide funds (Block Grant Supplement and ARP) to enable the tribes to implement evidence-based primary prevention programs. Tribes will be instructed in the use of the Strategic Prevention Framework and will identify prevention programs or strategies that were developed by or for Native American communities. DMHAS will offer guidance and support to the tribes at their request,

Underserved Individuals. An RFP was issued in August 2022 for providers to identify an underserved special population(s) to whom they would provide direct services. Ten SUD treatment providers were awarded a contract in November 2022. The underserved populations that will be served through this initiative include: veterans and their families, older adults, LGBTQIA+, homeless Black and Indigenous, and People of Color (BIPOC), Latinos, and Spanish speaking individuals. The services are intended to assist those who have experienced difficulties and challenges accessing SUD services. Providers were required to show the specific detail on how they identified their underserved population. These targeted services should be consumer-driven and planned with the specific needs of the individual and their special population in mind. This program is being funded with SUPTRS COVID-19 Supplemental and will continue with ARPA funding.

Consumers < 350% Federal Poverty Level. The SSA has established a guideline of 350% Federal Poverty Level (FPL) for the receipt of state funded substance abuse treatment. Clients are means tested with a web-based tool, known as the DAS Income Eligibility (DASIE) prior to admission into substance abuse treatment to determine whether they qualify for public funding. Upon admission to a treatment provider, the provider is required to collect documentation to prove the financial eligibility.

Other SUBTRS Criteria (8, 9, 10)

Referrals to Treatment (Criterion 8). DMHAS utilizes the criteria set by the American Society of Addiction Medicine (ASAM) for patient placement. The tool that is utilized for assessment and placement is the Level of Care Index Version 3, which is incorporated in DMHAS administrative data system, NJSAMS. In addition, the DSM- 5 is utilized for diagnosis. The Immediate Needs Profile (INP) is used as a screening tool.

DMHAS Licensed Substance Use Disorder Treatment Providers receiving funding from the Federal Substance Abuse Block Grant Women's Set-Aside are required to conform to current New

Jersey Licensure Standards for Intensive Outpatient, Outpatient Psycho/Social, Opioid Treatment, Short Term, Long Term Residential and Halfway House Programs. Contractees must ensure that pregnant women are receiving substance use disorder treatment prenatally through post-partum. Providers are required to complete the following assessments: 1) Addiction Severity Index (ASI); 2) American Society of Addiction Medicine (ASAM) Criteria 2013; 3) Level of Care Indicator (LOCI); 4) Diagnostic and Statistical Manual of Mental Disorders (DSM5); and the New Jersey Substance Abuse Monitoring System (NJSAMS).

Contractees are required to work collaboratively with the community, other stakeholders and state systems to identify potential clients. Providers must ensure that pre-admission service coordination shall be provided to reduce barriers to treatment, enhance motivation, stabilize life situations and facilitate engagement in treatment.

Contractees must ensure that priority admission and interim services to their programs will be given to IV using, pregnant women and parenting women and publicize the fact. If a contractee is at full funded capacity and unable to admit the pregnant woman, they must refer such women to another facility or make interim services available within 48 hours. Interim services for pregnant and parenting women is designed to reduce the adverse health effects of substance use and promote individual health. At a minimum, interim services includes the following: counseling and education about HIV and Tuberculosis (TB), about the risks of needle-sharing, the risks of transmission to sexual partners and infants, and about steps that can be taken to ensure that HIV and TB transmission does not occur, as well as referral for HIV or TB treatment services. Other interim services offered to pregnant and parenting women includes individualized education, case management, referrals and MAT. if needed, while awaiting admission. If necessary, linkage to Recovery Centers and/or other recovery supports in the community, and referral and/or and referral and/or linkage to community naloxone education programs. For pregnant women, interim services also include counseling on the effects of alcohol and drug use on the fetus, as well as referral for prenatal care.

Medication-Assisted Treatment (MAT) is the standard of care for pregnant women with opioid use disorder (Treatment Improvement Protocol 43, Chapter 13). Contractees are required to ensure that pregnant women are immediately provided with or referred to comprehensive medication assisted treatment and continue this modality of treatment throughout pregnancy. If a woman wishes to continue with this modality of treatment following her delivery, it is expected that the treatment agency coordinate continuance when clinically appropriate. All women will be given timely access to prenatal care either by the program or by referral to appropriate healthcare providers.

Contractees must ensure that program staff is qualified based on professional licensing regulations and be knowledgeable in the area of gender-specific women’s substance use disorder modalities and treatment interventions. Programs are required to develop treatment plans that are family centered, provide for family input when clinically indicated, and address specific services and community support for the family. Additionally, program staff must ensure each woman receives continuity of care and is linked with recovery supports after discharge.

Programs are required to provide an array of clinical and supportive services such as transportation, child care, ensure that children will be referred for primary pediatric care (including immunizations) and/or psychological care as needed. Programs are required to provide comprehensive medical services for women including prenatal care and/or referrals and linkages to the local Federally Qualified Health Center (FQHC). Other services include life skills training designed to nurture a range of skills needed for performance of everyday tasks, to attain self-sufficiency and to sustain independent living in the community. Programs are required to assist women with housing supports and assistance by linking them to transitional, permanent and/or supportive housing and to enhance the skills necessary to maintain safe and recovery-based housing. Programs are expected to collaborate and communicate with systems that provide services to pregnant and parenting women as well as referral agencies such as child welfare, maternal health, other social service providers, etc. Programs are required to implement Plans of Safe Care to address the needs of the mother, infant and family to ensure coordination of, access to, and engagement in services.

Independent Peer Review of Treatment Services (Criterion 9). DMHAS identified three treatment service providers to be reviewed for the FFY 2022 Independent Peer Review (IPR) cycle. The treatment providers selected for review constitute five percent of those receiving FFY 2022 SUPTRS Block Grant funds and are representative of the population of such entities. A letter was sent informing the agencies that they had been selected for review. The letter also clearly defined the purpose of the IPR. The stated purpose of the IPR is to ensure continuity and quality of care delivered to individuals with substance use disorders, to improve the system of care and ensure that the IPR focus is on education and remediation rather than monitoring and enforcement. The letter indicated that participants could anticipate independent suggestions for service delivery improvement from the IPR Reviewer, and that the review would not be used by any agency for certification, licensing, compliance monitoring, funding related decisions, or for litigation purposes.

Each IPR that was conducted and completed during FFY 2022 was based, in part, on the review of a limited number of discharged patients' records, a survey questionnaire, review of treatment process, and interviews with clinicians. In addition to the records review, the staff's treatment knowledge, skills level, and attitude were analyzed by a questionnaire survey. Agency counselors were asked to present cases for review, of clients who have recently completed the program. The focus of the case review was on implementation of the treatment process. During the FFY 2022 agency selection process, the focus was outpatient and intensive outpatient methadone maintenance programs. All three reports were completed by September 30, 2022.

DMHAS will repeat the process of hiring up to three credentialed substance use disorder professionals to conduct three IPRs in the North, South and Central regions of the State by September 30, 2023. The chosen modality of the FFY 2023 IPR is long-term and short-term residential treatment programs.

Strengthening the Behavioral Health Workforce

Professional Development (Criterion 10). As part of its on-going responsibility to address areas of concern that affect service access, quality, and outcomes, the SSA provided several educational

opportunities to enhance the competency of its addiction and behavioral healthcare workforce. Through its Addiction Training and Workforce Development (ATWD) initiative, the SSA has provided scholarships for initial and renewal/recertification alcohol and drug counseling courses for behavioral healthcare professionals, alcohol and drug counselors, peers, and prevention specialists in the State of New Jersey. All training initiatives assist prospective alcohol and drug counselors with navigating the credentialing process, exam preparation, internship recruitment, and placement.

To prepare clinical staff to obtain certification or licensure, and to comply with the New Jersey Board of Marriage and Family Therapy Examiners' Alcohol and Drug Counselor Committee continuing education requirements, the ATWD contract was renewed with the New Jersey Prevention Network (NJPN). The principal goal of this initiative was to provide accessible training opportunities statewide for those entering or presently working in the addiction field. The anticipated outcome was to increase the number of credentialed and licensed employees who provide treatment, prevention, and peer recovery support services. NJPN offered alcohol and drug counseling coursework leading to certification and licensure at geographically diverse training sites across New Jersey. Training opportunities were available to individuals and in outpatient, residential, opioid use disorder, prevention, peer led recovery programs/centers, and behavioral healthcare treatment programs. Since its inception in 2006 and through March of 2023, 1,193 students trained through ATWD have become credentialed as certified alcohol and drug counselors (CADC) or as Licensed Clinical Alcohol and Drug Counselors (LCADC).

NJPN also offered continuing education trainings for clinicians and peers that included Community Reinforcement Approach to Family Therapy (CRAFT), Mental Health First Aid, Medication for Opioid Use Disorder, Substance Use and Family Systems, HIV and Bloodborne Pathogens, Diversity and Inclusion, Ethics Refresher, Law Enforcement and Peer Services, Stimulant Training, Cultural Competence, Peer Supervisor Practice, and Self-Care Strategies. In addition, NJPN offered course work leading to Clinical Supervisor and Prevention Specialist certifications.

NJPN was instrumental in assisting practitioners who, due to COVID-19, were able to apply for a temporary waiver to provide alcohol and drug counseling services through the Division of Consumer Affairs, Marriage and Family Therapy Examiners, Alcohol and Drug Counselor Committee. NJPN provided technical assistance to prospective candidates with posting requirements, answering questions, completing forms, and uploading documents. Instituted in June 2020, the temporary CADC license was awarded to individuals 192 to fill in a gap of services needed in response to COVID-19.

Peer Development. DMHAS supports the advancement of peers by offering training and professional development activities that increase and enhance the peer workforce working in recovery-based initiatives. All peers attend a three-day Ethics training. The curriculum topics include Motivational Interviewing, self-reflection, self-disclosure, racial and culturally responsive practices, understanding MOUD, outreach and engagement and outreach techniques. In addition, peers attend the five-day Connecticut Community for Addiction Recovery (CCAR) which leads to peer certification. DMHAS supports two pathways to peer certification. The International Reciprocity and Credentialing Consortium (IC&RC) NJ affiliate, the Addiction Professionals

Certification Board, issues the Certified Peer Recovery Specialist (CPRS) and NAADAC/NCC AP, the Association for Addiction Professionals, issues the National Certified Peer Recovery Support Specialist (NCPRS). To ensure DMHAS recovery programs have adequate staffing levels and that peers have equal opportunities to employment, DMHAS provides scholarships for peer training, certification, and testing fees. Since program inception, 3,304 persons have engaged in 192 training opportunities, and 553 individuals have completed all training necessary to become a Certified Peer Recovery Specialist and 200 peers have obtained certification.

DMHAS held a virtual Peer Recovery Support Summit in collaboration with NJPN on September 1, 2022 entitled, Advance-Connect-Transform, The Future of Peer Recovery Support. This event equipped 708 attendees with strategies in providing recovery support services across the continuum of care with two keynote speakers and 19 workshop sessions, featuring a total of 35 multidisciplinary expert speakers. All workshops were intentionally coordinated based on best practices that are relevant to the addiction/recovery field, cultural humility, current events, and opioid use disorders.

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

The SSA continued to build capacity among current credentialed clinical and peer professionals through its Memorandum of Agreement with The Rutgers University, Center for Alcohol Studies (CAS), Education and Training Division. During 2021-2022 CAS offered 66 highly specialized, one-day professional development seminars as well as the Emerging Addictions Conference, a daylong event addressing the triple threat of stimulants, opioids and COVID-19 in April of 2022. Both the seminars and conference offered training education hours that can be applied towards recertification or renewal for alcohol and drug counselors and behavioral healthcare professionals working within the addiction and co-occurring treatment fields. Scholarships were provided for 149 individuals to attend.

DMHAS and NJPN created two innovative professional development opportunities for peer recovery specialists, addiction counselors, and behavioral healthcare staff. The first project, “Opioid Use Disorder Commitment to Change” is an immersive simulation training experience, called “SimMersion.” SimMersion is an online flexible approach based on simulated conversations and role-plays that allow peer recovery specialists and others working in the addiction field to build skills and core competencies at their own pace while receiving on-demand feedback. By integrating an online platform which allows participants to engage in actual conversations and interventions with real individuals, the communication exchanges provide instant evaluation and coaching on Motivational Interviewing. These unique client interactive training modules focus on topic areas fundamental to peer interactions, including treatment engagement and initiation,

MOUD, recovery capital, boundaries, ethics, etc. Topics were developed with input from NJ subject matter experts, including peer specialists, to enhance best practices and evidence-based practice. Over 230 individuals participated in the SimMersion training.

With the second project, DMHAS recognized how the impact of primary and secondary stressors placed on the helping profession can impact their personal and professional wellness. As a response, DMHAS and NJPN created safe spaces to discuss issues and strategies that can assist in the overall health and well-being of individuals working in the helping profession. Supportive and professional counseling sessions were offered to 500 peers and clinical staff as a proactive response to the Coronavirus (COVID-19). In addition, realizing most peer recovery specialists are maintaining recovery themselves, NJPN created a confab platform to provide a safe, virtual supportive environment for peers to engage in an informal conversation regarding self-care. This platform was designed with a hope to create an inclusive space that embraces and honors recovery allies and peers from all multiple pathways of recovery. Approximately, 130 peers participated in the Confab.

<u>Prevention Fellowship.</u> The Prevention Fellowship Program will expand New Jersey's prevention workforce to ensure that evidence-based quality services are being provided to the diverse communities across the state. We will recruit and select a cohort of young professionals with diverse backgrounds and experience to become part of the Prevention Fellowship Program. Though NJ has worked hard to address the health disparities that exist in the state, to truly eliminate health disparities, the prevention workforce will need to help communities implement strategies that are reflective of and sensitive to the multicultural population of the New Jersey. A competent and diverse prevention workforce is essential to accomplish this goal. Yet the prevention field—like the public health field generally—has struggled to create and maintain a robust LGBTQ-inclusive, ethnically and racially diverse workforce. The NJ Prevention Fellowship Program will work to expand and strengthen the prevention workforce for the future.

The first cohort of five fellows began their fellowship in January 2023. The fellowship program was developed (in collaboration with DMHAS), and is delivered by, the New Jersey Prevention Network and includes both didactic and experiential components. The initial months of the program include participation in CADCA's Coalition Academy and coursework required for the Certified Prevention Specialist examination. The experiential component includes internships at DMHAS-funded prevention coalitions and agencies. Fellows who complete the entire program will be qualified to take the Certified Prevention Specialist examination. The first cohort recently completed the didactic phase of the program and are now beginning their internships. Interviews are currently underway to select fellows who will make up the second cohort of the NJ Prevention Fellowship program.

<u>Other Training.</u> Project Echo® (Extension for Community Healthcare Outcomes) is a national guided practice model developed by the University of New Mexico that focuses on building provider capacity across a region by connecting specialists to local providers. The heart of the model is its hub-and-spoke knowledge-sharing networks which are led by expert teams who use videoconferencing to conduct virtual clinics with community providers. In this way, primary care doctors, nurses, and other clinicians learn to provide specialty care to patients in their own communities. The Project ECHO program in New Jersey, funded through the federal Substance

Abuse Prevention and Treatment Block Grant, has been training and educating Primary Care Providers (PCPs) on substance use disorders since January, 2020. Topics focus on three critical areas of substance use disorders: specific substances, medications for opioid use disorder (MOUD) and implementation of best practices for screening, managing and treating patients in the primary care setting. In March of 2020, New Jersey's Project ECHO redirected its resources to providing ECHO sessions focused on COVID-19, Mental Health and SUD to meet the needs of those with a substance use disorder in this current environment. Although the SUD ECHO Hub team has transitioned back to its original focus, virtual clinics continue to include discussions of the COVID-19 impact on patients with a substance use disorder in its curriculum.

This ECHO provides education and training to primary care practitioners, SUD treatment providers, behavioral health practitioners, and other stakeholders in multiple clinic settings and at home, utilizing a web-based video collaboration between a multi-disciplinary team of specialists and primary care practitioners on best practices for the assessment, case management, intervention, treatment and recovery support services for PPW with an OUD. The goal is to increase the capacity and competency of providers, community support organizations and clinical teams to support prevention, treatment and recovery of PPW with OUD. ECHO will position communities to reduce the NAS birth rates, improve use of medication assisted treatment, family formation and early infant development; improve access to physical and mental health care by educating more providers, midwives, doulas, and other health care professionals on best practices during prenatal and perinatal periods. The anticipated start date for the Program was set for March 2020. However, with the advent of the global COVID-19 pandemic, and the national and state orders to shelter in place effective late March 2020, limitations on who could go to the hospital added a level of complexity to care for those mothers expecting to give birth during this time or in recovery at home. These events required an immediate response to address the public health emergency. In late March, 2020 the DMHAS agreed to postpone the traditional MCH PPW-OUD ECHO Series until such time that the providers could return to a focus on pregnant and parenting women with an OUD. The ECHO team (DMHAS, Rutgers/RWJ and Hub members) refocused resources to provide COVID-19 MCH & OUD ECHO sessions. This temporary change in scope enabled the MCH PPW-OUD ECHO team to address treatment issues, access to healthcare services and how to meet the needs of specific populations of women during this crisis. The MCH PPW-OUD Hub team completed seven COVID-19 maternal child health and OUD sessions between April and the first week of June. The MCH PPW-OUD Hub team completed seven COVID-19 maternal child health and OUD sessions between April and the first week of June, 2020, and MCH PPW-OUD ECHO with COVID-19 (included as a discussion topic) reconvened June 15, 2020 through December 2020. MCH PPW-OUD ECHO series is scheduled after July of 2021. Each series was designed as 12 bi-weekly sessions. Project ECHO series with the new curriculums took place early Spring 2022 and concluded late Summer.

DMHAS renewed the MCH PPW-OUD ECHO series with 18 sessions scheduled for early 2023 through September 2023. The curriculum will cover the following areas: screening for SUD; new guidelines for prescribing buprenorphine; starting treatment: the patient contract, pharmacy partner and social services; managing buprenorphine treatment and follow-up; opioid dependency reporting guidelines; and hot topics. In an effort to reach out to practitioners and prescribers, the first ECHO 8 sessions was scheduled for a special evening time with a focus on the latest FDA approved techniques for MAT, integrated care, and wraparound services.

DMHAS contracts with Rutgers University to implement a program called the Rutgers Interdisciplinary Opioid Trainers (RIOT). The RIOT has been designed as a train-the-trainer program by faculty who educate/train university students. The university students provide a free 1-hour training (virtual since March 2020) to community members/groups to educate them about the opioid epidemic in NJ, how to manage an overdose, and increase education and reduce stigma and discrimination about Opioid Use Disorder (OUD) and the use of medications to treat the disease.

In 2019, DMHAS entered into a Memorandum of Agreement (MOA) with both Rutgers University and Rowan University/Cooper Hospital to coordinate statewide DATA 2000 Waiver trainings for practitioners to include physicians, Advance Practice Nurses (APNs) and Physician Assistants (PAs). The State held a total of 31 trainings statewide through both Rutgers University (northern region) and Rowan University (southern region) in CY 2019 and CY 2020. Over 1,000 prescribers were trained through this effort.

DHS has contracted with two Centers of Excellence (COE) to support and advance the use of Medication Assisted Treatment (MAT) in the State. Rutgers University covers Bergen, Essex, Hudson, Hunterdon, Middlesex, Monmouth, Morris, Passaic, Somerset, Sussex, Union, and Warren counties in the northern region. Rowan University in partnership with Cooper Health cover Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester, Mercer, Ocean, and Salem counties in the southern region. Both COEs provide a 24-hour call line, website information, a listserv for prescribers, prescriber training and support opportunities, a Project Echo, navigator support and trainings, coffee clubs, MAT lunch hours, links to toolkits and best practice resources. In addition, both COE serve individuals seeking treatment and MAT for opioids, alcohol or other substances.

Opioid Summits. In September 2019, DMHAS held its first annual Opioid Summit to address the stigma and misinformation surrounding Opioid Use Disorder (OUD) and to enhance the understanding of treatment options, such as Medication-Assisted Treatment (MAT). The Summit was held in-person at the Atlantic City Convention Center in Atlantic City, NJ on Friday, September 20, 2019. The theme of the Summit was "*Saving Lives & Changing Perceptions: Medication-Assisted Treatment*". The Summit keynote speaker was Sam Quinones, author of *Dreamland, The True Tale of America's Opioid* Epidemic. In addition to the keynote, individuals attended three panels, one with State officials, one with medical professionals discussing MAT in NJ, and one panel discussing how we could change the perceptions of OUD in our communities. After those panels, individuals were able to choose two different workshops to attend in the afternoon. Topics included integrating MAT in to opioid treatment, educating families on opioid treatment and OUD, opiate use guidelines in the justice system, public safety response to the opioid epidemic, MAT in emergency departments, MAT in jails and prisons, and innovative approaches to improve OUD treatment.

The Summit had over 500 attendees and the audience was comprised of medical professionals, family members, government officials, professional counselors, and other stakeholders. Continuing Medical Education Credits and Continuing Education Units were provided for medical and counseling professionals, respectively.

Unfortunately, due to the COVID-19 pandemic, DMHAS did not hold an Opioid Summit in 2020.

In 2021, DMHAS switched to a virtual conference. The summit was held over the course of two half-days on September 21st and September 22nd. The theme for the Summit was "*Medication for Opioid Use Disorder: Increasing Access and Saving Lives*". The 2021 Opioid Summit showcased the initiatives New Jersey had developed that aim to increase access to medications for opioid use disorder (MOUD), increase awareness against stigma/discrimination, and support the efforts of integrative care across the spectrum of recovery. The purpose of the Opioid Summit was to present relevant, research-based information to professional counselors, addiction professionals, medical professionals, nursing professionals, social workers, peers, family members, and other community stakeholders. Topics addressed at the Summit included the impact of COVID-19 on OUD, best practices for the use of MOUD as a tool in recovery, OUD and stigma, OUD and mental health, harm reduction, innovative, evidenced-based and best practices for OUD treatment, recovery support systems, and OUD treatment and support services populations such as the Deaf and Hard of Hearing community.

Due to this Summit being two days, we had two separate keynotes present. On the first day, Actress Marlee Matlin told her story of addiction and being a Deaf actress. The keynote speaker on the second day was Dr. Wilson Compton, the Deputy Director of the National Institute on Drug Abuse (NIDA). Dr. Compton spoke about NIDA and what they are doing to improve prevention and treatment of drug abuse and addiction. In addition to the keynotes, individuals attended one panel as well as a workshop session each day. The panel on day 1 discussed the collaboration of State Departments to mitigate the opioid overdose epidemic. The panel on day 2 discussed low-barrier approaches to MOUD and harm reduction strategies. Registrants were able to go back to the website and watch, or re-watch, the sessions on-demand after the summit was over.

Attendance for the 2021 summit was higher than 2019 due to the two half-day format. In total, there were about 1,400 registered for the two-day event. The audience was comprised of medical professionals, family members, government officials, professional counselors, and other stakeholders.

In 2022, DMHAS kept the summit virtual due to the success of the 2021 summit. The 2022 Opioid Summit was a one-day event on September 21, 2022. The theme for the 2022 Summit was "*The Evolving Opioid Crisis: A Collaborative Approach*". The purpose of the summit was to highlight the collaboration between various providers in New Jersey to treat Opioid Use Disorder. The 2022 Opioid Summit focused on topics including OUD and stigma, harm reduction and OUD treatment, supports for vulnerable populations such as older adults and the LGBTQIA+ community, the impact of COVID-19, trends within drug abuse, contingency management, advocacy for health equity, and integrating peers in to the system of care. The keynote speaker was Dr. Daniel Schneider, a pharmacist from Louisiana who lost his son to a drug deal gone wrong. The Netflix Docuseries, *The Pharmacist*, tells his family's story. In addition to the keynote, individuals attended two panels. The first panel was an update from State Department officials on their programs and efforts to mitigate the opioid crisis. The second panel showcased several recovery support programs and discussed their approaches to assist those suffering from an OUD. This panel included representatives from Telephone Recovery Support, Community Health Center of Asbury Park, STAR Program, Oxford House and NJ Association for the Treatment of Opioid Dependence

(ATOD). Since this summit was virtual, registrants had the ability to go back and watch, or re-watch, any of the sessions for a six-month period.

Attendance for the 2022 Opioid Summit was just over 700 individuals. There were attendees from Virginia, Pennsylvania, Texas, Delaware, Maryland and New Jersey. The audience was comprised of medical professionals, family members, government officials, professional counselors, and other stakeholders.

DMHAS is in the midst of planning for the 2023 Opioid Summit themed "*Revitalizing Communities: Healing Together from the Opioid Crisis*". The summit will be held as a one-day virtual conference on September 20, 2023. Topics for the workshops and panels include, but are not limited to, fentanyl and Xylazine, integrated health programs, harm reduction, NJ recovery services, grief supports, chronic pain community and treatment, stigma surrounding OUD, and Law Enforcement and First Responder addiction support programs. The Summit will be comprised of a keynote speaker, two panels, and workshop sessions. Continuing education credits will be offered in the form of CMEs and CEUs.

How These Systems Address the Needs of Diverse Racial, Ethnic, Sexual, and Gender Minorities

The population in New Jersey is diverse in its ethnic and cultural makeup, and several counties have significant minority ethnic populations. Staff providing services must be culturally competent, and education must ensure consumer access. Substance use disorder agencies are required to adhere to licensing standards that require culturally competent services. The state has not announced specific goals in regard to the Patient Protection Affordable Care Act (PPACA), but it has been actively working to promote structures to support the medical home component, and these are required to be culturally competent and meet the needs of a diverse population.

New Jersey's ongoing efforts to fully develop a community-based, client-centered, recovery-oriented, continuum of care that includes prevention, early intervention, treatment and recovery support services are based upon its ongoing needs and capacity assessment activities. These efforts incorporate standards established by state law and federal policies promulgated by SAMHSA. For example, the aforementioned NJ P.L. 1989, Chapter 51 stipulates that the needs of youth, drivers-under-the-influence, women, persons with disabilities, workers, and offenders committing crimes related to substance abuse are given special attention in all county plans. The SSA gathers data from many state administrative databases and reports to provide counties with the data necessary to describe the needs of these particular groups.

All DMHAS-funded prevention service providers (coalitions as well as organizations that provide individual and family curricula) are contractually-required to adhere to the standards listed below. Adherence to these standards is monitored as a component of the annual contract site visit conducted by DMHAS.

1. Promote and support the attitudes, behaviors, knowledge, and skills that are necessary to work respectfully and effectively with clients and each other in a culturally competent work environment.

2. Have a comprehensive management strategy to address culturally and linguistically appropriate prevention services, including strategic goals, policies, procedures, and designated staff responsible for implementation.
3. Develop and implement a strategy to recruit, retain, and promote qualified, diverse and culturally competent prevention staff that are qualified to address the needs of the communities being served.
4. Require and arrange for ongoing training for prevention staff in culturally and linguistically competent service delivery.
5. Provide all clients with limited English proficiency (LEP) access to bilingual prevention staff or interpretation services.
6. Provide a Registries of Interpreters for the Deaf (RID) Certified Interpreter for Deaf or hard of hearing participants when requested as required by the ADA. (American with Disabilities Act).
7. Provide oral and written notices, including translated signage at key points of contact, to clients in their primary language informing them of their right to receive no-cost interpreter services.
8. Translate and make available signage and commonly-used written client educational material and other materials for members of the predominant language groups in service areas.
9. Use a variety of methods to collect and utilize accurate demographic, cultural, epidemiological and clinical outcome data for racial and ethnic groups in the service area, and become informed about the ethnic/cultural needs, resources, and assets of the surrounding community.

In an effort to ensure that the services funded by DMHAS ensure diversity, inclusion, equity, and cultural and linguistic competence to the target population, DMHAS has included cultural competency requirements in its RFPs. In their proposals, bidders must describe their ability and commitment to provide culturally competent services (CLAS Standards) and diversity (Law against Discrimination, N.J.S.A. 10.5-1et seq.) and submit a cultural competency plan as an attachment. In addition, bidders must describe program efforts to recruit, hire and train staff who are from or have experience working with target population and their strategy to address topics related to diversity, inclusion, cultural competence, and the reduction of discrepancies in the access, quality, and program outcomes, which includes information on implicit bias, diversity, recruitment, creating inclusive working environments, and providing languages access services.

<u>Multi-cultural Services Group.</u> The Division of Mental Health and Addiction Services (DMHAS) within the New Jersey Department of Human Services (DHS) has a long standing commitment to culturally and response care and addressing the unique mental health needs of multicultural populations. The DMHAS defines cultural competence as: "… the ability to honor and respect the beliefs, languages, interpersonal styles and behaviors of individuals and families receiving services, as well as staff members who are providing such services. Cultural competence is a dynamic, ongoing developmental process that requires a long term commitment and is achieved over time" (HHS 2003a, p. 12).

The DMHAS Multicultural Services Advisory Committee (MSAC) formed in 1981. Its mission is to address issues of the quality of mental health and addiction services provided; the quantity of

services provided; staffing levels, qualifications and training. Additionally, the MSAC devises strategies that are appropriate to the lifestyles, special needs and strengths of New Jersey's diverse minority and cultural groups such as administrative strategies, service delivery system strategies, education strategies and appropriate direct care strategies. MSAC members include representatives from the community and academic arenas as well as division participants.

In Fiscal Year 2012, the DMHAS committed funding and resources to enhance and improve culturally responsive and culturally competent service delivery to consumers via the development of two Regional Mental Health Cultural Competence Training Centers. These Centers provide knowledge, training, technical assistance and serve as a resource regarding multicultural issues in mental health and addiction. More specifically, their major initiatives include the following.

- Developing and reviewing needs assessments relating to the cultural competency of the DMHAS system of care.
- Providing technical assistance to the DMHAS mental health and addictions agencies in the implementation of an agency cultural competence plan based on the information from both SAMHSA and CSAT TIP 59.
- Providing accredited trainings that match the cultural and linguistic competencies, skills and needs of staff.

In Fiscal Year 2018, the DMHAS committed funding and resources to develop a Multicultural Diversity and Statewide Consultant. This individual provided consultation, technical assistance, training and services as a statewide resource for DMHAS contracted mental health and addiction providers on issues relating to culture, language, and diversity in the DMHAS system of care.

In 2019, DMHAS with the assistance of the Cultural Competency Center and the Cultural Competency Consultant required all DMHAS contracted SUD agencies to submit a Multicultural Competency Plan for their agency. As of 2020, there is a 45% compliance for the submission of the plans.

Promoting/Integrating Health and Behavioral Health

<u>Smoking Cessation.</u> DMHAS has focused on a broad plan to reduce smoking rates in individuals with mental illness and or substance use disorders (SUDs). DMHAS continues to contract with the Robert Wood Johnson School of Medicine, for technical assistance from Dr. Jill Williams, who is an addiction psychiatrist and a nationally recognized leader in treating tobacco dependence in individuals with mental illness and addiction. DMHAS is also funding a consumer-driven program called CHOICES that has peer educators who go to mental health programs around the state to increase consumer awareness about the negative impact of smoking and to help with efforts to quit or reduce their tobacco use.

In 2017, DMHAS coordinated a State Strategy Session/Leadership Academy for Wellness and Tobacco-free Recovery, which allowed collaborative planning with the Department of Health (DOH), the Department of Children and Families (DCF), and other state and county agencies. Some of the initiatives that increased understanding and awareness about the impact of smoking on those with mental illness and /or SUDs; in addition, a variety of steps were taken to address

smoking, which included an increase in Medicaid coverage for smoking cessation. While many elements of the plan were stalled, DMHAS held a follow-up of the State Strategy Session/Leadership Academy Recovery in late July 2019 that reinvigorated these activities and opened the discussion with the NJ Department of Health (DOH).

Thus, the recent efforts have been the result of a collaboration between DMHAS began to and the Office of Tobacco Control in the NJ DOH, which has had a number of new smoking cessation projects funded by a 1% set aside from tobacco tax. This tax has funded 11 quit centers in the state, as well as prevention grants, a collect campus NJ QUITS initiative, and mini grants for colleges to create some smoke-free policies. A grant from the Association of State and Territorial Health Officials (ASTHO) has allowed DMHAS to establish a formal "community of practice" (CoP) with the Office of Tobacco Control in the NJ Department of Health (DOH) that aimed to develop a plan to promote smoking cessation among clients with behavioral health disorders. The CoP has expanded use of Quitline and Quit Center resources, trained behavioral health provider to provide smoking cessation interventions, and promoted smoke-free treatment environments. In formal discussions with the Quit Centers, arrangements were made to send referral packets to the DMHAS provider community so that the programs would know how to make referrals to the centers. DMHAS has also partnered with the Quit centers and Smoke-Free NJ to provide webinars on the '2As and an R' (Ask, Advise, Refer) so that the behavioral health agency staff can work more effectively to get clients to make use of cessation services.

As part of the CoP, NJ DOH provided DMHAS with funding to train 52 behavioral health staff as Certified Tobacco Treatment Specialists (CTTSs) in 2022, and discussions are underway to use DMHAS funding to train another 50 staff in the Fall, 2022 and in 2023. Efforts are underway to survey the trained staff and to determine whether the training has increased their effectiveness in providing tobacco cessation activities. As part of this effort, DMHAS is surveying agencies to see what barriers exist to providing more onsite tobacco cessation services, and it is developing a toolkit for behavioral health services to address tobacco use, which will focus on providing smoke-free environments and .the provision of on-site tobacco use treatment.

In addition, smoking cessation services continue to be incorporated into various DMHAS initiatives to address the opioid epidemic. The New Jersey Substance Abuse Monitoring System (NJSAMS) is a treatment database that collects data on client tobacco use and smoking cessation treatments. NJSAMS is providing valuable data about the efforts to address tobacco use in addiction programs, but no such data exists for the mental health programs. Some DMHAS initiatives and grant-funded programs continue to promote medications for smoking cessation in behavioral health and affiliated medical settings. These include the programs involved in the Division's Promoting Integration in Primary and Behavioral Health Care grant and the Certified Community Behavioral Health Clinics (CCBHCs), among others.

<u>Medical Director's Integration Office.</u> DMHAS' Medical Director's Office has an Integration Unit with the goal of promoting integration between behavioral health agencies and primary health care providers. DMHAS works closely with the NJ DOH on a variety of initiatives to increase bi-directional integration. Please see "Roles of Other State Agencies with Respect to the Delivery of SUD Services/Interdivisional and Interdepartmental Collaboration" for details of the collaboration. DMHAS works with its partners at the Division of Medical Assistance and Health

Services to address billing and eligibility requirements that effect integrated care. The main goal of the collaboration is to increase consumers with mental health and/or substance use disorders (SUDs) access to primary care and improve collaboration between behavioral health agencies and primary health care providers.

Certified Community Behavioral Health Clinics. DMHAS was selected to be one of the eight Certified Community Behavioral Health Clinic (CCBHC) demonstration states. The NJ CCBHC demonstration providers began services in July 2017. This project is a collaboration between the Department of Human Services' Division of Medical Assistance and Health Services (DMAHS) and DMHAS and the Department of Children and Families (DCF). This demonstration is part of a wider effort to integrate behavioral health with physical health care, increase consistent use of evidence-based practices, and improve access to high quality care for people with mental and substance use disorders. There are seven behavioral health providers that are part of NJ's demonstration and that have been certified as CCBHCs by the DMHAS. Many CCBHC provider outcomes continue to improve year after year and some of NJ's providers outperform the HEDIS measures.

Promoting Integration of Primary and Behavioral Health Care (PIPBHC). In March of 2020 NJ was awarded a SAMHSA Promoting Integration of Primary and Behavioral Health Care (PIPBHC) grant. The goal of this project is to provide integrated care that serves individuals with an opioid use disorder (OUD) and other health co-morbidities. Sterile Syringe Programs, in NJ, called Harm Reduction Programs, are an integral part of this program and will provide an additional referral source. The grant program ends in March 2025 and DMHAS is working with providers and partners to sustain the integrated services.

Office Based Addictions Treatment. The Office Based Addictions Treatment (OBAT) initiative, rolled out in 2019, is based on the "hub and spoke" approach. In this model, specialty SUD clinics, such as the opioid treatment programs (OTPs) serve as the 'hubs' and treat patients with more complex needs; meanwhile, the 'spokes' are small office based practices and primary care settings where patients with more routine treatment needs are treated. Office-based practitioners (e.g., family physicians, psychiatrists, medical specialists, advanced practice nurses and others) prescribe buprenorphine and naltrexone, and they would have to either make referral arrangements or directly provide counselling for the patients. As of March 2023, there were 129 Medicaid-approved OBAT providers.

To assist OBAT practitioners, Medicaid provides a bundled rate for this services which includes a cost for a patient navigator, whose role is to arrange social services and supports for patients and to help monitor their progress. The OBAT system of OUD services, also referred to as the MATRx, allows a two-way referral of patients with other Medicaid funded providers. Office-based providers can refer patients needing a higher level of medical and /or addiction services to specialty providers (e.g., substance use treatment agencies, certified community behavioral health clinics, federally qualified Health Care centers, etc.) or to one of two Centers of Excellence (COEs). DMAHS contracted with Rutgers University and Cooper/Rowan Universities to serve as COEs for the OBAT initiative. In addition to providing MAT services, these Centers are available for treatment and consultation referrals of individuals with complex needs. Because many practitioners were without extensive experience with prescribing buprenorphine, and support was

needed to maintain a MAT practice, the Centers also provided MAT training through CY 2020 to assist prescribers attain their Buprenorphine Waiver. The waiver requirement was permanently removed in December 2022, so any provider who is registered with the DEA to provide controlled substances can now provide buprenorphine.

Beginning in 2023, FQHCs may bill for the OBAT intake assessment and peer services outside of their current encounter payment system. This provides additional support to Federally Qualified Health Centers (FQHCs) who are providing peer services intended to connect members with community behavioral health supports offered outside of the FQHC.

Single MH/SUD License. DMHAS is working with the Department of Health licensing office to comment on ambulatory regulations that act as barriers to integrating services, with the goal of streamlining the regulations and increasing integration of services. The plan is to develop a single, unified ambulatory care regulation that will remove current barriers and allow integrated services to operate seamlessly.

System Improvements

SUD Promoting Interoperability Program (PIP). Health Information Technology (HIT) and Electronic Health Records (EHR) are critical elements in New Jersey's strategy to address the substance use disorder (SUD) and opioid use disorder (OUD) crisis. Due to limitations in federal statute, SUD/OUD providers have generally not been able to participate in the federal Promoting Interoperability Program or meaningful use incentive programs. To promote interoperability between behavioral health and physical health providers caring for SUD/OUD individuals, the State of New Jersey made available a total of $5.4 million in funding for a milestone-based SUD provider incentive program. Implementing EHR technology allows behavioral health providers to efficiently capture and store data in structured format that, with the proper privacy and security processes in place, can be easily retrieved, shared and transmitted to assist in patient care, monitoring and recovery. Among a host of benefits, the behavioral health provider adopting an EHR will have the ability to: (1) gather, analyze and report clinical and operational data; (2) prepare for and demonstrate interoperability to a Health Information Exchange (HIE) and associated use cases; (3) generate electronic prescription and connect to a Prescription Drug Monitoring Database (PDMP) and (4) collect and transmit information to the NJ Substance Abuse Monitoring System (NJSAMS).

In order to make meaningful progress in connecting residents of New Jersey being treated for SUD/OUD, clinical information needs to be portable between SUD clinics, hospitals, and other providers. This will allow all types of providers caring for patients to be armed with the latest clinical information on a patient, enhancing care quality and appropriateness at all sites and avoiding inappropriate or duplication of care.

This requires meaningful investment in the IT infrastructure of SUD clinics, which Governor Murphy intended to provide with these funds. This will not only serve the purpose of modernizing systems; it is intended, specifically, to connect siloed systems of care to each other, to enhance care coordination and quality. In addition, these investments present an opportunity to allow for EHRs in SUD clinics to better align with workflow barriers and needs at the point of care.

This program was originally administered by the New Jersey Department of Health (DOH) in collaboration with the New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS) and the Division of Mental Health and Addiction Services (DMHAS). An MOA is under preparation and administrative oversight will be managed by the Department of Human Services. Funding is available to participating SUD provider entities on a first-come, first-serve basis through New Jersey Institute of Technology (NJIT) and its New Jersey Innovation Institute (NJII), formerly NJ-HITEC, the designated state entity that manages the New Jersey Health Information Network (NJHIN). The program will be extended to 6/30/2024.

The SUD provider must meet the following criteria to be eligible to participate in the program.

1.1.1 A non-profit or for-profit entity or governmental entity.
1.1.2 A Medicaid provider and have adjudicated claims from Medicaid.
1.1.3 Licensed by the Department of Health's Certificate of Need and Licensing (CN&L) to provide SUD treatment prior to the start of services.
1.1.4 Have at least 1 SUD admission during the prior CY which is documented in NJSAMS.

The program anticipated that there would be two categories or tiers of SUD providers that will be able to participate.

1.1.5 Tier 1 providers are SUD providers who currently do not have an EHR and will be implementing a new EHR.
1.1.6 Tier 2 providers are SUD providers who currently have an EHR but will be upgrading to an Office of the National Coordinator for HIT (ONC) Certified EHR Technology (CEHRT).

As SAMHSA notes, grantees that provide clinical services are encouraged to demonstrate ongoing clinical use of an EHR. The SUD PIP program reinforces this and requires participants to use a certified EHR that has been approved by the Office of the National Coordinator (ONC). Our program requires a 2015 ONC certification for adopted EHRs.

Incentive payments are disbursed by NJII to participating providers after the achievement of milestones as defined below. The State reserves the right to revise the milestone definitions based on current or future system capabilities and/or overall program milestone achievement progress. Designated personnel from the State will review all supporting document and approve incentive payments. The State will have an option to implement an attestation application to allow participating SUD providers to register and submit attestation information. All milestones are expected to be achieved over a two-year funding period.

Milestone 1 – Participation Agreement / EHR Vendor Contract Agreement $5,000
Milestone 2 – EHR Go-live / Upgrade $20,000 / $7,500
Milestone 3 – NJHIN/HIE Connectivity $7,500
Milestone 4 – PMP Connectivity $5,000
Milestone 5 – NJSAMS Connectivity $5,000

If all five milestones are achieved, the total amount of incentive payment a Tier 1 participating SUD provider may potentially receive is $42,500, while a Tier 2 participating SUD provider may potentially receive $30,000. The goal is to have 120 providers participate. There have been 204 applications sent. As of June 2023, there are 104 qualified agencies participating in this project. In terms of milestones, 95 have achieved Milestone 1, 67 achieved Milestone 2, 38 achieved Milestone 3, and 42 achieved Milestone 4.

A webinar was held in September 2020 with over 60 attendees. While the program was due to expire in March 2021, it was recently extended to June 2024. The New Jersey Association of Mental Health and Addiction Agencies (NJAMHAA) is providing technical assistance and developing learning collaboratives.

Discussions are underway to expand the milestone program. Potential new milestones may include behavioral e-consent and the use of telehealth.

Health Information Technology. In addition to its SUD PIP program described above, DMHAS implemented a *DMHAS SUPTRS COVID 19 Supplemental Reimbursement Program* (DSCOVRS) program to allow SUD providers to enhance their information technology infrastructure needs. The technology is to improve access to and coordination of SUD prevention, intervention, treatment and recovery support services consistent with the provisions of HIPAA and 42 CFR, Part 2. Providers are allowed to request up to $20,000 for this purpose. One of the options we have promoted is the use of interactive communication technologies (ICT). Our partner NJAMHAA has hosted webinars for our providers to see various recovery support apps that are currently on the market.

Pay for Performance. Incentivizing provider performance or paying for performance (P4P) is an approach being explored to achieve better health and or behavioral health outcomes for clients. However, the literature suggests that few organizations use P4P to improve clinical outcomes directly. DMHAS has implemented a program, described below, to incentivize the provision of MAT in Long-term Residential facilities.

Long-Term Residential Incentive Payment. Another new innovation is paying Long-term Residential treatment agencies for providing Medication Assisted Treatment (MAT) to clients. Effective June 1, 2020, the Long-term Residential (LTR) base reimbursement rate was increased as well as the ability to pay for MAT and MAT related services. On August 20, 2021, the Department of Health (DOH) issued Guidance 7-2021 that reported Long Term Residential (LTR) facilities do not need to seek approval from DOH to prescribe medication, other than Methadone, for the treatment of substance use disorders. As a result, effective October 15, 2021, the base rate for Long Term Residential [H0019HF] includes the MAT add-on of $5.00 per unit and increased to $152.60 per day inclusive of Room and Board.

Beginning July 1, 2020, additional incentive payments became available for the utilization of MAT and MAT capacity in LTR. The incentive rate creates the capacity to prescribe and administer MAT, which minimally includes Buprenorphine, but also may include Naltrexone and other FDA-

approved products for Opioid Use Disorder (OUD) and for Alcohol Use Disorder (AUD). The rates and incentives are structured as follows.

1) The increased base LTR treatment rate with the MAT add-on plus Room and Board per diem.

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

   To qualify for the incentive rates, Medicaid and DMHAS will determine a 40% MAT utilization rate through NJSAMS reporting at client discharge. This benchmark is measured as those individuals who are medication-eligible who receive qualifying medications as reported in the NJSAMS Discharge data. The measurement will include all discharges, including duplicated and unduplicated individuals.

	Base Rate	MAT Add-on	40 % threshold	Room & Board	Tier Total Including Room & Board
LTR Rate	x	x		x	152.60
LTR Incentive Payment	x	x	x	x	162.60

.

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

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

Treatment Provider Performance Reports. The Senate and General Assembly of the State of New Jersey enacted an Act concerning substance use treatment facility performance (N.J.S.A. 26: 2G-38.) requiring the annual preparation of a "Substance Use Treatment Provider Performance Report". The performance report shall show and compare the overall performance of each substance use treatment provider in the State with the Statewide average performance based on national outcome measures for each level of care. The division shall use the national outcome measures (NOMs) identified below and, as appropriate, any other national outcome measures identified by the Substance Abuse and Mental Health Services Administration. The performance report shall include the following national outcome measures: (1) percentage of clients abstinent

from alcohol on admission and discharge; (2) percentage of clients abstinent from drugs on admission and discharge; (3) percentage of clients employed on admission and discharge; (4) percentage of clients enrolled in school or a job training program at admission and discharge; (5) percentage of clients who are homeless on admission and discharge; and (6) average length of client treatment.

The performance report includes data on number of admissions and discharges, length of stay in treatment and performance on the national outcome measures for each provider as well as statewide performance. The domains of focus are: abstinence, employment, education/training, stability in housing and retention in treatment. The report is broken out by the level of care provided. Outcomes are only reported if the agency had at least 20 discharges. The outcomes are based on data for the same client. That is, all discharges were selected for the reporting year and then the admission information for that discharge was linked in order to compute the outcome measures. By publically reporting these outcomes, the DMHAS hopes to provide consumers with information on the outcomes achieved so they can make informed decisions about choosing a provider and helps providers see how they are doing compared to their New Jersey peers and to the state so that they can identify areas that might need improvement. These performance reports are one strategy that DMHAS has adopted in its continuous quality improvement efforts focused on helping to improve services to the clients we serve. The NOMs are one way to monitor client outcomes, help direct system improvements and achieve better accountability.

State Outcome Measures. The State Outcome Measures (SOMs) is a system created that simplifies the Provider Performance Reports into a single, sortable file for counties to evaluate the performance of contracted providers. The SOMs scores were created to provide county directors with a tool to help them review providers for their programs in the AEREF. The county directors use the scoring to evaluate the performance of their current contracted providers. In addition, they also to help them choose which providers they would like to purchase for new programming in their planning. On occasion, counties have discontinued contracts with providers, influenced by poor performances seen in their SOMs scoring over a span of a couple years.

The SOMs scores range from 1-4, worst to best. The system uses the percentiles of five categories which are the following.

- Alcohol Abuse: Absolute Percentage change of clients abstinent from alcohol at admission vs. discharge
- Drug Abuse: Absolute Percentage change of clients abstinent from other drugs at admission vs. discharge
- Employed: Absolute Percentage change of clients employed at admission vs. discharge
- Job Training: Absolute Percentage change of clients enrolled in school or job training at admission vs. discharge
- Arrested: Absolute Percentage change of clients arrested in prior 30 days at admission vs discharge
- Homeless: Absolute Percentage change of clients homeless at admission vs. discharge

The formula to calculate the SOMs scores requires taking the average of the five categories for each provider, which is called the Agency average. Then, the average and standard deviation of the Agency averages of those providers are taken together within their respective level of care (LOC) to create the LOC average and LOC standard deviation. The LOC average is subtracted from the Agency average to yield a difference (Agency Average – LOC Average). The differences are put against the LOC standard deviation to determine the rank the score of each provider. A set of determinants, (TRUE or FALSE functions) are used to place the scores from 1-4. Essentially, the lower the difference against the LOC standard deviation, the lower the SOM score. The higher the difference against the LOC standard deviation, the higher the SOM score. Each provider is only scored in competition with other providers within their LOC.

Financing Strategies. The SSA has explored financing strategies involving payment for an episode of care. Since the SSA has a fee-for-service billing system for many of its treatment initiatives, it has the data available to conduct this analysis. Costs by episode for the different initiatives by the level of care initially entered are analyzed to support fiscal planning. The analysis has indicated the episode costs vary widely across initiatives even though they start at the same level of care. These data have helped inform the SSA in developing benefit management strategies for high cost services such as residential with the goal of ensuring that individuals get the right service at the right time in the right amount (as per SAMHSA's recommendation). Maximizing the appropriate use of services in the most cost-effective manner, allows the SSA to provide more services to clients in need and helps reduce the treatment gap between met and unmet demand.

Quality Reporting. The purpose of the Certified Community Behavioral Health Clinic (CCBHC) is to provide ready access and an expansive scope of services to clients who present with behavioral health concerns and most often present with needs in multiple life domains. The CCBHCs offer services within an integrative, holistic framework, thereby closing a treatment gap that frequently results in inadequate service provision for individuals with co-existing social, physical and behavioral health care needs.

New Jersey selected seven CCBHCs in six counties, including six CCBHCs in five metropolitan counties plus one provider in a rural pocket of Atlantic County. The CCBHCs include: Care Plus in Bergen County; Northwest Essex in Essex County; Catholic Charities and Oaks Integrated Care in Mercer County; Rutgers UBHC in Middlesex County; CPC Behavioral in Monmouth County; and AtlantiCare in Atlantic County.

New Jersey's CCBHCs are expected to: decrease the time from patient's initial outreach to first appointment, increase access to a wide scope of mental health services, meet treatment gaps for individuals with substance use disorders, expand the use of mental health and substance use peer supports, and increase use of evidence-based practices such as Medication Assisted Treatment (MAT). New Jersey's CCBHCs offer 24-hour crisis care, treatment for co-occurring substance use disorder and mental illness, ambulatory and medical withdrawal management, evidence-based outpatient counseling, case management, and family support services.

SAMHSA identified 22 standardized variables based on the above domains of service that will be used to measure the aggregated impact of the CCBHCs, including six measures that may qualify for a quality bonus payment. If a CCBHC reports all six quality bonus payment measures, it will

receive a QBP for meeting or exceeding national standards established by the Healthcare Effectiveness Data and Information Set (HEDIS).

Nine of the measures are clinic level which means they are reported by the individual CCBHC clinics. Listed below, they include time to evaluation along with eight preventive care and screening measures for adults and children.

- Time to Evaluation
- Adult and Child Body Mass Index
- Tobacco Use
- Unhealthy Alcohol Use
- Adult and Child Major Depressive Disorder/Suicide Risk Assessment (QBPs)
- Screening for Clinical Depression and Follow-up
- Depression Remission at Twelve Months

Thirteen of the measures are state level measures which are primarily reported using Medicaid claims data. These measures, listed below, include Uniform Reporting System housing status and consumer satisfaction, information about follow up after emergency department visits and hospitalizations, adherence to medications, and alcohol and other drug treatment.

- Housing Status
- Adult and Youth/Family Patient Experience of Care
- Follow-up After Emergency Department Visit
  - Mental Illness
  - Alcohol and Other Drug Dependence
- Plan All-Cause Readmissions Rate
- Diabetes Screening for People with Schizophrenia or Bipolar Disorder Using Antipsychotic Medications
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia (QBP)
- Adult and Child Follow-up After Hospitalization for Mental Illness (QBPs)
- Follow-Up Care for Children Prescribed Attention-Deficit Hyperactivity Disorder Medication
- Antidepressant Medication Management
- Initiation and Engagement of Alcohol and Other Drug Dependence

In addition to the 22 measures required by SAMHSA, New Jersey created seven variables that are used to measure the local impact of the specialized substance use disorder services implemented at the CCBHCs in New Jersey. The New Jersey-created measures are listed below.

Scope of services:

- Unhealthy Drug use-screening and cessation intervention
- Targeted case management
- Peer recovery support while in treatment
- Family support services
- Supported employment services

- Medication-assisted treatment (MAT) for individuals with Opioid Use Disorder (OUD)

Access to services:

- Number/percent of treatment admissions by target group

Care Coordination and Identification of Co-occurring Conditions. Care coordination through case management has been described as the "linchpin" of the person-centered CCBHC model. Care coordination within the integrated care model allows for the coordinated treatment of substance use disorders and mental health conditions as co-occurring diagnoses among a subset of the mental health population who are also identified with a substance use disorder. Through systematic screening, the CCBHCs identified and provided brief cessation counseling and referral to 3,456 consumers who screened positive for unhealthy drug use in Demonstration Year 4 (July 1, 2020 to June 30, 2021), the latest period for which CCBHC data are available. Of those identified with unhealthy drug use in DY4, 29% had a ***primary*** Serious Mental Illness diagnosis. Similarly, of the 800 clients served during Demonstration Year 4 with Medications for Opioid Use Disorder (MOUD), 29% had a ***primary*** SMI diagnosis. CCBHC data consistently indicate the integrative treatment model embodied in the CCBHC appears to promote effective screening, access to, and *coordination* of care for clients with needs in multiple behavioral healthcare domains.

OPIOID Settlement Funds

New Jersey joined the nationwide settlement agreements with New Jersey-based Johnson & Johnson and the country's three largest pharmaceutical distributors – McKesson, Cardinal Health, and AmerisourceBergen – to resolve claims involving their roles in fueling the country's opioid crisis. The nationwide settlement agreements include lists of approved uses, which are incorporated into a Memorandum of Understanding announced on March 11, 2022, entered between the State and its counties and municipalities. The Memorandum of Understanding sets forth that almost all of the $641 million New Jersey will receive will be divided evenly—with 50 percent going to the State and 50 percent going to counties and municipalities. Payments are scheduled for 18 years. Of the $641 million coming to New Jersey, the agreement will distribute about $326 million to the State and $314 million to the counties and eligible municipalities. These funds will be spent on strategies to reduce the opioid epidemic's ongoing harms to residents and communities.

In 2021, New Jersey settled another $13.287 million opioid related settlement with global consulting firm McKinsey & Company, resolving an investigation into the company's role in fueling the opioid epidemic by designing aggressive marketing strategies used by some of the nation's largest opioid manufacturers, including Purdue Pharma.

A bill introduced by the NJ State Legislature on June 3, 2021, established the Opioid Recovery and Remediation Fund and the Opioid Recovery and Remediation Fund Advisory Council. It provides for funds received from opioid settlements to support substance use disorder prevention and treatment programs.

A survey was developed that will be sent to all 21 counties and 241 municipalities that received opioid abatement funding. The recipients will provide information about the programs they are implementing. Reports are due September 1 and a final report is to be published October 1.

SUPTRS COVID-19 Supplemental Grant Funded Initiatives

Primary Prevention

Screening with EB tools (Universal ACE's, Social Determinants of Health Screening). The Prevention Hubs will incorporate evidence-based tools for screening into their programs. Some of the planned tools will involve Universal ACE's (Adverse Childhood Experiences), and Social Determinants of Health Screening. The Prevention Hubs will also utilize a screening process to determine if an individual's behavior can be modified through SUD primary prevention education activities or services.

Preventure. PreVenture is an evidence-based prevention program that uses personality targeted interventions to promote mental health and skill development and delay youth substance use. PreVenture is designed to help at-risk youth ages 12-17 learn useful coping skills, set long term goals, and channel their personality towards achieving them. It focuses on at-risk youth and introduces motivational pathways and coping skills based on the individual's personality. PreVenture can be implemented in school/non-school and online settings. PreVenture has been

shown to reduce drug use, alcohol use and likelihood of binge drinking by 50%, delay initiation and frequency of cannabis use, reduce conduct problems and reduce risks for mental health struggles, such as anxiety and depression.

Strengthening Families for Criminal Justice. This service is for families that are involved with the criminal justice system (Family Court, Drug Court, etc.). Prevention agencies will provide the 7 or 14 week Strengthening Families program. Strengthening Families will greatly benefit the underserved communities within NJ. When families are engaged they tend to stay connected to larger supports. The connection between families and the community increases the likelihood of positive experiences that can combat ACEs (Adverse Childhood Experiences).

Purchase of Technical Assistance. Entity to coordinate the development and operation of Prevention Hubs and the new programs and initiatives that will be offered

COVID-19 Awareness for persons with SUD. Agencies will provide a broad range of support and make available public health trainings and outreaches regarding vaccination to encourage people getting vaccinated/access local support

Transportation to access prevention and vaccines. Prevention agencies will make available transportation, and connect individuals and families to additional financial supports and health resources like COVID Vaccine centers.

College Recovery. Establish and/or enhance Collegiate Recovery Programs at 2 and 4-year public Higher Education institutions. Services are to include: recovery support, dedicated recovery housing, crisis and relapse prevention, and environmental management on campus

Survey of 18-25 year olds. Few data on substance use/abuse within this population are available, especially individuals in this age group who are not in college. Montclair will develop and field a survey to collect data about this population.

Risk Messaging (adolescents/young adults and parents)/Social Media. Expand web-based/mobile tools for risk messaging for adolescents and young adults and enhance social media utilization. DMHAS will explore working with the Public Good Project, which has expertise in health messaging, campaign development and effective use of social media and other technology to reach high risk youth. Messaging strategies would be utilized by the Prevention Hubs to maximize strategic local reach.

Warm Lines by prevention providers. There is a need for the public to have a better awareness of our prevention services. While NJ has helplines for accessing treatment (both mental health and substance use) and crisis, individuals are not adequately familiar with the array of prevention and recovery support services that are available. DMHAS will develop and provide a prevention warm line service.

Creation of Prevention Hub Infrastructure. Prevention Hubs will be developed in each of NJ's 21 counties. NJ’s system of prevention agencies will become Prevention Hubs where individuals, local government entities, and community organizations youth, families and community members

can obtain information and resources, get connected to outreach events, and do brief screenings and/or be connected to needed services.

Prevention for Tribal Groups. Prevention services for the three (non Federally-recognized) tribes in NJ.

Youth Peer Leadership and Education. The Governor's Council on Alcoholism and Drug Abuse will create Youth Prevention Groups in each county and, at the state level, create a representative board (Youth Advisory Board). These Youth Groups can train youth to educate their peers on effecting change within their schools and communities.

Over the Counter (OTC) Prevention. Coalitions will use the Over-the-Counter Medicine Safety Guide developed by Community Anti-Drug Coalitions of America. Agencies and coalitions will provide education and outreach to families, individuals, and merchants. Populations of focus will be adolescents and older adults.

Marijuana Prevention. NJ will enhance programs that target underage marijuana use and marijuana abuse with these BG resources.

Military/Veteran Enhance services. Adapt the NJPN developed, evidence-based WISE (Wellness Initiative for Senior Education) curriculum to be culturally appropriate and sensitive to the needs of older veterans. NJPN to field test the new curriculum content at Veterans service and housing organizations.

Early Intervention

988 Implementation. On July 16th, 2022, as per a Federal Communications Commission mandate, 988 became the national three-digit dialing code for suicide prevention, mental health and substance use crisis. In response to the FCC's mandate, the New Jersey Legislature passed P.L. 2022, c.35 and the Commissioner of DHS identified DMHAS as the agency to develop the structure and programming for 988 in New Jersey.

People experiencing suicidal, mental health and/or substance use crisis, or those worried about a loved one or friend, can call or text 988, or chat using the 988 Lifeline's online platform. There, trained crisis counselors will understand the primary concern, de-escalate the individual, provide support, and offer appropriate linkages to specialized and local mental health and/or substance use services. Individuals with SUD are at risk for suicide, which is a finding well documented in research studies. Substance use is a risk factor for both fatal and nonfatal overdoses, suicide attempts, and death by suicide. Compared with the general population, individuals with alcohol dependence and persons who use drugs have a 10–14 times greater risk of death by suicide, respectively, and approximately 22% of deaths by suicide have involved alcohol intoxication. One study found that opiates were present in 20% of suicide deaths, marijuana in 10.2%, cocaine in 4.6%, and amphetamines in 3.4%. Among the reported substances, alcohol and opioids are associated with the greatest risks of suicidal behavior.

New Jersey has five (5) locally based crisis call centers that provide services for the 988 Suicide and Crisis Lifeline in the state. Calls come into the Lifeline network from across the United States and are routed to a locally-based, independently operated 988 Lifeline center based on the caller's telephone number. NJ 988 crisis counselors have access to in-state substance use resources such as ReachNJ and CCBHCs and can connect directly with 911 on behalf of an individual in need of emergency rescue (i.e. police, fire department or emergency medical services).

SBIRT. Integrate behavioral health services into primary care through the implementation of substance use Screening, Brief Intervention and Referral to Treatment services at obstetric and gynecologic practices at Rowan Medical School clinics.

Media Campaign. DMHAS engaged in a media campaign that brought awareness to New Jerseyans across the state to the effectiveness of medication to treat addiction and suggesting that individuals should call their physician or 1-844-ReachNJ for more information. The campaign was designed to reach populations diverse in age, ethnicity, culture. The media campaign was delivered in Spanish and English. There was a materially significant and direct relationship between when the media campaigns run and increased call volume to ReachNJ, our central call-in line New Jersey residents can use to access assistance in connecting addiction treatment and recovery support services. DMHAS allocated COVID-19 supplemental funding to support the media campaign.

SBIRT in ED's. In the fall of 2023, DMHAS will issue a Request for Proposals to identify an entity to provide SBIRT services in hospital emergency departments in New Jersey. The awardee will be required to prescreen a minimum of 200,000 unique individuals annually.

Naloxone Portal. DMHAS developed a web-based portal for community organizations to order naloxone kits. Community groups include Harm Reduction enters, county correctional facilities, EMS, law enforcement, libraries, shelters and contracted SUD and mental health programs. Naloxone or other FDA opioid antagonist kits will be made available through this portal. The SUPTRS ARPA grant will continue funding this initiative (for a lesser amount) once SUPTRS COVID-19 Supplement funding ends.

Naloxone and Training. Since 2016, staff from the Robert Wood Johnson Medical School in New Brunswick, NJ have provided virtual and in-person training (known as the Opioid Overdose Prevention Network - OOPN) throughout NJ on how to recognize an overdose and administer naloxone. In addition to these community trainings, they developed a training of trainers model from recovery specialists who work in the Opioid Overdose Recovery Programs and Support Teams for Addiction Recovery whereby the recovery specialists train clients with whom they are working on how to recognize an overdose and administer naloxone. OOPN also provides naloxone, which the recovery specialists give to their clients. DMHAS will provide additional funding (BG Supplement and ARP) to OOPN to enable its trainers to deliver the program and naloxone to additional populations, such as: persons who work in the construction industry.

Treatment

Special Populations. DMHAS issued an RFP to providers to identify an underserved special population(s) to whom they would provide direct services. The services are intended to assist those who have experienced difficulties and challenges accessing SUD services. Funding attached to the special population initiative is aimed at ensuring that services provided will include diversity, inclusion, equity, cultural and linguistic competence to the target population identified by each provider. Providers awarded this funding are committed to continually assessing and utilizing the demographic data collected from participants' service areas to continue the development and delivery of programming, evaluation, and program outcomes to their targeted underserved population.

Providers are required to show the specific detail on how they identified their underserved population and how their provided services will focus on the outreach techniques used to help minimize the negative impact of a crisis and how their direct clinical services have benefited the underserved population. These targeted services should be consumer-driven and planned with the specific needs of the individual and their special population in mind.

Crisis Receiving and Stabilization Centers (CRSC). This program will provide services to those in need of immediate in-person crisis intervention and stabilization for a behavioral health crisis. The decision was made to combine both mental health (MH) and substance use disorder (SUD). This program will assess individuals 18 years of age with SUD. CRSC offers a no-wrong-door access to crisis stabilization, operating much like a hospital emergency department (ED) that accepts all walk-ins, law enforcement drop offs, and fire department drop offs. The individuals served in the program will receive community-based treatment and supportive services 24 hours a day, 7 days a week, 365 days per year, with the goal of mitigating the need to use the ED to access community-based services and preventing unnecessary or inappropriate hospitalization. The program will result in strong, positive individual outcomes and an improved individual experience while accessing services. The program will also result in cost savings through the reduction in avoidable ED visits, inpatient admissions, police engagement, arrests, incarcerations and 911 calls. In 2021 there were 49,219 visits to EDs related to alcohol use disorder (AUD) with about 55 in 10,000 individuals visiting EDs for AUD. There were 110,386 visits for drug related issues with about 124 individuals per 10,000 using the ED for a drug issue. Currently, there is no alternative to EDs for individuals who are in crisis due to a SUD.

Recovery Support Care Management (RSCM). RSCM has been developed to assist consumers as they transition throughout the SUD continuum of care. The intent is to identify available resources, and then assist them to access the care/services in order to meet their needs identified in their Multi-disciplinary Care Plans. The intent is to remove any barriers to their recovery and achieve successful community living.

Peers in Residential Treatment Programs. Over the last several years, DMHAS has made significant efforts to increase the SUD peer workforce. Peer support services have positively impacted and provided specialized assistance to persons in recovery from serious mental illness, substance use or co-occurring mental and substance use conditions before, during and after treatment. As a means to close the gap in the provision of peer services in residential settings, DMHA has issued a request for proposal to expand the peer workforce to include peer services in inpatient withdrawal management, short-term and long-term residential and halfway house

settings. The successful bidders will hire peers who will assist with issues that often occur concurrently with SUD, such as homelessness, legal issues, employment, child care, documentation, etc. In addition to linking individuals with the appropriate community resources, peers will also encourage individuals to remain in treatment as recommended in the treatment plan and modeling strategies on how to manage addiction successfully. The anticipated contract start date is July 12, 2023.

Recovery Support

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

Simulation Training. The Simulation Training initiative is targeted to individuals working in the recovery support services and behavioral health workforce (e.g., peers, peer supervisors, LCADC, LPC, LCSW, etc.). Upon training completion, participants enhance their knowledge, skills, and attitudes on self-care, emotional wellbeing, and mindfulness-based recovery. The simulation trainings are specifically designed for NJ peer recovery specialists working in various community settings focus on MOUD, boundaries, commitment to change, and ethical scenarios. This initiative includes SIMmersion, an interactive training tool used to enhance evidence-based counseling skills. SIMmersion allows students to practice and develop core competency skills while gaining knowledge on motivational interviewing strategies that can improve effective communication. SIMmersion is based on simulated conversations and role-plays that allow participants to engage in real conversations and counseling interventions with life- like individuals. The exchanges provide instant evaluation and coaching on the student's motivational interviewing and engagement skills.

Pregnant and new moms (other substances). The Maternal Wraparound Program (M-WRAP) combines intensive case management, wraparound services, and recovery supports for pregnant/postpartum women who have a substance use disorder during pregnancy and up to one year after birth. The M-WRAP model is intended to promote maternal health, improve birth outcomes, and reduce the risks and adverse consequences of prenatal substance exposure. Intensive case management focuses on developing a single, coordinated care plan for pregnant/postpartum women, their infants and families. Intensive Case Managers work as liaisons to all relevant entities involved with each woman. Recovery Support Specialists provide non-clinical assistance and recovery supports while maintaining follow-up with the women and their infants.

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

The overall goal with the M-WRAP is to alleviate barriers to services for pregnant opioid dependent women through comprehensive care coordination implemented within the five major timeframes when intervention in the life of the substance exposed infants (SEI) can reduce potential harm of prenatal substance exposure: pre-pregnancy, prenatal, birth, neonatal and early childhood. Care coordination also addresses screening, early intervention, assessment, treatment and recovery supports. To ensure that the needs of the mother, infant and family receive coordination, access to and engagement in services, providers are required to develop Plans of Safe Care. The plan shall be developed prior to the birth event whenever possible and in collaboration with treatment providers, health care providers, early childhood service providers and other members of the multidisciplinary team as appropriate.

The onset of the COVID-19 pandemic resulted in many significant safety precautions at the national and state level. The stay-at-home orders, such as closures of businesses, schools, restrictions in gatherings has had an impact on the social determinants of health (food, security, employment, income, access to medical care, etc.). Pregnant and parenting women with a history of substance use disorder (SUD) could be at risk for increase in substance use or experience relapse due to feelings of isolation, lack of family supports, or social support systems. Their mental health could be adversely affected exhibiting depression during pregnancy and postpartum. July, 2021 the M-WRAP statewide initiative eligibility criteria was expanded to include pregnant women with substance use disorder, not exclusive to opioid dependency.

In late Fall, 2022 ReachNJ, the central call-in line for New Jersey residents seeking help with a SUD, dedicated their public service announcement campaign to reach pregnant women. MWRAP provided training to ReachNJ to offer MWRAP as a resource and to provide warm hand-offs. MWRAP services provides the support needed to help pregnant and parenting women maintain a healthy recovery, resulting in less overdoses, and improved birth outcomes and maternal child health. SFY 2023 DMHAS expanded MWRAP through SUPTRS ARPA funds. MWRAP has been increased from fifty (50) per region to sixty (60) pregnant individuals, for a total of 420 unduplicated pregnant women.

Peer Roster. A peer recovery roster was developed to collect information on peer staffing, employers, training, and certification, etc. The roster allows DMHAS to generate and analyze data to increase the depth of technical assistance and training that supports credentialing of the peer workforce. To date information has been collected on 401 Peer Recovery Specialists. With the information collected from the peer roster, reports for each funded DMHAS initiative are compiled that include summary data points to track certification progress, training completed and current employment information.

Recovery Data Platform. Recovery Data Platform is one of the largest collections of Community Peer Recovery Center data for the state of NJ. RDP is being used by several initiatives to centralize

information which allows a robust real-time analysis of recovery support services. Participating organizations entered data on peer recovery support services provided to over 12,000 participants which exceeded the earmarked 10,000 and is anticipating exceeding 15,000 in the current year.

Peer Recovery Specialist Training. A peer recovery roster was developed to collect information on peer staffing, employers, training, and certification, etc. The roster allows DMHAS to generate and analyze data to increase the depth of technical assistance and training that supports credentialing of the peer workforce. To date information has been collected on 401 Peer Recovery Specialist. With the information collected from the peer roster, NJPN has developed dashboard reports for each funded DMHAS initiative to represent summary data points to track certification progress, training completed and current employment information.

Infrastructure

Increased connectivity, Wi-Fi, equipment to improve service delivery. DMHAS recognizes the need to improve contracted provider agency connectivity and equipment to improve service delivery in light of the current and continuing need for virtual services. Funding was allocated for DMHAS Substance Use COVID-19 Reimbursement (DSCOVERS) program to reimburse community-based, non-profit SUD providers under contract with the DMHAS for eligible IT expenses up to a maximum of $20,000 per provider. Eligible IT expenses include items such as: Improved Internet Bandwidth Services; Behavioral apps/digital approaches for SUD therapy, recovery, patient reminders, etc.; Expanded technology options for callers, e.g., texting; Enhanced broadband and cellular technology for provider use (not consumers); Video Conferencing; Wi-Fi Connectivity; Equipment such as laptops, headphones, webcams, smartphones, etc. for staff; Other technology to improve access to and coordination of SUD prevention, intervention, treatment and recovery support services consistent with the provisions of HIPAA and 42 CFR, Part 2; and Other software to improve service delivery, like evidence-based screening tools and treatment planning products. Eligible providers must submit completed DMHAS payment vouchers and documentation such as receipts and invoices in order to be reimbursed.

Personal Protective Equipment. Funding was allocated for DMHAS Substance Use COVID-19 Reimbursement (DSCOVERS) program to reimburse community-based, non-profit SUD providers under contract with the DMHAS for eligible personal protective equipment (PPE) expenses up to a maximum of $20,000 per provider. Eligible PPE expenses include: face coverings; masks; face shields; gowns; gloves; and goggles. Eligible providers must submit completed DMHAS payment vouchers and documentation such as receipts and invoices in order to be reimbursed.

Recovery Management Check-Up. Recovery Management Check-up (RMC) is service for discharged clients to support independent living and success with recovery and provide more methods of outreaching to clients. This will include virtual face-to-face visits, text messaging and chat features, and also the opportunity for actual in person contacts. This check-up service will help provide local recovery supports. RMC aims to identify and alleviate client problems before they derail recovery. Monthly contact forms the core of the proposed RMC. Problems will be addressed using motivational interviewing techniques or connecting clients to appropriate community resources or treatment if needed. The conceptual framework of RMC is to treat

addiction as a chronic disease, with long-term management to minimize the number of acute episodes of substance abuse and with prompt treatment when episodes occur to prevent them from becoming more severe and consequential.

Workforce Support

Workforce Support. The Prevention Fellowship Program is will expand New Jersey's prevention workforce to ensure that evidence-based quality services are being provided to the diverse communities across the state. We will recruit and select a cohort of young professionals with diverse backgrounds and experience to become part of the Prevention Fellowship Program. Though NJ has worked hard to address the health disparities that exist in the state, to truly eliminate health disparities, the prevention workforce will need to help communities implement strategies that are reflective of and sensitive to the multicultural population of the New Jersey. A competent and diverse prevention workforce is essential to accomplish this goal. Yet the prevention field—like the public health field generally—has struggled to create and maintain a robust LGBTQ-inclusive, ethnically and racially diverse workforce. The NJ Prevention Fellowship Program will work to expand and strengthen the prevention workforce for the future.

SUPTRS American Rescue Plan (ARPA) Funded Initiatives

Primary Prevention

Vaping Prevention. Evidence based/informed prevention activities specific to vaping.

POMS Upgrade. Develop new MIS to collect data on DMHAS-funded prevention programs and initiatives. Current system (POMS) is cumbersome and is not capable of collecting all program data.

User Friendly Prevention Website. Will develop new website (for DMHAS pages) that accurately describes current prevention programs and initiatives.

Strengthening Families for Women and Other Treatment Programs and Marginalized Groups. This service is for women in treatment and their families. Prevention agencies will provide the seven (7) or fourteen (14) week Strengthening Families Program (SFP). When families are engaged they tend to stay connected to larger supports. The connection between families and the community increases the likelihood of positive experiences that can combat ACEs (Adverse Childhood Experiences). SFP will also be provided to marginalized groups – as defined by the provider's needs assessment.

Military/Veteran and Civilian First Responders Services. Working with the New Jersey National Guard Family Program and its eight Family Assistance Centers based at armories around the state, the SSA funds the New Jersey Prevention Network to provide programs to serve returning military personnel and their families through two evidence-based programs, Coping with Work and Family Stress and the Strengthening Families Program. Both programs are designed to enhance protective factors to support military members and their families in making responsible parenting and

individual choices in regards to drug and alcohol use. Services were recently expanded to include first responders.

The following programs are funded under the SUPTRS COVID-19 Supplemental and will continue with ARPA funding. A description of these programs is under the previous section.

Risk Messaging (adolescents/young adults and parents)/Social Media.

Crisis or warm lines by prevention providers.

Creation of Prevention Hub Infrastructure.

Prevention for Tribal Groups.

Youth Peer Leadership and Education.

Over the Counter (OTC) Prevention.

Marijuana Prevention.

Military/Veteran Enhance services.

Early Intervention
Funded by the SUPTRS COVID-19 Supplemental grant and will continue with the SUPTRS ARPA grant. A description of these programs is under the previous section.

SBIRT in ED's.

Naloxone Portal.

Naloxone and Training.

Treatment

Expanded Hours. The New Jersey Department of Human Services (DHS), Division of Mental Health and Addiction Services (DMHAS) released an RFP for the development of Expanded Hours for Substance Use Disorder (SUD) Outpatient Programs. The funds for this initiative was funded through the Substance Abuse and Mental Health Services Administration's (SAMHSA) American Rescue Plan Act (ARPA). This funding was intended for a one (1) year program with providers having the program continue as part of their sustainability plan. These expanded services were developed to enhance access to treatment by removing barriers such as traditional service hours. These expanded hours will provide increased access to outpatient treatment for individuals with an SUD. The purpose of this expansion for outpatient services is to support, enhance and encourage the emotional development and the development of consumer's life skills in order to maximize their individual functioning during alternate times from standard business hours (after hours and weekends).

These services are designed to preserve or improve current functioning, strengths and resources. In outpatient services, consumers and staff work together to plan and implement effective treatment and offer individual, group and/or family sessions during these expanded hours. The expanded hours will also allow for an increase in medication monitoring, education and administration time that have all proven a reduction to barriers for engagement and ongoing treatment. By increasing the access to treatment for consumers, they are more readily willing to seek treatment because services are available at times that accommodate their work, school and family obligations.

The expanded hours initiative is designed to increase treatment options through expanded operating hours to ensure all consumers are able to attend treatment uninterrupted and maintain personal as well as business requirement. This will assist consumers in fulfilling personal needs, i.e. employment, etc. Providers are required to expand their hours at a minimum of six (6) days per week with the goal of extending hours into the evening and admitting new consumers for these services during these times. The additional operating hours from providers can either be continuous or separated by times when their programs/facilities closes and reopen for their doors for business.

The following programs were funded by the SUPTRS COVID-19 Supplemental grant and will continue with the SUPTRS ARPA grant. A description of these programs is under the previous section.

Underserved Populations.

SUD Crisis Services (CSC).

Recovery Support Care Management.

Peers in Residential Treatment Programs.

Recovery Support

Mobile Recovery Vans. The Recovery Mobile Van Program is a startup initiative funded by the ARPA that provides a recovery mobile van program for NJ's six counties that don't have an existing program: Bergen, Camden, Gloucester, Hudson, Mercer and Union. Each of the six participating counties receive $200,000 in funding for one year to purchase of a mobile van.

Interim Housing and Case Management. As part of ARPA funding, SAMHSA approved a plan to develop case management for individuals with an SUD who are homeless. SUD individuals who receive Interim Housing services, will also have access to case management (CM). This service will allow SUD homeless individual to work with a case manager in accessing needed services, such as healthcare benefits, medical, dental, housing options and any other resources they are seeking and need. These support services can be done by Peers or Case Managers, the rate of pay is $16 hours for 15-minute units for peers, with a limit of 6 hours per month per individual; case

management rate is $25 for 15-minute units, with a total of 2 hours per month per individual, with extension of hours if needed.

The following are funded by the SUPTRS COVID-19 Supplemental grant and will continue with the SUPTRS ARPA grant. A description of these programs is under the previous section.

Pregnant and new moms (other substances).

Peer Roster.

Recovery Data Platform.

Peer Recovery Specialist Training.

Infrastructure
The following are funded by the SUPTRS COVID-19 Supplemental grant and will continue with the SUPTRS ARPA grant. A description of these programs is under the previous section.

Recovery Management Check-Up.

Increased connectivity, Wi-Fi, equipment to improve service delivery.

Workforce Support
The following is funded by the SUPTRS COVID-19 Supplemental grant and will continue with the SUPTRS ARPA grant. A description of this program is under the previous section.

Workforce Support.

SUPTRS COVID-19 Mitigation Grant Funded Initiatives

COVID-19 Testing Kits and Related Items. Funding was allocated for DMHAS Substance Use COVID-19 Reimbursement (DSCOVERS) program to reimburse community-based, non-profit SUD providers under contract with the DMHAS for eligible testing kits and related items expenses up to a maximum of $20,000 per provider. There are three types of test kits eligible for reimbursement through the DSCOVERS program. The first are tests administered at a CLIA waivered facility and are designated with an Authorization Setting of "W" on the website link provided above. The second and third tests are distributed to consumers directly for home testing prior to entering the facility and are designated with an Authorization Setting of "H" or "M" on the website provided above. Testing-related allowable expenses include: test administration and supplies necessary for administration; activities/items to maintain healthy environments, and educational materials and printing costs of such materials to address consumer hesitancy regarding testing. Eligible providers must submit completed DMHAS payment vouchers and documentation such as receipts and invoices in order to be reimbursed.

Personal Protective Equipment. Funding was also allocated to support reimbursement through the DSCOVERS program of gloves and masks necessary for the administration of COVID-19 Rapid Testing. Eligible providers must submit completed DMHAS payment vouchers and documentation such as receipts and invoices in order to be reimbursed.

Prevention/ Virus Mitigation. Grant funds is available for agencies to conduct prevention and virus mitigation. Examples include services to prevent the spread of the virus and addressing consumer hesitancy regarding testing, and maintaining healthy environments such as cleaning and disinfecting, ensuring ventilation systems operate properly, installing physical barriers and guides to support social distancing.

Public Education. Grant funds is available to provide agencies with posters, fact sheets and videos to help alleviate consumer hesitancy regarding testing.

Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system.

Narrative Question:

This step should identify the unmet service needs and critical gaps in the state's current systems, as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state's behavioral health system, including for other populations identified by the state as a priority. This step should also address how the state plans to meet the unmet service needs and gaps. The state's priorities and goals must be supported by data-driven processes. This could include data that is available through a number of different sources such as SAMHSA's National Survey on Drug Use and Health (NSDUH), Treatment Episode Data Set (TEDS), National Survey of Substance Use Disorder Treatment Services (N-SSATS), the Behavioral Health Barometer, **Behavioral Risk Factor Surveillance System (BRFSS)**, **Youth Risk Behavior Surveillance System (YRBSS)**, the **Uniform Reporting System** (URS), and state data. Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention and treatment planning. States with current Partnership for Success discretionary grants are required to have an active SEOW.

This narrative must include a discussion of the unmet service needs and critical gaps in the current system regarding the MHBG and SUPTRS BG priority populations, as well as a discussion of the unmet service needs and critical gaps in the current system for underserved communities, as defined under **EO 13985**. States are encouraged to refer to the **IOM reports**, *Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement* and ***The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding***[1] in developing this narrative.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Planning Step 2: Identify the unmet service needs and critical gaps within the current Children's System of Care (CSOC)

The summary of the CSOC strengths as well as unmet service needs and gaps within the current system of care is based on the following sources of information:

- Department of Children and Families Strategic Plan
- DCF Commissioner's Dashboard
- CSOC Child and Youth Behavioral Electronic Record (CYBER) Data Collection and Reports
- CSOC Internal Data Collection and Reports
- DCF Internal Data Collection and Reports
- CSOC Youth Services Survey for Families
- Monthly statewide system partner meetings (CMO, FSO, JJC)
- County-based Children's Inter-Agency Coordinating Council (CIACC) meetings
- Bi-Annual Needs Assessments submitted by the HSACs
- CIACC Dashboard
- Traumatic Loss Coalition for Youth Program Reports
- New Jersey Kids Count – The State of Our Children, Advocates for Children of New Jersey
- New Jersey Student Health Survey
- Robert Wood Johnson Foundation County Health Rankings and Roadmaps
- SAMHSA National Study on Drug Use and Health
- CSC Youth Risk Behavioral Surveillance System

To operationalize the DCF vision of ensuring New Jersey children and families are safe, healthy, and connected, the Department of Children and Families has established a Strategic Plan to best align the priorities of CSOC with the DCF vision and values. The Strategic Plan identifies the following CSOC priorities:

- Promote integrated health and behavioral health.
- Build capacity to deliver evidence-based interventions and services.
- Enhance CSOC capacity to ensure equitable access.

CSOC acknowledges the following gaps and unmet service needs within the current system of care and has identified activities to address them, as follows:

- In recognition of unprecedented workforce challenges for behavioral health systems, DCF has engaged in efforts to inform strategies of workforce recruitment and retention to ensure continued quality service delivery, including:
  - A contracted labor market analysis including diagnostics and recommended strategies and solutions
  - Holding conversations with partner/provider groups and stakeholders
  - Adjustment of practice elements that provide efficiencies for providers and maintain youth safety and quality service delivery.

- Access to integrated physical healthcare and behavioral healthcare for youth. Planned activities:
    - Infuse integrated care and wellness activities across the CSOC continuum by identifying and expanding opportunities for integration within the CSOC service array and supporting the development of other primary health-behavioral health integration models.

- Access to evidence-based practices (EBP), services, and supports across the CSOC service continuum. Planned activities:
    - Support evidence-based practices in the continuum by increasing EBP capacity in both community-based and out-of-home services.

- Improved outcomes for youth through increased collaboration among system, family, and other partners. Planned activities:
    - Encourage collaboration among all partners through strategic statewide and local partnerships.
    - Continue collaboration through external advisory group.
    - Strengthen CSOC's quality improvement strategy, including development and implementation of outcome measures aligned with the CSOC logic model goals, objectives, and activities.

- Strengthen and expand youth and family peer support. Planned activities:
    - Promote the importance of youth and family support.
    - Explore opportunities to increase access to peer support services.

- Increase public awareness of availability and accessibility of the Children's System of Care. Planned Activities:
    - Promote usage of the CSOC Social Media Tool Kit and Public Service Announcement by all partners.
    - Presentations provided to community stakeholders upon request.
    - Design and implement training and support to increase access to services for unhoused youth and their families.

- Ensure equitable access and eliminate racial disparities. Planned Activities:
    - Promote data collection and entry to decrease rate of unknown race/ethnicity across the service array.
    - Participate in DCF Office of Diversity, Equity & Belonging learning activities.

- Expand Service Array to include supports and services for infant mental health/youth under five years old. Planned Activities:
    - Continuation of "Zero to Five: Helping Families Thrive" infant and early childhood mental health workforce training and technical assistance activities.

Planning Step 2: Identify the unmet service needs and critical gaps within the current system. Please provide a description of how the state plans to meet these identified unmet service needs and gaps.

State Mental Health Authority (SMHA)

The State of New Jersey is geographically, demographically, culturally, and socioeconomically diverse. Identifying populations historically under-served by mental health services is vital to the SMHA's success at facilitating the wellness and recovery of all of its citizens. The SMHA has undertaken needs assessments to determine underserved areas for targeting requests for proposals (RFPs) and contract efforts (e.g., Outpatient Services, Community Support Services (CSS)), using a myriad of data sources in order to better understand the needs and service gaps on a statewide basis. Examples of relevant indicators to be observed on a county level include (but are not limited to): population density, racial composition, proportions of residents age 65 and older, unemployment rates, median household income, screening center admissions, and crime rates.

I. A Data Driven Process for Identifying Unmet Needs and Critial Gaps

Data Sources - The SMHA has steadily improved its capacity to organize mental health promotion initiatives utilizing prevalence estimates and epidemiological analyses at the state and county levels. The data sources SMHA will continue to utilize in driving the planning for the prevention and mental health promotion initiatives include:

- DMHAS internal data systems such as Quarterly Contract Monitoring Report (QCMR), Beds Enrollment Database (BEDS), Unified Services Transaction Form (USTF) database, Systems Review Committee (SRC) Data, and Oracle Hospital Census Database.
- Data obtained from different mental health community programs funded by DMHAS.
- SMHA Consumer Perception of Care Survey
- Other State and National Data Sets
  - Demographic Data from the US Census Bureau.
  - SAMHSA's New Jersey Behavioral Health Barometer.
  - SAMHSA's Uniform Reporting System (URS) Data Tables.
  - Annual Demographic Profiles summarized by New Jersey Department of Labor and Workforce Development based upon Census 2020, Intercensal Population Estimates, and Population projection estimates by the U.S. Census Bureau.
  - New Jersey State Health Annual Assessment Data, Center for Health Statistics, New Jersey Department of Health (DOH).
  - The New Jersey Violent Death Reporting System (NJVDRS), a CDC-funded surveillance system, which records suicide (with known circumstances).
  - CDC-funded New Jersey Behavioral Risk Factor Survey, in which mental health modules were implemented (Depression and Anxiety Module, 2010 and 2011; and Mental Illness and Stigma Module, 2012, 2013, 2014 and 2017). The SMHA funded the collection of Mental Illness and Stigma Module in NJBRFS in 2014.

- New Jersey DOH Uniform Billing data which show hospital and emergency room use by demographic factors.
- New Jersey DOH Healthcare Facility Licensing data, with which occupancy rates for psychiatric beds in general hospitals are calculated.

The SMHA's data sources in details:

Quarterly Contract Monitoring Report (QCMR) Database. QCMR collects quarterly, cumulative, program-specific data from each of the service providers contracted by DMHAS via a web-based portal. It tracks data consisting of consumers served, as well as quantifies service utilization across the mental health system. QCMR data is provided to the SMHA by 111 separate agencies on 22 different program elements for roughly 630 separate sub-program elements (e.g., a specific program element, run by specific agency and specific site) on a quarterly basis.

Of these 22 program elements 16 are included in the web-based QCMR portal. These 16 programs consist of Affiliated Emergency Services, Acute Family Support Programs, Community Advocates, Designated Screening Centers/Psychiatric Emergency Services, Early Intervention Screening Services, Integrated Case Management Services, Intensive Family Support Services, Intensive Outpatient Treatment and Supports, Legal Services, Outpatient Services, Program in Assertive Community Treatment, Partial Care, Partial Hospitalization, Peer Recovery Centers, Residential Services, and Supported Employment. The remaining six programs not currently captured by the web-based portal are Coordinated Specialty Care/First Episode Psychosis, Community Support Services, Involuntary Outpatient Commitment, Justice Involved Services, Projects for Assistance in Transition from Homelessness, and Supported Education. Data for these programs is collected separately and updated by DMHAS central office staff. As new program elements are added, new QCMRs are developed. Beginning with CSS, DMHAS is working with program coordinators and database programmers to add each of these program elements into the QCMR portal, allowing for standardized and automated data collection and reporting of all DMHAS-funded programs.

The QCMR historically emphasized program-level data, but as the QCMR data field layouts change over time, increasing numbers of data points related to aggregate consumer outcomes have been included. The QCMR does not collect client level data. The QCMR provides essential data for many routine reports generated by the SMHA including: DMHAS Evaluation data table for URS reporting of numbers served by program, annual Budget Briefing reports, and planning resources for the annual Consumer Perception of Care Survey. In addition, the QCMR provides reliable information for the majority of ad-hoc reports created by the Division, specifically around the topics of utilization management, provider performance and the geographic distribution of available services.

Beds Enrollment Database (BEDS). In May 2012, the SMHA began development on a web-based bed enrollment data system. BEDS is a secure web-based system designed and administered by the SMHA to facilitate the assignment of consumers from state psychiatric hospitals into safe and appropriate community-based residential settings, in accordance with

SAMHSA's Supportive Housing EBP[1], the SMHA's Olmstead Settlement Agreement[2], and the revised DMHAS Administrative Bulletin 5:11[3]. Since 2015 BEDS has been a reliable web-based system which provides real-time access to vacancy information and helps facilitate assignments in a more streamlined manner. Analysis of the utilization of independent (e.g. Community Support Services) and supervised settings (e.g. group homes and supervised apartments) allows for assessment of the Division's progress toward community integration. The system also enables planning at both the individual consumer level for placement purposes and system-wide for purposes of enhancements in community resources. In addition to Community Support Services and residential (i.e. group home and supervised apartment) living arrangements, DMHAS has recently added short-term care facility (STCF) placements into BEDS. This allows for analysis and quality improvement measures geared toward improved tracking of utilization management of STCF beds in the Division's acute care system. For the purpose of data-driven planning, BEDS is a powerful utilization management and planning tool that will allow the SMHA to observe resource utilization, vacancy rates, and the geographic distribution of resources and housing requests. In the Spring of 2021 BEDS was updated to contain functional improvements, including streamlined search features, and the addition of short term care facility (STCF) beds, to give the SMHA a better view of the acute care system.

Provider Weekly Reports (PWRs). DMHAS Olmstead and Diversion Office facilitated a performance improvement initiative in 2019 designed to facilitate hospital discharges and diversions from admissions; reduce the current length of time to place state hospital clients into residential beds; identify complex issues impacting discharges from a state hospital; and provide a mechanism to gather information on agency capacity, census, vacancy, and specific information on pending assignments, including barriers to discharge. The performance improvement initiative was a collaborative effort with the State Psychiatric Hospitals, DMHAS Office of Community Services, DMHAS of Housing, and DMHAS funded providers. The Provider Weekly Report was developed as a result of this performance improvement initiative. The report contains information that is not included in the current BEDS system and assists with tracking and following up of referrals as weekly updates from agencies are provided which assists the Olmstead/Diversion office with following up on those referrals that require assistance.

Web-based Referral and Tracking System. DMHAS is looking to replace its current BEDS database and the PWRs with a new comprehensive online, statewide, database and referral tool for a broad continuum of services that go beyond just beds or residential placements and include include DMHAS services such as acute care, outpatient, recovery supports, and harm reduction services for individuals with behavioral health needs in NJ.The DMHAS anticipates starting with acute care services, as the rollout of 988 necessitates having a system in place to make referrals and eventually dispatch mobile responses. The solution will be rolled out in phases. As other care components are added, the solution will be designed to expand to accommodate additional services, resources and functionality. In addition to being used for the 988 system, subsequent

[1] https://store.samhsa.gov/product/Permanent-Supportive-Housing-Evidence-Based-Practices-EBP-KIT/SMA10-4509
[2] http://www.nj.gov/humanservices/dmhas/initiatives/olmstead/olmstead_settlement_agreement.pdf
[3] http://www.state.nj.us/humanservices/dmhas/regulations/bulletins/Mental%20Health/5_11.pdf

phases will incorporate the full array of contracted and licensed behavioral health services. The solution will include a real-time connection between crisis call center professionals, mobile crisis response teams, and treatment providers, including crisis stabilization services. The solution will have the ability to search for services using various criteria, real-time facility availability, and two-way digital communication. There will be the ability to dispatch mobile crisis outreach using GPS-enabled technology. The system will provide the ability to create and send a digital referral to a facility based on service need, payment type, special needs, geographic location, and other criteria.Ability to close the loop on referrals and provide feedback regarding treatment engagement and outcomes using secure messaging. The solution will include robust analytic capabilities to assist in tracking various metrics as well as a real-time analytics dashboard.

Unified Services Transaction Form (USTF). The USTF database is an electronic client level registry originally developed in 1978 (revised in SFY 1990, and as of the Spring of 2022 is in the end-stages of development to an exclusively web-based, secure application) called the USTF+ which will still serve as one of the primary sources for populating the URS data tables. The current system is an Access desktop application which was last updated in 2000 and used by all MH providers who submit their files to DMHAS each quarter. In SFY 2022, there were over 500,000 records—with each record containing the potential for over 50 separate data fields. The current USTF data system will be utilized for reporting SFY 2022 data and the data for the 2022 URS data tables.

The development of a DMHAS USTF+ secure, web-based comprehensive client level data system (CLD) was essential due to four key imperatives: 1. to streamline reporting from DMHAS providers eliminating duplication of reporting, 2. to manage the transition of DMHAS to outcomes reporting, 3. to provide the public with more “forward facing” online performance data, and 4. to satisfy federal mandates of SAMHSA—including reporting of data required by the Community Mental Health Services Block Grant (CMHBG), Mental Health National Outcome Measures (NOMS), using Client-Level Data, and Mental Health Treatment Episode Data Set (MH-TEDs).

The development and implementation of the USTF+ data system will greatly facilitate the reporting of URS Data tables, MH-TEDS, and Client Level NOMS, as well as significantly improve the quality of ad hoc reporting and production of data dashboards. In addition to the reporting mentioned above, the SMHA will be including evidence based assessment tools in the CLD such as the WHODAS. T1/T2 client level outcomes (e.g., changes in educational achievement, employment and involvement wih the criminal justice system) have been built into the system. Program level outcomes (including outcomes from SAMHSA’s evidence based toolkits) are planned for future phases of the USTF+. The CLD will enable the SMHA to provide data dashboards for provider agencies as well as the SMHA senior leadership to drive planning and evaluate programs. It will allow the SMHA to collect detailed data on various target populations to help determine unmet needs. It will serve to: 1. streamline community reporting processes by providing DMHAS (and its contracted agencies) with a single source of data entry for its users—thereby replacing several outdated data systems (e.g., the Unified Services Transaction Form (USTF), the Quarterly Contract Monitoring Report (QCMR), and the

Systems Review Committee (SRC) data system) and reducing duplication of data entry, 2. provide fine-grained utilization management data that allows the Division to drill down to service use at the program level, the agency level, the county level and the client level, 3. document consumer outcome measures to evaluate program (and provider) effectiveness, and 4. provide users with reliable and meaningful data to drive and inform decision-making. With the ability to utilize encounter data from Medicaid and NJMHAPP combined, along with the data from the USTF+ CLD (client level of functioning, quality of life measures, etc), the SMHA will be able to gauge the impact of services, Medicaid penetration rates, etc. The SMHA would be able to significantly enhance its planning efforts and capacity for data informed decision making. The USTF+ data will be critical data when preparing a comprehensive need assessment inclusive of county based needs, barriers, critical gaps, and reporting on target populations.

In the Spring of 2020, the SMHA renewed construction of its updated USTF system. The USTF+ is desgined to serve as DMHAS's web-based client registry and client-level data system. Phase 1 of USTF+ was rolled out in FY 2022, and was the "staging environment" (e.g., the trial/practice version of the application where functionality and user interface was tested and evaluated) in iterative stages – initially to a small number of pilot agencies and later, to the entire group of the 60+ providers whom the SMHA works with. That version of the USTF+ consisted of updated versions of current fields as well as new data elements that will satisfy federal CLD guidelines and evolving needs for data-driven understanding of special populations served by the SMHA. Upon satisfactory testing of the system on a pilot basis in the Summer/Fall of 2022, the SMHA launched a series of nine statewide videoconferences in late 2022 to demonstrate its entire provider community on the use of the new system. Over 400 representatives/staff members from community-based provider agencies participated in these video conferences.

The DMHAS went live with the USTF+ application on July 5, 2023. DMHAS provided the opportunity for providers to do a one time upload of their current active caseload or to enter their information manually. DMHAS issued a correspondence to each provider in mid July informing them that DMHAS would provide them with one time funding to help them with entering the data into the new application. At the same time, DMHAS is issuing credentials to each provider for an Administrator at their site who would in turn create and maintain the credentials for their agency.

DMHAS is currently preparing the business requirements for Phase 2 which would move the reporting for Systems Review Committee (SRC) Designated Screening Centers (DSC) and Short Term Care Facilites (STCFs) into the USTF+ thus streamling reporting, decreasing duplication of data entry, and enhancing the integrity of the data. Additional phases of the USTF+ will include incorporating outcomes and reporting requirements specific to each program and the Quarterly Contract Monitoring Report (QCMR).

Systems Review Committee (SRC) Datasets. SRC are a series of linked MS-Excel documents submitted monthly from 25 Short Term Care Facilities (STCFs) and 23 Designated Screening Centers (DSCs). By regulation, SRC data is collected and reviewed monthly by localized county specific committees comprised of acute care providers and governmental staff. These SRC processes include review of trends related to volume, capacity, referral patterns, system flow, length of stay and disposition. The SRC dataset provides program/agency-specific data that is the

aggregate of each program's consumers served within a given month. The conversion of the SRC data submission files (from STCF and DSC provider agencies) into single 'flat files' has improved the ability of DMHAS staff to efficiently and accurately query SRC data. DMHAS is also in the process of preparing a Business Requirements Document for phase 2 of the USTF+ that will add the SRC data to the web-based application, eliminating duplication of data submission from SRC providers and enhancing the completeness of the SRC data.

Oracle Hospital Census Database. Oracle Hospital Census database is the central information system for storing client-specific records on consumers admitted into New Jersey's three regional inpatient adult psychiatric state hospitals and one forensic state psychiatric state hospital. To keep up with the flow of consumers entering, and exiting the state hospitals, this data is updated on a daily basis by hospital personnel. Because Oracle is scalable, the Hospitals Census database has been modified slightly to meet the unique needs of each hospital. The scalable nature of the Hospital Census database has allowed the SMHA to also develop modules specific to data requirements imposed by the Olmstead Settlement Agreement for the three regional hospitals, including an "Individual Needs for Discharge Assessment" designed to identify discharge barriers as early as possible during the course of hospitalization. The INDA is first administered within seven days of admission and subsequently updated every 30 day, so that successful community integration can be addressed in advance of discharge readiness. Although Oracle provides client-level data, this information is aggregated on a daily basis to provide critical reporting at the hospital level as well as the statewide level. Both the INDA and Oracle hospital census database provide reports allowing for hospital and central office users to summarize and examine hospital census data in an aggregated and/or snapshot view of approximately 2,000 consumers served each year. The Hospital Census database is used by the Division for utilization management; Olmstead monitoring, planning and evaluation; and reporting of URS data.

Consumer Perception of Care Survey. Since 2011, the SMHA Consumer Perception of Care Surveys have been distributed in the summer/fall of each year to a representative sample of adult consumers of all community-based, non-acute programs[4]. The survey results are reported in the annual CMHBG Implementation Report. An unmodified version of the Mental Health Statistics Improvement Program (MHSIP) Adult Survey (Draft Version 1.2, February 17, 2006)[5] is used as the survey instrument, with the addition of ten questions related to primary health, from the Behavioral Risk Factor Surveillance System (BRFSS) survey[6]. Each non-acute mental health program contracted by the SMHA, has served as sampling stratum. Agency program coordinators are instructed by the SMHA on techniques of random sampling and bias reduction. Consumers are empowered to participate in this survey with little/no intervention from direct care staff. The results of this survey are studied and used to guide the SMHA's planning efforts for future initiatives and resource allocation. The information gleaned from these survey efforts is used to populate the relevant URS Data Tables, as well as inform the SMHA on the quality of community-based, state funded mental health services, as perceived by the sample of consumers responding to these surveys. This survey data is helpful at looking at needs among specific

[4] Prior to the 2011 survey, the SMHA administered survey questionnaires to all consumers of one specific program element, which varied annually.
[5] http://media.wix.com/ugd/186708_3175909b8c1640988e6bee6edf865edd.doc?dn=%22URS_MHSIP_Adult_Survey2.doc%22
[6] http://www.cdc.gov/brfss/questionnaires/pdf-ques/2011brfss.pdf

program elements and at service needs in different parts of the state. Between 2011 and 2022 the average General Satisfaction score was 97.4% .

The 2020 Consumer Perception of Care Survey was not expedited due to reasons directly related to the Covid-19 global pandemic/State emergency (e.g., clients receiving services via telehealth and not onsite at the provider agency where the surveys are usually distributed, and workflow distruptions at the SMHA).

Following the pandemic, the SFY 2021 Survey of Adult Mental Health Percpetion of Care was undertaken (for the first time) using an electronic platform (e.g., SurveyMonkey), rather than the more cumbersome (and expensive) paper format. Consumer engagement in the survey was high (over 750 questionnaires were received) of which 92% (+/-5.4%) respondents reported positively about general satisfaction with services (URS Data Table 11). The susbsequent survey in SFY22 was again conducted via the same electronic platform, and yielded an increased satisfaction rate (97% +/-6%).

Coordinated Specialty Care Client Level Data System. DMHAS has a data collection tool to capture demographic and outcome data elements. This manual data collection system will no longer be utilized once all of the program outcomes specific to CLD are added to the new USTF+. Currently the data is collected every three months and analyzed to track the progress of CSC clients who have received services. Client measures include client referral source; age; gender; race; psychiatric and medical hospitalizations; psychotropic medication adherence; co-occurring substance use disorder; discharge and re-admission; insurance status; language, and global functioning using the MIRECC GAF scale. In addition to the CSC data spreadsheet, CSC programs submit a quarterly progress report to DMHAS. The quarterly progress report outlines community outreach progress and any problems with the client service model, client referral demographic data, and other services on the client population.

Other Statewide and Nationwide Data Sets

The SMHA uses several independent datasets, alongside national and statewide datasets to shed light on goals, priorities and success. Specifically, this constellation of datasets is most commonly used to identify counties that are most appropriate (in terms of need and access to mental health services) for new community services and Requests for Proposals (RFPs). Additional statewide and county-specific data is obtained from the US Census Bureau (e.g.https://www.census.gov/acs/www/data/data-tables-and-tools/data-profiles/) to inform comparisons of population density, residential characteristics, racial diversity, unemployment rate, age distribution, household income, poverty levels and other factors helpful in determining need. The NJ Jersey Department of Labor and Workforce Development also generates important economic and employment data (https://www.nj.gov/labor/lpa/employ/uirate/lfest_index.html) which is often used by the SMHA in making inter-county comparisons of economic need. Data on crime statistics in New Jersey is compiled by the NJ State Police, and its reports (https://www.njsp.org/ucr/crime-reports.shtml) are utilized by the SMHA in obtaining a clear picture of county stressors and crime rates.

National data is often examined by the SMHA to shed light on New Jersey mental health efforts, relative to similar states. SAMSHA, through its compilation of Behavioral Health Barometer (Behavioral Health Barometer: New Jersey, Volume 6 (samhsa.gov)) and URS data tables, and state level detail reports provide useful information in this regard (New Jersey 2021 Uniform Reporting System Mental Health Data Results (samhsa.gov)). The National Research Institute (NRI) of the National Association of State Mental Health Program Directors (NASMHPD) is another source that the SMHA consults on a regular basis for national mental health data (http://www.nri-incdata.org/).

II. Unmet Needs and Critical Gaps and How to Meet the Identified Unmet Service Needs and Gaps

New Jersey currently uses the federal definition of SED and SMI: Children with SED refers to persons from birth up to age 18 and adults with SMI refers to persons age 18 and over; who (1) currently meet or at any time during the past year has met criteria for a mental disorder – including within developmental and cultural contexts – as specified within a recognized diagnostic classification system (e.g., most recent editions of DSM, ICD, etc.), and (2) display functional impairment, as determined by a standardized measure that impedes progress towards recovery and substantially interferes with or limits the person's role or functioning in family, school, employment, relationships, or community activities.

Prevalence*:* According to the Federal methodology proposed for estimating the prevalence of SMI, the proportion of adults within the state with SMI is 5.4% (Federal Register, Volume 64, No. 121, p. 33890)[7].

According to figures released by the United States Census Bureau, the 2022 adult population of New Jersey was 7,275,144. The size of the New Jersey child population was 1,992,555. Using the SAMHSA's SMI prevalence rate among persons 18 and older (5.4%) the estimated number of adults with SMI in New Jersey in 2022 was 392,858. Using the upper SMI limit of 7.1%, the estimated number of adults with SMI in New Jersey in 2022 was 516,535. Accordingly, using the lower SMI limit of 3.7%, the estimated number of SMI adults in New Jersey in 2022 was 269,180.

Estimates of SMI, SED, and General Population of New Jersey, 2010, 2011, 2016, 2018, 2020 and 2022

Year	Total Adult Population	Total Adult SMI (5.4%)	Adult SMI Lower Limit of Estimate (3.70%)	Adult SMI Upper Limit of Estimate (7.10%)	Total Children	Total Children SED (8%)	Total New Jersey Population
2010	6,726,680	363,241	248,887	477,594	2,065,214	165,217	8,791,894
2011	6,778,345	366,031	250,799	481,263	2,042,810	163,425	8,821,155
2016	6,959,717	375,825	257,510	494,140	1,984,752	158,780	8,944,469
2018	6,948,646	375,227	257,100	493,354	1,528,702	122,296	8,477,348
2020	6,947,836	375,183	257,070	493,296	1,934,535	154,763	8,882,371

[7] https://www.gpo.gov/fdsys/pkg/FR-1999-06-24/html/99-15377.htm

2022	7,275,144	392,858	269,180	516,535	1,992,555	159,404	9,261,699

According to URS Table 2a, a total of 335,429 unduplicated persons ages 18 and over received services in programs provided or funded by the SMHA in FY 2022. The SMHA served 121,616 unduplicated adults with SMI (refer to URS data table 14a) in FY 2022. That was 30.96% of the total estimated adults with SMI in New Jersey (392,858).

Also shown in URS data table 14a, out of the total 121,616 unduplicated adults with SMI served by the SMHA in FY 2022, 51,869 (42.6%) were ethnic minorities (and those who did not report a racial affiliation). The SMHA will be re-evaluating the data once there is sufficient data in the new USTF+ application.

Persons who are SMI are the primary target population for SMHA funded services. However, the SMHA also prioritizes services to persons with special access needs, including older adults, ethnic and linguistic minorities, and individuals with co-occurring mental health and substance use disorders, hearing impairment, developmental disabilities, and criminal justice involvement. The SMHA also prioritizes services to individuals with SMI who meet the criteria for first episode psychosis, as well as individuals with SMI in need of crisis intervention and stabilization services. SMHA uses a few different approaches to determine unmet mental health services needs and gaps for New Jersey. They include 1) community surveys (e.g., direct survey, key informant), 2) local, state, and national data, which include the client level data and 3) the input from different stakeholders, such as members of the Behavioral Health Planning Council. With the aid of these tools, the SMHA has identified unmet needs in these target populations: SMI/SED, homeless people, older adults, LGBTQ populations, women with, and persons with past criminal involvement. The unmet needs and critical gaps are identified for the following target populations: SMI/SED, homeless people, older adults, LGBTQ populations, and persons with past criminal involvement.

Homeless Adults. The SMHA is the recipient of the federally funded PATH program, which is matched with state funding. The SMHA contracts with 25 non-profit agencies to operate PATH programs within the state's 21 counties. The target population is homeless adults or those at risk of homelessness who have a serious mental illness, including those with co-occurring substance use disorders who are not currently engaged in and are resistant to mental health and other community support services. Programs for homeless adults are described in Planning Step 1 under Criterion 4.

The most critical gaps and unmet needs identified by PATH providers are: 1) lack of shelters and shelter beds, romming and boarding homes, safe transitional/emergency housing. . 2) The lack of available affordable, safe, permanent housing; 3) Limited Supportive Housing resources and group homes accepting referrals from the community. 4) Lack of Housing subsidies and housing programs, especially for persons who are not Chronically Homeless, or who have criminal backgrounds for distribution or Meghan's Law.

There is no way to pay for a shelter stay if an individual does not qualify for General Assistance/Emergency Assistance because PATH funds cannot be used to support emergency shelters. The SMHA has created some housing for the population at risk for homelessness, but sustained efforts are needed to combat the housing problem. In 2019 and 2020, the Governor expanded housing for individuals with a substance use disorder and mental illness through the provision of state dollars under the Governor's Opioid Funding Initiative.

Other unmet needs include subsidies do not cover utilities; lack of financial/emergency assistance for persons who are sanctioned by the state of NJ for drug distribution charges and for people who have reached their maximum allowable time on General Assistance or who do not otherwise meet the criteria for General Assistance, such as those with SSI/SSDI benefits; delays in approval for benefits from the Board of Social Services; long wait time to see a psychiatrist; obtaining medications for those persons without health insurance; availability of inpatient integrated treatment for persons with co-occurring mental illness and substance use disorder; public transportation; and limited Spanish speaking services.

The Mental Health Block Grant COVID19 Supplemental Funds will be used to provide resources that support housing stability. New Jersey and the federal government have eviction moratoriums in place related to COVID. Once the eviction moratorium is lifted landlords will be able to commence eviction proceedings. Housing stability is an important component of recovery. The DMHAS will use funds to support housing stability to avert homelessness through eviction. The resources will be used to enter into a contract with an agency that is staffed to provide landlord/tenant legal services to individuals facing eviction. The funds will also be used to cover rent arrears for individuals and assist with initial housing costs for individuals displaced.

Older Adults. In 2011 the SMHA saw a need to develop specialized services to assist screening centers and nursing homes to respond to an increasing number of older adults with behavioral problems. In 2012, the SMHA awarded a contract for the development of a program to provide specialized clinical consultation, assessment, treatment and intervention to older adults who were at risk for presentation to emergency rooms for psychiatric hospitalization. Trinitas Regional Medical Center in Elizabeth, New Jersey was the recipient and has been administering this Statewide Clinical Outreach Program for the Elderly (S-COPE), which is fully funded by NJ-DMHAS and has been in operation since April 2012. Prior to S-COPE's inception, individuals with dementia or presenting with behavioral health behaviors were more likely to be referred to mental health crisis screening centers and emergency rooms, and many were subsequently being admitted to inpatient psychiatric facilities, including state psychiatric hospitals. With S-COPE involvement, many of these older adults could be referred to S-COPE, and diverted from screening centers and hospitalizations. In calendar year 2022, 1,028 individuals were served in S-COPE. Services to older adults are described in Planning Step 1 under Criterion 4.

Services for the LGBTQ Population.

DMHAS is commitment to improve services to individuals from diverse cultural backgrounds, including LGBTQ. The DMHAS defines cultural competence as: "… the ability to honor and respect the beliefs, languages, interpersonal styles and behaviors of individuals and families receiving services, as well as staff members who are providing such services. Cultural competence is a dynamic, ongoing developmental process that requires a long term commitment and is achieved over time" (HHS 2003a, p-. 12).

In its long standing commitment to address cultural competency and diversity, DMHAS formed a Multi-Cultural Advisory Committee in 1981. The role and membership of this group devises strategies that are appropriate to the lifestyles, special needs, and strengths of New Jersey's diverse populations and cultural groups, and most recently, addresses challenges to ensure that BIPOC (Black, Indigenous, People of Color) and the LGBTQ population receive quality equitable services in the behavioral health system of care adhering to Culturally and Linguistically Appropriate Services (CLAS) standards. Additionally, MSAC makes recommendations to DMHAS regarding training content, statewide cultural competency goals, agency self-assessment processes, and in collaboration with other stakeholders, ensures that cultural competency principles are disseminated across the State and to other disciplines.

In addition, DMHAS contracts with two Cultural Competence Training and Technical Assistance Centers designed to improve mental health and substance use services and outcomes by enhancing the cultural competence of mental health professionals and their organizations. The Centers accomplish this through the provision of cultural competence resources, on-site and virtual training, and technical assistance, and consultation for agencies, self-help centers, community wellness, and recovery centers seeking to develop proficient plans and improve organization cultural competence. Each Center also offers annual conferences on topics relating to social cultural foundations and at least 6 full-day accredited trainings provided to DMHAS contract agency direct care and managerial staff. To date the Centers have conducted more than 30 trainings, training more than 1300 individuals on topics included but not limited to Intro to Cultural Competency, Unconscious Bias, Micro Aggressions, Understanding and Addressing LGBTQIA+ Mental Health Substance Abuse, Accountability and the Art of the Apology, Historic and Intergenerational Trauma. Additionally, the Centers hold regional technical assistance hands-on workshops to assist agencies with developing a cultural competency plan.

DMHAS also has allocated funding for a Diversity Consultant to increase efforts to provide research-based training, assessments, and outreach with behavioral health agencies. The diversity consultant collaborates Centers and MSAC to:

- Review provider agency cultural competency plans for relevance with regards to service delivery.
- Quantitatively and qualitatively analyze cultural competency plan data and make recommendations for system-wide changes.
- Provide guidance and support to the Training and Technical Assistance Centers.
- Network with leaders in the field to advance cultural competency throughout the State.
- Assist in the development of cultural competency training and workshops sessions.

- Research subject matter and make recommendations to provide evidence-based, timely training, workshops, and conference content.
- Research and utilize assessment tools to measure and assess cultural competency trends and delivery.

Coordinated Specialty Care (CSC). With the recent issuance of Block Grant Supplemental funds in March 2021, DMHAS is in the process of expanding CSCs services by supporting a total of up to six Coordinated Specialty Care programs. These programs will serve individuals with FEP as well as individuals with affective psychosis. Additionally, DMHAS will establish up to six CSC Community Integration (CSC CI) programs to serve as step down programs providing treatment and supports to individuals who either complete the CSC program or do not need the intensive supports of a CSC program with weekly visits, but rather a less intensive ESMI Community Integration or step-down program. New research has shown that many clients struggle to maintain superior outcomes after CSC [8]. Evidence also has shown that shortening the duration of untreated psychosis by limiting gaps in service can have a positive impact on long-term outcomes for the FEP population [9]. The CSC CI programs will serve as transitional programs that provide clinical stability through reducing external triggers after care as well as a continuation of client medication motoring and referral networks that provide external community supports for FEP clients. Clients will be able to transition to step down or transition up to CSC seamlessly based upon clinical need without changing providers or their clinical team.

Service for Those With Criminal Backgrounds.

Legally Involved Intensive - Provider agencies who offer Community Support Services (CSS) to individuals in the community and state psychiatric hospital treatment teams seeking to discharge individuals into the community are voicing a need for a level of care that offers up to 24-hour care with specialized supports and staff with specialized training to provide care for individuals with significant legal histories who are identified as high risk. The development of a Forensic ACT (FACT) team would provide for a less restrictive level of care with specialized services and supports for the forensically involved population. Staffing would be enhanced to include criminal justice specialists, a peer specialist with lived criminal justice experience as critical additional members of the integrated, multi-disciplinary team. Training for staff would focus on addressing mental health, co-occurring and criminal justice needs. Individuals would also have access to up to 24 hours of individualized psychiatric treatment and social service to address immediate needs fostering improved stabilization.

[8] Jones, N. (2016). What comes after early intervention? Step-down, discharge and continuity of care in early intervention in psychosis programs for first episode psychosis. Retrieved from https://www.nasmhpd.org/sites/default/files/Issue%20Brief%20-%20What%20Comes%20After%20Early%20Intervention_0.pdf.
[9] Jones, N. (2016). What comes after early intervention? Step-down, discharge and continuity of care in early intervention in psychosis programs for first episode psychosis. Retrieved from https://www.nasmhpd.org/sites/default/files/Issue%20Brief%20-%20What%20Comes%20After%20Early%20Intervention_0.pdf.

Peer Recovery Warm Line.

The Peer Recovery Warm line (PRW) is entering its 15th year of operation and continues to be hub for peers looking for support. PRW has become a significant referral source this past year for as the awareness grows of the value of peer support. Demand for these services continues to grow outside of fiscal resources. The greatest challenge continues to be the resources needed to fully fund the Peer Recovery Warm Line to answer and return call up to the industry standard goal of 90%. MHANJ has in the place the structure and technical capacity to expand the PRW to dramatically grow the program. The increased referrals from 988 will continue to grow the volume of calls. This is an opportunity to introduce many individuals experiencing a crisis to the value and effectiveness of peer support and provides callers with education and support until and after access to counseling services to support recovery. PRW is a proven effective method of providing evidence-based peer delivered services.

- **Challenges and Opportunities:** Funding to expand Peer Outreach Support Teams within the mental health system either by direct positions or allow Medicaid reimbursement is the major barrier. MHANJ has established a strong program model that can work within the traditional treatment system, but also work effectively with the large number individuals with mental health and substance use disorders who are not receiving services. MHANJ is using the POST model with other funding sources to engage individuals with emotional issues and is currently involved with a pilot project with Horizon BlueCross/Shield to offer Peer Support services to its commercial clients. Once Medicaid funding to peer support flows MHANJ is in the position to significantly expand these peer support services.

Gaps Observed by the New Jersey Behavioral Health Planning Council

The partnership of community stakeholders with the SMHA is critical to the success of the Division. The New Jersey Behavioral Health Planning Council (NJBHPC, a.k.a., "The Planning Council") is the primary (but by no means sole) voice of the community. Through the participation of the Planning Council, and its Advocacy subcommittee, the Division has obtained the following guidance on service needs and gaps within the current system of care. The Council has been concerned with the continuity and provision of behavioral health services. DMHAS has provided updates to the Council on grants received during the pandemic including the block grant supplemental funds and other Covid emergency assistance grants such as the SAMHSA Covid19 Emergency Response grant. Funding from this grant was targeted to several population groups including; SMI, non-SMI and healthcare providers. CBT and brief treatment services were provided via telehealth and on-site services.

Waiting Times for Children and Youth In Emergency Rooms: The Council has voiced sustained concern over current wait times for children and youth in emergency rooms for evaluation, treatment, and clearance to return to educational settings (if/when school officials raise

concerns). Because this issue cross-cuts several different departments of state government this remains a complicated issue. The Council has sustained contact with officials from the SMHA, the NJ State Department of Health, and the Children's System of Care (CSOC). Concern has been voiced that wait times will increase in September with the school year and if there are any diversionary efforts that can be implemented? The Council has requested that ther be ownership for crisis response and maintenance of centralized data collection including the following: mobile response or Psychiatric Emergency Screening Services), presentation to the emerency department (by family, crisis, or school system), percentage of admissions that are youth that present to the emergency department, emergency department wait times and recidivism.

Older Adult and Trans Youth LGBTQIA+ Populations: Behavioral healthcare needs of older adult members of the LGBTQIA+ community has specific needs which should be compassionately provided by sensitive and knowledgeable clinicians, as well as for Trans youth/people of color who have high rate of suicide/depression due to violence and lack of support/services.

Increased attention to the knowledge base of front-line staff at contracted agencies. Members of the Council have reported inconsistent levels of knowledge among front-line staff members of behavioral health agencies with regard to locally available community-based resources.

Retention of Front Line Staff in Community Care Settings: The Council has voiced concern about turnover/staffing loss of Behavioral Health. Reasons cited by the Council for staffing reductions is related to workers salaries, job concerns related to the Covid-19 pandemic, and turnover of frontline workers who leave the field to pursue professions of higher renumeration and greater job security.

First Episode Psychosis (FEP) /Coordinated Speciality Care (CSC): should be the standard of community-based mental health care. This important service should be expanded throughout the state in each county and offered more widely throughout New Jersey.

Planning Council Membership and Advocacy: Looking internally at its own operations and memebership, the Planning Council remains concerned about attracting members from more diverse racial/ethnographically diverse populations, expanding to include members representing the interests of children/adolescents, and those with substance use disorders. To address those challenges, as well as improve the scope and efficacy of its advocacy, the Council will be receiving technical assistance from SAMHSA and its consultants.

Resources for Youth leaving Juvenille Detention Centers. Members of the Planning Council who represent the NJ Juvenille Justice Commission (JJC) report a need for increased recovery environments for children leaving juvenile detention facilities.

Peer Bridger Program and Peer Navigators: The Community Wellness Centers aspire to amplify their impact by incorporating the Peer Bridger approach. This addition would empower the centes to provide one-on-one peer support, thereby fostering smoother community integration and offering invaluable guidance during moments of crisis. Our vision extends to encompass short-term care facilities and screening centers, leveraging and enhancing the capabilities of our existing Peer Advocates program. We seek to introduce a dedicated team of Mobile Peer Respite

Advocates. This ensemble of support champions will be equipped to serve individuals, wherever you may be in New Jersey, for up to four hours on multiple days each week. Peer navigators can be used to help link with housing.

Planning Step 2: Identify the Unmet Service Needs and Critical Gaps within the Current System

The SSA has a long tradition of conducting needs assessments to determine overall treatment need for substance abuse treatment, demand and gap, and treatment need and gaps for special populations in New Jersey. Obtaining reliable substance abuse treatment need estimates is critical to the state's ability to promote a rational planning and resource allocation process. The Division of Mental Health and Addiction Services (DMHAS) employs 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.

Our methodologies also allow us to determine need at the county level. This information is important for the planning and development of new substance abuse prevention and treatment services. Needs assessment data are incorporated into our Request for Proposals (RFPs) for developing new substance abuse and treatment services, are incorporated into funding formulas for distribution to our counties per Alcoholism, Education, Rehabilitation and Enforcement Fund[1] (AEREF) legislation and utilized in the Division's applications for federal grants. Various social indicators that have been demonstrated to have a relationship to substance abuse are employed in our relative needs assessment methodology, such as, mortality from alcohol and drug poisoning, treatment admissions, child abuse and neglect, DUI arrests and drug law violations. The SSA utilizes numerous data sources, e.g., national, state, SSA data systems and surveys to inform its need assessment and planning processes.

The SSA uses a variety of methodologies such as large-scale population-based surveys (NJ Household Survey; Middle School Risk and Protective Factors Survey); targeted surveys such as Older Adults, Veterans; Young Adults; relative needs assessment; synthetic estimation such as capture-recapture; and social indicator analysis. in order to develop needs assessment strategies. For 25 years, New Jersey has used a household survey to estimate: 1) the prevalence of both legal and illegal substance use, 2) alcohol treatment need and 3) unmet treatment demand. The SSA also utilizes Geographic Information Systems (GIS) for the spatial visualization of social service needs and advanced analytic techniques such as multiple regression, logistic regression, survival analysis and structural equation modeling.

Data Driven Planning Process

The SSA is committed to providing timely and high-quality data to inform our various stakeholders and the public to help them understand substance use trends. It believes in a data-driven approach to inform our policies and assess the impact of our programs. The SSA has numerous Memorandum of Agreements with a variety of university partners to assist us in the evaluation of key programs and managing our large-scale population surveys.

Data Sources Used to Identify Needs and Gaps

[1] The AEREF legislation refers to P.L.1983, c.531, amended by Chapter 51 of P.L.1989.

The SSA uses a wide variety of data sources in its needs assessment process in order to identify needs and gaps across the full continuum of care. These include:

SSA Information Systems

- New Jersey Substance Abuse Monitoring System (NJSAMS)
- Prevention Outcomes Management System (POMS)
- Contract Information Management System (CIMS)
- CSC Fiscal Agent Billing System

SSA Surveys

- NJ Household Survey on Drug Use and Health (2009, 2016, 2018, 2020)
- NJ Middle School Risk & Protective Factor Survey (2007, 2010, 2012, 2016, 2021)
- Survey of Older Adults (2012, 2015)
- Returning Veterans Survey (2015)
- Young Adults (new for 2023)

Other SSA Data Sources

- NJ Epidemiological Profile for Substance Abuse (2008, 2023 in preparation)
- County and Municipal Social Indicator Chartbooks (2005, 2013, 2016, 2022 under review)
- NJ Substance Abuse Provider Performance Reports (bi-annual)
- NJ Substance Abuse Overviews (annual)
- Treatment Provider Performance Reports (annual)

Other State Data Sources

- NJ DOH Uniform Billing (UB-04)
- Uniform Crime Reports
- NJ Department of Education Student Health Survey (2013, 2019)
- Pregnancy Risk Assessment Monitoring System (PRAMS)
- Behavioral Risk Factor Surveillance System (BRFSS)
- New Jersey State Health Assessment Data (NJSHAD)
- Prescription Drug Monitoring Program
- Overdose Data (Medical Examiner)
- Narcan Reversals (State Police and Department of Health)
- Drug Arrests (State Police)
- Drug Seizures (State Police)
- State Police Regional Operations Information Center (ROIC) reports
- NJCARES website
- DOH Data Dashboard

Federal Data Sources

- U.S. Census Bureau
- National Violent Death Reporting System (NVDRS)
- National Survey of Drug Use and Health (NSDUH)
- SAMHSA's NJ Behavioral Health Barometer
- Treatment Episode Data System (TEDS)

- National Survey of Substance Abuse Treatment Services (N-SSATS)
- Behavioral Risk Factor Surveillance System (BRFSS)
- Fatality Analysis Reporting System (FARS)
- National Vital Statistics System (NVSS): Multiple Causes of Death (Mortality)
- Uniform Crime Reports (UCR): Police Reported Crimes
- CDC Youth Risk Behavior Surveillance System (YRBSS)
- CDC State Unintentional Drug Overdose Reporting System (SUDORS)
- Web-based Injury Statistics Query and Reporting System (WISQARS)
- Substance Abuse and Mental Health Data Archive (SAMDHA)
- Wide-ranging Online Data for Epidemiologic Research (CDC WONDER)

All these data sources allow the SSA to examine current data as well as to make comparisons over time for trend analysis. Also, utilizing Federal data allows New Jersey to examine its state performance in comparison to national data.

Data Collection Systems

Since the SSA promotes the use of data to drive its planning, there are several key IT systems that are instrumental in achieving this goal and are described below. Depending on the system, information is able to be reported at the client, program, financial, provider, and encounter level. Information systems exist for treatment, prevention, fiscal management and billing data. These systems provide needed data for SABG and TEDS reporting, needs assessment, evaluation and planning processes. Other new systems allow for the collection of outcome data.

New Jersey Substance Abuse Monitoring System. The client level data system, known as the New Jersey Substance Abuse Monitoring System (NJSAMS) was developed and implemented in 2005 by the SSA to be a real-time, web-based substance abuse treatment data collection and reporting system. The system is required to be used by all licensed substance use clinic-based treatment providers in New Jersey, regardless of whether or not they contract with the SSA. It collects basic demographic, substance use, financial, clinical and service information on all clients enrolled and served in New Jersey's substance abuse treatment system. Admission data are collected and reported for services that may have different payers. In 2022 there were 84,437 admissions to treatment. The system consists of numerous modules and contains all the clinical assessments providers are required to complete. There are 271 licensed providers reporting on NJSAMS, representing 441 sites with 3002 active users. There are also 204 Intoxicated Driver Resource Center (IDRC) affiliated providers representing 326 sites and 1,786 active users.

NJSAMS was developed over time under the initial auspices of the Center for Substance Abuse Treatment (CSAT). The purpose was to develop the state's capacity to use web-based information technology for the collection and reporting of data necessary to meet Federal Performance Partnership Grant (PPG) and Government Performance and Reporting Act (GPRA) reporting requirements. NJSAMS was developed in response to the need for: timelier reporting on substance abuse treatment episodes, better monitoring of client outcomes, quality improvement, better client placement into appropriate level of care based on assessed need, and tracking of treatment through the continuum of care. The NJSAMS website is hosted by the Rutgers University Computer Center under a Memorandum of Agreement with the SSA. It is a secure

web-based system designed to collect confidential health information and is HIPAA and 42CFR compliant.

A major IT accomplishment was the complete re-architecture of NJSAMS, which was originally written in classic ASP and included numerous webpages making data entry slow. Work began on this project in September 2011 and the new system was successfully launched mid-November 2013. The NJSAMS includes the latest Addiction Severity Index V.5, the Level of Care Index (LOCI-3), DSM-5, as well as additional modules that can collect further information on client care and needs. The system is capable of producing the CSAT National Outcome Measures (NOMs) and generates the data needed for Provider Performance Reports. Data from NJSAMS are used to fulfill Block Grant reporting requirements and are also submitted quarterly to the Treatment Episode Data System (TEDS). The system contains nearly 1000 data elements and over 1 million records, dating back to 2006.

Fiscal Intermediary MIS. Through an open competitive bid, a Fiscal Agent Billing system contract was awarded to the Computer Sciences Corporation (CSC), now Gainwell Technologies. This web-based system, nj-das.net, went live July 1, 2010 and continues today as the billing system for all of the SSA's Substance Use Disorder (SUD) fee-for-service (FFS) initiatives: Recovery Court (formerly Drug Court), MAP-SPB, SJI, MATI, DUII, NJSI, SAPT, SHARE, ISI and the Co-Occurring Network. The amount of funding available to support these initiatives was $44,116,665 in SFY 2021, $47,475,098.00 in SFY 2022 and $48,709,183.00 in SFY 2023.
* SFY 2021 October 1, 2020 to May 10, 2021, 10 months due to COVID-19 State of Emergency
** SFY 2022 October 1, 2020 to June 30, 2021, 9 months due to COVID-19 State of Emergency

The number of admissions in the DMHAS SUD FFS initiatives of the total NJSAMS admissions for the past three fiscal years are as follows:

- SFY 2020 – 15,739 FFS admissions of 89,399 total NJSAMS admissions
- SFY 2021 - 10,256 FFS admissions of 71,181 total NJSAMS admissions
- SFY 2022 – 12,438 FFS admissions of 87,500 total NJSAMS admissions

The DMHAS FFS Network Initiatives claim volume for the same period is as follows:

- SFY 2020 was 315,433 (7/1/2019-3/26/2020, 9 months due to COVID)*;
- SFY 2021 was 455,606 (10/1/2020-5/10/2021, 10 months due to COVID)*; and
- SFY 2022 was 527,846 (7/1/2021 – 6/30/2022, 12 months).

* To ensure a predictable cash flow for providers, payment methodology transitioned from FFS to contract payments based on pre-COVID volume. Providers had to attest to keeping doors open and continuing to take new admissions in order to be eligible for this payment methodology. In SFY 2022, payment methodology returned to FFS reimbursement for services provided.

Providers submit a request via a web service to Gainwell for authorization approval then submit their claims through the Gainwell's nj-das.net system for reimbursement. Detailed service data is inputted which includes the CPT codes. Gainwell Technologies and the SSA have developed an automated interface with NJSAMS to link services data reported in NJSAMS which correspond to the claim for payment. All the billing data tables, approximately 124, are transferred to NJSAMS on a nightly basis to the SSA's server. This allows the SSA capability to analyze detailed encounter

data. This information is easily linked to NJSAMS data so service utilization patterns can be analyzed by client characteristics and levels of care.

Contract Information Management System. The Contract Information Management System (CIMS) is a web-based, paperless contract processing system that providers use to submit their contract actions. CIMS went live July 1, 2010 for renewal contracts which included the electronic submission of the Annex B (budget). On January 1, 2011, the system went live for the Annex A and Programmatic Requirements.

The four main areas CIMS was designed to address are:

- ensure compliance with Department of Human Services (DHS) contracting policies
- provide more accountability for the utilization of state funds
- improve transparency and tracking of SSA contracting
- develop a more efficient process for submitting, reviewing and approving contract documents

DMHAS is seeking to secure a new vendor for contract management to provide enhanced reporting capability.

Prevention Outcomes Management System. The web-based Prevention Outcomes Management System (POMS) collects process data on evidence-based substance abuse prevention services that are delivered in New Jersey. This system went live in August 2009 and has been enhanced since that time. All New Jersey substance abuse prevention providers and coalitions that receive SSA funding are required to use the system for data reporting. POMS includes two modules that collect county-based prevention coalition and education data. The system supports download of 1-6 reports per module, and has 131 password-registered agency users (representing 25 agencies and 88 grants), 6 administrators, and 3 system administrators.

Contracted agency users report data into POMS via: (1) Environmental Module, and (2) Curriculum-based Module. The Environmental Module, deployed in March 2016, includes 10 items. It collects priority-specific data on implementation of CSAP strategies and engagement with community sectors. It also measures progress on: (1) the use of environmental strategies, (2) the development and enforcement of policies (and laws/ordinances) to: (a) Reduce Underage Drinking, (b) Reduce use of Illegal Substances, (c) Reduce Prescription Misuse Across the Lifespan, and (d) Reduce use of New and Emerging Drugs. The Environmental Module also collects data on media campaigns, public service announcements, and information that is shared with lawmakers, schools, and businesses. Quarterly reports for the Environmental Module include summary data for each item of the questionnaire. These reports are used for program monitoring and evaluation.

The POMS Curriculum-based module, updated and re-deployed in February 2018, collects priority-specific and summary demographic data for individuals that are served by evidence-based prevention education programs. It allows users to track participant attendance, retention, and program completion levels. Curriculum-based data entry includes: (1) type of service, (2) target audience, (3) priority, (4) curriculum/program name, (5) county of service, (6) date of service, (7) # of individuals/families in attendance, and (8) applicable CSAP strategy. Curriculum-based

reports include participant demographic data by county, priority, strategy, and curriculum. These reports are used for program monitoring.

Plans are underway to update the POMS system to more accurately address the changes in prevention services and new strategies to address the opioid epidemic confronting new Jersey. A survey of prevention agencies was conducted by the Center for Prevention Services at the Rutgers School of Social Work to collect feedback. While feedback on using the system is generally positive, several design and technical issues were identified.

Maternal Wrap Around System (MWRAPS) and Integrated Opioid Treatment and Substance Exposed Infants (IOT-SEI) Initiative Systems. The MWRAP and IOT&SEI collect program data consistent with federal and state maternal health strategies.[2,3] Using MS Office software, the initiatives ensure quality data collection and dissemination in order to measure program impact and outcomes as well as to inform program and policy decisions. Some providers use electronic medical record (EMR) systems alongside the program required reporting tools. Data sourced from 10 contracted providers are documented using three approved surveys developed through MS Word documents: 1) Intake Survey, 2) Birth and Postpartum Survey, and 3) Discharged Survey. Information gathered through these surveys are recorded and reported through an approved custom-designed MS Excel reporting template on the 15th of each month. The reporting requirements also include regular data monitoring, quarterly data quality check, and a quarterly meeting with the contracted providers and state partners.

Data collected through the MWRAP and the IOT&SEI initiates covers eight data categories: 1. Biographical data, 2. Enrollment and admission data, 3. Contact data, 4. Maternal health data, 5. SUD and OUD data, 6. Other care and support data, 7. Legal data, and 8. Exit data. These eight categories also comprise additional data sets to fully capture a wide-range of information across various levels of care:

1. Biographical data
    - Consumer's name
    - Date of birth
    - Race
    - Hispanic origin
    - Residence
    - Marital Status
    - # of children in home
    - # of children out of home
    - Individual's housing status
    - Education status
    - Source of income and employment status

---

[2] The White House. "*White House Blue Print for Addressing the Maternal Health Crisis"*. https://www.whitehouse.gov/wp-content/uploads/2022/06/Maternal-Health-Blueprint.pdf. June 2022

[3] New Jersey. "*Nurture New Jersey 2021 Strategic Plan"*. nurturenj.nj.gov/wp-content/uploads/2021/01/20210120-Nurture-NJ-Strategic-Plan.pdf. 2021

2. Enrolment and admission data
    - Admission data
    - Admission status
    - Referral source
3. Contact data
    - Total number of attempted contacts
    - Total number of successful contacts
    - Date of last contact
    - Mode of communication
4. Maternal health data
    - Health Insurance
    - Health rating
    - # of lifetime pregnancies
    - # of live births and birth details
    - Week of gestation at intake
    - Prenatal care
5. SUD and OUD data
    - Co-occurring mental health diagnosis
    - Has client even been in SUD treatment and # of times
    - # of times withdrawal/detox
    - Current SUD treatment and type of treatment center
    - Referral to SUD treatment
    - Current MAT
    - Substance use in past 30 day and type of substance
    - Substance use in past 12 months and type of substance
    - Current use of tobacco or cigarettes
    - Current use of e-cigarettes or vape
    - Overdose in past 30 days
    - Overdose in past year
    - Current frequency of use of any substance
    - Past year total time abstinent from identified substance
6. Other care and Support data
    - COVID-19 and most urgent reported challenges
    - Plan of safe care
    - Hep C
    - Treatment care status
    - NAS
7. Legal data
    - Arrested in the past 30 days
    - Arrested, if yes, how many times?
    - Awaiting charges
    - Currently on probation or parole
    - Currently in Intensive Supervision Program (ISP)
    - Currently in recovery court

8. Exit data
    - Care or service discharge
    - Care or service exit categories
    - Care or service exit concerns

Support Team for Addiction Recovery (STAR) Data Collection. In addition to GPRA, STAR clients also receive the Support Team for Addiction Recovery Survey which is captured in a HIPAA-compliant web-based Survey Monkey database developed by RU-CPS. STAR collects data on individuals' demographics including age, race, and gender. The STAR key outcomes are assessed as follows: past 30-day substance use; number of overdoses since engaging with STAR; time to relapse; individuals receiving MAT (Buprenorphine, Methadone, Vivitrol); GED/vocational; employment; housing stability; Medicaid enrollment; and provider outreach and engagement efforts. STAR providers collect baseline and follow-up surveys (every three months until discharge a year later) regarding substance use, recovery, quality of life, and demographics.

Family Support Centers (FSC) Data Collection. Data collected measures the family members' loved one's recovery/treatment status and is captured in Qualtrics. Self-care measures such as communication, understanding recovery and resources, effects on interpersonal relationships, effects of the Center on the participants' financial, family and vocational responsibilities as well as their own emotional wellbeing and welfare are also measured. FSC providers collect baseline, three-month, and six-month follow-up surveys which contains items on demographics, service needs, and loved one's substance use.

Telephone Recovery Support (TRS) System. Data collected from TRS is recorded in the provider's Salesforce system. TRS staff capture demographic information, as well as information on referral source, engagement, and other outcomes such as housing and employment. The Salesforce system also tracks the number of calls, the length of the call, and allows for TRS staff to enter specific call-related notes for record keeping and continued relationship building.

Opioid Overdose Recovery Program (OORP) Database. A data collection system has been designed to collect detailed information on clients who are brought to the emergency department after being reversed with naloxone. Information is collected on patients' mental health and substance use disorder history, referrals, linkages to treatment and other services provided by the Recovery Specialists and Patient Navigators, patient outreach and follow-up, and the client's participation in recovery.

The OORP Database website is developed in PHP 7 using Drupal 7 for the framework and content management system. The tables are created through an automated process initiated by Drupal using MySQL 5.7. All data pertaining to the OORP application is stored in databases on a single server and retrieved only through the Drupal web interface. The OORP Database contains field validation to ensure responses are in the appropriate format and to reduce invalid responses.

Contingency Management. Contingency management utilizes multiple data gathering tools. First, surveys are administered at admission to and at conclusion of the program. Intake and discharge surveys are conducted via MS Forms with data downloaded as an Excel worksheet. The intake survey, measures patient demographics as well as treatment goals. The discharge survey measures

how well the patient did in the treatment program, number of treatment sessions taken as well as total amount of incentives given throughout their course of treatment. The data gathered here is linked to the providers' entry of client information into the New Jersey Substance Abuse Monitoring System (NJSAMS) as part of the intake process. Finally, since this program is funded by SOR, data is also obtained through administration of the GPRA on intake, at discharge and the 6-month follow-up GPRA.

Special Population SUD Program. The Special Population for SUD Program is intended to increase service and treatment provided to special population individuals with an SUD. MS Forms data collection system for Special Population program was designed in late 2022 and implemented in January 2023 to capture program progress. All awarded provider sites utilize their own real-time data input website link to update their program data. Each time a client used the special population service, their provider is required to input detailed information of this visit. As of July 2023, the nine providers have provided 312 times of service to special population individuals.

Data collected through the Special Population data collection system covers three data categories: 1. Biographical data, 2. Enrollment and admission data, 3. Service data. These three categories also comprise additional data sets to fully capture a wide-range of information of how Special Population program services consumers:

1. Biographical data:
    - Date of Birth
    - Type of Special Population
2. Enrollment and admission data:
    - Consumer's ID in New Jersey Substance Abuse Monitoring System (NJSAMS)
    - Consumer's treatment admission date in NJSAMS
3. Service data:
    - Date of the service
    - Type of evidence-based treatment provided
    - If this is the first time the consumer uses this service as a Special Population
    - Interpreter service used
    - In-person or telehealth service

Expanded Hours for Outpatient Treatment. The Expanded Hours for SUD Outpatient Programs is intended to provide increased access to outpatient treatment for individuals with an SUD. MS Forms data collection system was designed in late 2022 and implemented in January 2023. Each awarded provider site has its own real-time data input website link to input its data each time client used the expanded hour services. As of July 2023, the 11 providers have provided 2,640 times of service to a total of 563 unique individuals.

Data collected through the Expanded Hours data collection system covers three data categories: 1. Biographical data, 2. Enrollment and admission data, 3. Service data. These three categories also comprise additional data sets to fully capture a wide-range of information of how Expanded Hours Outpatient program services consumers:

1. Biographical data:
    - Date of Birth
2. Enrollment and admission data:

- Consumer’s ID in New Jersey Substance Abuse Monitoring System (NJSAMS)
- Consumer’s treatment admission date in NJSAMS

3. Service data:
    - Date of the service
    - Time of the service
    - Type of service provided
    - If this is the first time the consumer uses this service.

Peers in Residential Services. The Peer Recovery Specialists for SUD Residential Treatment Program is intended to expand and increase SUD peer workforce and to provide peer services in residential settings. MS Forms data collection system for Peer Program is being designed and will be implemented in August 2023 to capture program progress. All awarded provider sites utilize their own real-time data input website link to update their program data. Each quarter, all providers are required to input detailed information of each of their peer’s work progress. As of August 2023, 8 providers with a total of 26 peer recovery specialists are awarded this program.

Data collected through the Peer Residential data collection system covers three data categories: 1. Peer Biographical data, 2. Peer qualification data, 3. Peer Service data. These three categories also comprise additional data sets to fully capture a wide-range of information of how peer recovery specialists service consumers:

1. Peer Biographical data:
    - Name
    - Date of Birth
    - Gender
    - Race
    - Ethnicity
2. Peer Qualification:
    - Qualification or certification of the peer
    - If Peer completes DMHAS ethics training
    - If Peer receives adequate supervision
3. Peer Service:
    - Level of Care Peer works on
    - Type of service provided
    - Number of consumer contacts, visits, meetings serviced

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

The data used to conduct outcome analyses is gathered in RDP using scientifically validated tools. The three outcome measures predominately used by the RDP pilot program are: Assessment of Recovery Capital, Cravings Rating Scale, and Outcome Rating Scale. These scores are based off of participant answers to questionnaires that are administered at regularly scheduled intervals. The outcome analysis focuses on establishing a baseline at the initiation of services and then re-evaluating.

Currently 13 programs are participating in the RDP Pilot. The 2021 annual report indicated there were over 12,000 participant records. Participating organizations provided peer recovery support services to 7,435 participants during 2022. The RDP is currently in a pilot phase and there are plans to eventually expand this to all SUD peer-based programs.

Summary. As a result of our IT and data collection systems, the SSA can report any of its data at the client level (demographic, clinical, financial, encounter, etc.). Currently it reports on all Treatment Episode Data System (TEDS) items, which includes the System Data Set (SDS), the Minimum Data Set (MDS) and the Supplemental Data Set (SuDS). The SSA has been reporting TEDS data through NJSAMS for many years. The Fiscal Agent system allows the SSA to determine costs for episodes of care and by specific services. The specialized systems allow for reporting outcomes on eight programs: M-WRAP, SEI/NAS, STAR, FSC, OORP, Contingency Management, Special Populations and Expanded Hours at multiple points in time, rather than only at admission and discharge. Additionally, RDP reports outcomes for peer delivered services. A new is being implemented for Peers in Residential Programs.

2. Need Assessment Overview

Over the years, the SSA has performed regular statewide needs assessments for substance abuse prevention and treatment. Information from general and special populations surveys combined with treatment utilization data from the New Jersey Substance Abuse Monitoring System (NJSAMS), as well as the application of Geographic Information Systems (GIS) methodology using Arcview for visual data presentations, provides the SSA with data to assess both service needs and delivery capacities which drive its SUPTRS Block Grant Application, its statewide strategic planning, and its multi-year county comprehensive planning. In addition, it prepares numerous reports which are publicly posted to help stakeholders identify system issues.

At both the state and local levels, the New Jersey substance abuse planning process is designed to employ both quantitative and qualitative data to assess the relative need for alcohol and drug abuse prevention, early intervention, treatment, and recovery support services. It uses both administrative databases prepared by federal, state, and local governments, as well as general and special population and service provider surveys conducted by DMHAS to engage in "gap" analysis of unmet treatment demand by age, race and sex among New Jersey residents. The periodic scheduling of surveys and other studies has provided the SSA with the capacity for longitudinal analysis and forecasting to estimate future prevalence of substance abuse treatment need and demand at both state and county levels and by demographic characteristics of subpopulations warranting special surveillance. Analysis of treatment admissions and delivery at the municipal level provides the SSA with the capacity for spatial analysis of unmet treatment demand and access

to care. Thus, analysis of both primary and secondary data sources drives New Jersey's state planning and policy development for substance use services.

Needs Assessment: Treatment

NJ Household Survey. In 1993, 1998 and 2003, the SSA was awarded a State Treatment Needs Assessment Program (STNAP) grant from SAMHSA's Center for Substance Abuse Treatment (CSAT) to conduct a "family of studies" centered around a statewide household survey supplemented by special surveys of sub-populations not expected to be included in the telephone sampling frame.

Over time, the SSA expanded the size of its household sample to 4,200 completed telephone interviews in 1998 and to 14,700 in both 2003 and 2009. The expansion to N = 14,700 provided approximately 700 completed household interviews per county, enough to allow survey data analysis for planning purposes in each county. After the STNAP ended in 2003, the SSA conducted its 2009 needs assessment "family of studies" using SUPTRS Block Grant funding.

The SSA conducts the New Jersey Household Survey on Drug Use and Health (NJ-HSDUH) at five-year intervals using a questionnaire developed by CSAT during the STNAP that is nearly identical to the questionnaire employed for the National Survey of Drug Use and Health (NSDUH). For 27 years, New Jersey has surveyed its adult population 18 years of age or older by telephone using a random-digit dialed sample to estimate: 1) the prevalence of both legal and illegal substance use, 2) alcohol treatment need and 3) unmet treatment demand. The questionnaire employs a core set of questions provided originally by the Center for Substance Abuse Treatment. The need for alcohol treatment is derived from a series of questions based on Diagnostic Statistical Manual (now DSM-5) criteria. Questions address use, quantity, effect on behavior, symptoms experienced, associated health problems, etc. Sample proportions are applied to state and county population estimates.

The primary focus is the population distribution of substance use and the population prevalence of substance abuse and addiction. It employs DSM diagnostic criteria of abuse and dependence in combination with "past 12 month" drug use to obtain alcohol and illegal drug treatment need estimates. The questionnaire also asks those with a treatment need about their treatment histories and obtains an estimate of unmet treatment. Beyond these core elements, the SSA's questionnaire regularly includes sections on tobacco use and gambling behavior.

Since the household survey underestimates drug treatment need due to under-reporting of illicit drug use, a statistical technique known as the two-sample capture-recapture model is applied to illicit drug treatment unique 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 (NJSAMS), DMHAS' administrative, client information system for substance abuse treatment. Together with the alcohol treatment need estimates obtained from the NJ household survey, DMHAS produces an annual estimate of total treatment need that is used in the distribution of alcohol and drug abuse treatment funds.

Typically, the NJ-HSDUH includes one or more special topics, such as the needs of pregnant women in 1993 and 1998, the needs of persons impacted by the 9/11 attacks in NYC in 2003, and in 2009, both substance use among New Jersey Veterans and obstacles to treatment access among persons who need but do not get care. For the 2013-2014 NJ-HSDUH, which was the first NJ-HSDUH after the merger of the Divisions of Mental Health and Addiction Services, the SSA included a new permanent section on mental health treatment needs and access to community-based, mental health treatment opportunities and to return to the special topic of substance use among pregnant women.

Due to changes in state procurement rules, the survey was not fielded as planned in 2014. As an interim measure, the survey was repeated in 2016 with a much smaller sample (N=1,052). Approximately 55% of the sample were households contacted via a landline while 45% were cell phone only households. The interviews were distributed by regions: north (N=422), central, (N=338) and south (N=292). The 2016 questionnaire introduced a new permanent mental health section that uses validated questions from the federal behavioral risk factor surveys to estimate New Jersey's mental health treatment needs.

The 2018 Household Survey is the largest of the three most recent surveys, sampling a total of 3,100 New Jersey adults. Sample sizes decreased in each subsequent survey year, with the 2019 Household Survey sampling 2,423 residents and the 2020 Household Survey, 1,622 residents. The sample size aggregated across the three survey years will totaled 7,145, which includes approximately 340 residents per county.

NJSAMS. A keystone source of information for need assessment and gap analysis for addiction services is the NJSAMS. The SSA is able to establish the number of persons receiving substance use disorder treatment from licensed treatment providers through its mandated reporting of essential client health data to this combined public health disease surveillance and provider-oriented, management information system.

Stakeholder Input. The SSA utilizes local input such as this to help guide its overall statewide program development. As some specific examples, the Medication Assisted Treatment Initiative (MATI) has helped improve "access on demand" to medically assisted treatment for opiate injection drug-users in six urban locations. It has also provided 63 units of supportive housing for clients referred through the MATI. As part of its fee-for-service initiatives, the SSA developed a network of providers with "co-occurring treatment capability" to enhance treatment effectiveness for individuals who have a substance use disorder and co-occurring mental illness. This network helped community advocates realize "one-stop", "treatment on demand", or "no wrong door" access to care. One county noted a service gap for early intervention services and planned for better integration of ASAM Level .5 into Level 1.0 outpatient programs and advocated for the inclusion of Level .5 (Early Intervention) into NJSAMS reporting. Interim Services is now a newly funded (October 2019) fee-for-service initiative.

IDTA. As noted in Step 1, the SSA in 2014 was awarded technical assistance through the SAMHSA supported National Center on Substance Abuse and Child Welfare (NCSACW) to address the multi-faceted problems of Substance Exposed Infants (SEI) and Neonatal Abstinence Syndrome (NAS). The goal was to develop uniform policies/guidelines that address the entire

spectrum of NAS and SEI from pre-pregnancy, prevention, early intervention, assessment and treatment, postpartum and early childhood.

In SFY23 New Jersey Department of Health successfully applied for 2023 In-Depth Technical Assistance (IDTA) through SAMHSA's National Center on Substance Abuse and Child Welfare: – *Advancing Collaborative Practice and Policy: Promoting Healthy Development and Family Recovery for Infants, Children, Parents, and Caregivers Affected by Prenatal Substance Exposure.* Several goals have been established: conduct a statewide landscape analysis of resources targeted at individuals and the families of individuals with SUD: establish a comprehensive and seamless system of care among state agencies, healthcare providers, and community level and non-profit organizations to address SUD during and after pregnancy; increase the percentage of prenatal Plans of Safe Care that community partners develop; develop and update protocols and policies that aim to prevent NAS, SEI and SUD to implement care coordination through the NJ Plans of Safe Care model.

<u>Estimation of the Population in Need of Treatment.</u> The estimated size of New Jersey's 2021 resident adult population in need of treatment for *alcohol* abuse or dependence is 373,984 persons. It is found by applying the proportion in need identified by the 2018 NJ-HSDUH to the U.S. Census Bureau's estimate of New Jersey's resident adult population for 2021. The size of the 2021 adult population needing treatment for *drug* abuse or dependence in New Jersey is 181,494 persons. It is found by applying a procedure known as the two-sample capture-recapture method to the count of unique clients receiving drug abuse treatment in 2020 and 2022 as reported in the NJSAMS. This technique was utilized due to under-reporting of illicit drug abuse or dependence observed in the household survey. The sum of these two estimates of treatment need, one for alcohol abuse and one for drug abuse, equals the 2021 New Jersey total substance abuse treatment need or 555,478 (See Table 1).

Table 1					
Estimate of Treatment Need for Alcohol and Drug Addiction, New Jersey 2021					
County	**Adult Population 2021**	**Need for Alcohol Treatment**	**Need for Drug Treatment**	**Total Need for Alcohol and Drug**	**Total Need as % of the Adult County Population**
	[1]	**[2]**	**[3]**	**[4]**	**[5]**
Atlantic	217,498	12,180	14,407	26,587	12.2
Bergen	753,517	30,894	8,251	39,145	5.2
Burlington	368,630	24,698	9,511	34,209	9.3
Camden	404,875	15,385	16,874	32,259	8.0
Cape May	79,494	3,180	4,693	7,873	9.9
Cumberland	116,449	6,870	6,186	13,056	11.2
Essex	652,302	46,966	21,717	68,683	10.5
Gloucester	239,014	12,429	9,080	21,509	9.0
Hudson	559,863	29,113	11,194	40,307	7.2
Hunterdon	106,018	4,347	1,696	6,043	5.7
Mercer	304,088	15,204	9,474	24,678	8.1
Middlesex	674,873	17,547	13,487	31,034	4.6
Monmouth	511,120	34,245	13,939	48,184	9.4
Morris	405,719	28,400	5,539	33,939	8.4
Ocean	488,695	31,276	15,867	47,143	9.6
Passaic	400,504	24,431	10,560	34,991	8.7
Salem	50,866	3,357	2,139	5,496	10.8
Somerset	275,481	12,948	4,026	16,974	6.2
Sussex	117,453	8,339	2,935	11,274	9.6
Union	438,239	3,944	9,084	13,028	3.0
Warren	89,471	8,231	2,703	10,934	12.2
Total	**7,254,169**	**373,984**	**193,362**	**567,346**	**7.8**

[1] Source: U.S. Census Bureau, Population Division: 2021 American Community Survey 5-Year Estimates.
[2] Alcohol treatment need derived from the 2018 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 2020 and 2022 NJSAMS data.
[5] Percent of Drug treatment need was derived by dividing the population in need of treatment in each county (column 4) by the adult population in that county, times 100.

Met and Unmet Treatment Demand. Table 2 presents the met and unmet demand for substance abuse treatment as well as the ratio of unmet to met treatment demand, or "gap" in New Jersey by county. It can be seen that of 127,288 individuals who wanted substance abuse treatment, 47,538 received it. This resulted in an unmet demand of 79,750 or a gap of 63.0%.

The 2018 NJHSDUH asked people who either had been treated or felt they needed treatment in the past year, what prevented their access to care. The most prevalent response was individuals felt they could manage problem on their own (74%), 54% were afraid others would find out, 49% indicated time constraints, 44.3% were not ready to stop using, and 39% feared treatment information was not confidential. Other reasons given were couldn't afford the cost (38%), inconvenient program hours (35%), transportation issues (35%), couldn't find right treatment (35%), thought treatment wouldn't help (28%), and worried about legal consequences (14%).

Table 2

2022 Estimates of Met and Unmet Demand for Substance Use Treatment of the Adult Population in New Jersey

County	Adult Population 2022 (1)	Met Demand (2)	Unmet Demand (3)	Total Demand (2)+(3)	Gap: Unmet Demand As Percent of Total Demand
Atlantic	218,030	3,187	3,270	6,457	50.6
Bergen	752,868	1,871	4,517	6,388	70.7
Burlington	370,086	2,090	9,622	11,712	82.2
Camden	405,753	3,679	4,869	8,548	57.0
Cape May	79,472	1,139	954	2,093	45.6
Cumberland	114,728	1,604	2,868	4,472	64.1
Essex	648,151	4,735	11,019	15,754	69.9
Gloucester	240,682	1,863	2,888	4,751	60.8
Hudson	560,583	2,499	5,045	7,544	66.9
Hunterdon	105,898	392	106	498	21.3
Mercer	299,982	2,138	11,399	13,537	84.2
Middlesex	675,352	3,185	675	3,860	17.5
Monmouth	510,126	3,232	14,794	18,026	82.1
Morris	405,854	1,152	406	1,558	26.1
Ocean	493,768	3,507	5,925	9,432	62.8
Passaic	397,273	2,417	2,384	4,801	49.7
Salem	50,921	473	1,528	2001	76.4
Somerset	276,459	958	3,318	4,276	77.6
Sussex	117,890	623	2,829	3,452	82.0
Union	436,478	1,902	1,309	3,211	40.8
Warren	89,628	540	2,151	2,691	79.9
Total	**7,249,982**	**47,538**	**79,750**	**127,288**	**62.7**

[1] 2022 Estimates of the Resident Population for Counties in New Jersey. U.S. Census Bureau, Population Division.

[2] Met demand: The number of unduplicated counts of adults admitted for alcohol and drug treatment in 2022. Source: NJSAMS data – 2022 Substance Abuse Overview.

[3] Unmet demand: Proportion of the 2018 NJ Household Survey estimated adult population who did not receive treatment in the 12 months prior to the interview but who felt they needed and wanted treatment, times the 2022 adult resident population.

Relative Needs Assessment Scale. In addition to utilizing survey data, the DMHAS addiction 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 is the Relative Needs Assessment Scale (RNAS), developed by DMHAS researchers, Mammo & French (1996), using social indicators with known correlations to the incidence and prevalence of substance abuse. The RNAS is used to target prevention and treatment resources by location and socio-economic characteristics of at-risk populations. The scale calculates an index of risk for each county 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. In FFY 2014, the SSA provided RNAS indexes down to the municipal level for use in the county comprehensive planning process. In the past county comprehensive planning process for 2016 to 2019, the RNAS model, updated to include data from the 2019 U.S. Census, was used to identify areas within counties with potentially high concentrations of people with substance abuse prevention, treatment and recovery support service needs.

Geographic Information Systems. The SSA maps the spatial distribution of treatment services across all counties and modalities of care and uses this information in its county comprehensive planning. It routinely uses Geographic Information Systems (GIS) to map its treatment services in order to guide its planning of services in underserved areas. GIS is used in the County Substance Abuse Overviews to assist counties by providing color-coded choropleth maps that show the distribution of treatment admissions in their municipalities and where utilization is greatest. In the statewide report a choropleth map is also provided so the SSA can easily see the counties with the greatest treatment utilization. It is used to present spatial visualizations of key issues. It is used for the SYNAR coverage study and annual SYNAR inspections to produce walking maps for the inspectors to follow.

Treatment Initiatives Based on Need

Medication Assisted Treatment. Data from NJSAMS for Calendar Year 2022 indicates that 16% of methadone and 12% of buprenorphine is planned in treatment for clients admitted to treatment, yet heroin and other opiates are the primary drugs of 44% of admissions in New Jersey's addiction treatment system. The development of the Medication Assisted Treatment Initiative (MATI) has been an attempt to help reduce this gap by providing increased access to medication assisted treatment by offering methadone, as well as buprenorphine, to individuals with an opioid use disorder through five mobile medication units. One mobile medication unit currently provides methadone to inmates at Atlantic County Jail as part of their business plan and connects them to continued care when released. Another attempt to increase access to MAT, specifically buprenorphine, has been the development of statewide buprenorphine training courses utilized as an educational component for physicians, Advanced Practical Nurses (APNs) and Physician Assistants (PAs) to attain their Buprenorphine Waiver. The State held a total of 31 trainings statewide through both Rutgers University (northern region) and Rowan University (southern region) in CY 2019 and CY 2020. Over 1,000 prescribers were trained through this effort. In December 2022, the buprenorphine waiver requirement was permanently removed in, so any

provider who is registered with the DEA to provide controlled substances can now provide buprenorphine in the State of New Jersey.

Other initiatives implemented to expand the use of Medication-Assisted Treatment (MAT) in New Jersey have been the Expanded Hour Access OTP Program and the Mobile MAT Program. In early CY 2021, DMHAS initiated contracts with four OTPs that provide over 35 additional hours of service per week and began in July 2021, with most providing evening hours, in efforts to assist individuals access services during times intakes at OTPs are not typically available. The intent of the program has been to provide low barrier, on-demand MAT followed by treatment or referral to ongoing care for individuals with an OUD. DMHAS secured funding to start-up two additional Expanded Hour OTPs and contracts began with those entities in by the end of CY 2021. Services commenced with the two additional providers in CY 2022. The other initiative which was developed provides funding for programs to facilitate low induction medication, case management and other ancillary services through use of a mobile van for individuals with an OUD in counties with low access to MAT as well as areas of the State with individuals who are homeless or at higher risk for homelessness. In CY 2022, two agencies were awarded contracts. In CY 2023, both contracted programs procured Mobile Access Vehicles (MOVs) from Mission Mobile, a vendor recommended by the National Association of Addiction Treatment Providers. Both are scheduled to begin buprenorphine prescribing in May 2023. Both are working with the NJ Department of Health, Certificate of Need & Licensing (CN&L), to attain an OTP license, which will enable them to dispense both methadone and buprenorphine from the vehicles. DMHAS goal is to solicit additional funding for a third contract, expected later in CY 2023.

The SSA's goal is to continue to develop a system of care that offers high risk clients the means to enter and sustain recovery. In this effort, the SSA implemented a pilot program in September 2011 for the DUI offender with an alcohol or opioid use disorder that included medication assisted treatment using the FDA approved medication Vivitrol (an injectable form of naltrexone). A comprehensive research protocol was developed, and numerous client outcomes were assessed. The pilot was launched in September 2011; clients received the medication for up to six months. There was a follow-up survey six months after the client's last injection. The pilot ended in September 2013 once 100 clients had received the medication. Since results were promising, Vivitrol has since been incorporated as an enhancement in most of its current SUD Fee for Service Initiatives, including Recovery Court (formerly, Drug Court), New Jersey Statewide Initiative (NJSI), South Jersey Initiative (SJI), Mutual Agreement Program-State Parole Board (SPB), Medication Assisted Treatment Initiative (MATI); Substance Abuse Prevention and Treatment Initiative; State Hospital Access to Rehabilitation and Education (SHARE), and the Driving Under the Influence Initiative (DUII). Acknowledging that addiction is a medical disorder that postulates client-centered treatment, the purpose of this funding is to have an array of medication treatment alternatives for individuals with an opioid use disorder.

The Division continues to offer trainings on MAT for licensed substance use disorder treatment providers as well as peer recovery specialists who work at licensed SUD agencies or through DMHAS-funded initiatives. DMHAS has also incorporated language requiring acceptance of clients on all forms of MAT into contract requirements, as well as all applications for new funding, and has provided training on MAT for systems to include, but not limited to, Drug Court, the Administrative Office of the Courts, the Department of Children and Families' Children System

of Care, Harm Reduction Centers, Psychiatric Hospitals and the New Jersey County Jail Wardens Association. DMHAS also contracts with Rutgers University, who has implemented a program called the Rutgers Interdisciplinary Opioid Trainers (RIOT). The RIOT has been designed as a train-the-trainer program by faculty who educate/train university students. The university students provide a free 1-hour training (virtual since March 2020) to community members/groups to educate them about the opioid epidemic in NJ, how to manage an overdose, and increase education and reduce stigma and discrimination about Opioid Use Disorder (OUD) and the use of medications to treat the disease. Another training initiative, launched in CY 2023 is with Cooper Medical School of Rowan University (CMSRU), the State's Southern Center of Excellence (COE). CMSRU is contracted to provide tailored training and technical assistance on Addiction Medicine, specifically buprenorphine induction, throughout New Jersey. This includes various training topics, formats, office hour sessions, and "elbow to elbow" on-site consultation services. The training is aimed at increasing the use of buprenorphine to treat opioid use disorders, specifically at Emergency Departments, Federally Qualified Healthcare Centers and Primary Care offices.

From FY 2018 to FY 2020, New Jersey received a total of $120.3 million from SAMHSA, the Center for Substance Abuse Treatment (CSAT) through the initial State Opioid Response (SOR) grant and supplemental SOR funding. In FY 2021, NJ received $65.97 million through SOR 2.0 for FY 2021 and FY 2022. Subsequently, NJ received $66.56 million through SOR 3.0 in FY 2023. The goals of the SOR have been to address the State's opioid crisis as well as a rising issue of stimulant use disorder (SOR 2.0 and SOR 3.0) by providing treatment, family and peer recovery support, community prevention and education programs and training. The key objectives of funding have been to increase access to medication-assisted treatment (MAT), reduce unmet treatment need, reduce opioid-related deaths, and most recently to provide services to address individuals who have a stimulant use disorder. Some of the activities of the SOR grant are highlighted below.

Through SOR funding, DMHAS contracted with 10 licensed substance use disorder agencies to support the development of medical capacity to provide MAT to eligible individuals at their programs. DMHAS offered similar contracts for up to eight mental health agencies to ensure these services for individuals with a co-occurring mental health and substance use disorder.

DMHAS began a pilot low threshold buprenorphine induction program for participants at two Harm Reduction Centers (HRCs) in late 2019. Through this initiative, individuals who attend the program obtaining sterile syringes and other harm reduction programming are offered immediate enrollment in buprenorphine treatment and care management services. The program provides services to individuals who seek care in a safe and nonjudgmental environment despite continued drug use or lapses in care. DMHAS commenced a statewide program in CY 2022, therefore all HRCs, currently seven, are be able to participate in this initiative.

DMHAS began funding Interim Services through its Fee-for-Service (FFS) Network in October 2019 for individuals on waiting lists at ambulatory and residential programs. This program offers individuals early intervention services prior to being admitted to a full array of treatment services. DMHAS partners with both Rutgers University and Rowan University to ensure funding is available to support individuals at clinics who are indigent, so they can be inducted and/or

maintained on MAT. Services for these individuals include other ancillary services such as care coordination and peer services and commenced in July 2021.

DMHAS, in collaboration with the NJ Department of Corrections (DOC) and the NJ Department of Health (DOH) have jointly initiated a program to expand the use of Medication-Assisted Treatment (MAT) for inmates with opioid use disorders in all but one of the New Jersey county jails (SOR funds support four of the county jails). The only jail not initially funded (Monmouth County) had a discretionary grant enabling them to provide this service which ended and as of CY 2023, DMHAS has begun funding. The medications prescribed include methadone, buprenorphine, naltrexone and extended release naltrexone (Vivitrol). In efforts to support jails in this endeavor, DMHAS is utilizing funds to support the State Centers of Excellence (COE) so they can provide technical assistance to the county jails participating in this initiative.

Recovery Initiatives Based on Need

DMHAS implemented contracts in all 21 counties to support it Opioid Overdose Recovery Program which utilizes recovery specialists and patient navigators to engage individuals, bedside, who were reversed from an opioid overdose and provide non-clinical assistance, recovery supports and appropriate referrals to substance use treatment services while also maintaining follow-up with clients for a minimum of eight weeks.

DMHAS contracts for Support Team for Addiction Recovery (STAR) programs in all 21 counties. This program provides case management and recovery support services for individuals with an OUD who are at risk for opioid overdose. All STAR programs continued to be operational during the pandemic and offered services virtually, through the phone, and in-person (where social distancing could be maintained). STAR teams obtain their referrals from community partners including treatment providers, state child welfare agencies, Drug Court, re-entry organizations, and community agencies, among many others. STAR providers also actively collaborate amongst themselves to ensure that individuals who leave one county can receive a warm handoff to another county's STAR program and continue to receive these vital recovery support services.

DMHAS funds 21 Community Peer Recovery Centers (CPRCs) to provide peer support recovery services and/or activities to the community that include, but are not limited to: access to resources on substance use disorder and behavioral health treatment; naloxone training and kits; peer recovery coaching; assistance in development of recovery plans; social events and/or recreational activities; support groups; wellness classes; and special programs to address special issues and concerns. During the COVID-19 pandemic, all CPRCs provided virtual community support services via phone and online service) and provide limited safe distancing in-person recovery support services.

DMHAS funds a Telephone Recovery Support (TRS) program. TRS is a peer check-in type service where staff help provide local recovery supports, including information about resources such as self-help meetings, food pantries, and sober living and treatment services, if needed. TRS provides support and peer coaching to program participants. Participants receive weekly support calls and are connected to information on local recovery support services. Specialists assist in

identifying resources such as housing, transportation, training programs, employment services, or recovery support groups.

Recovery Management Check-Up (RMC). RMC is a service for discharged clients to support independent living and success with recovery and provide more methods of outreaching to clients. This will include virtual face-to-face visits, text messaging and chat features, and also the opportunity for actual in person contacts. This check-up service will help provide local recovery supports. RMC aims to identify and alleviate client problems before they derail recovery. Monthly contact forms the core of the proposed RMC. Problems will be addressed using motivational interviewing techniques or connecting clients to appropriate community resources or treatment if needed. The conceptual framework of RMC is to treat addiction as a chronic disease, with long-term management to minimize the number of acute episodes of substance abuse and with prompt treatment when episodes occur to prevent them from becoming more severe and consequential. Three regional awards (North, Central and South) were awarded in March 2023 to two agencies (one agency will cover two regions) to provide this service.

Recovery Support Care Management (RSCM). RSCM was established and became effective on March 7, 2023 and is a behavioral health service intended to support consumers who have a SUD with complex physical and/or psychosocial needs. RSCM provides direct and comprehensive assistance to consumers to ensure access to the necessary treatment, rehabilitative and recovery services with the intent of reducing psychiatric and addiction symptoms, connect consumers with services, improve transitions between levels of care, implement strategies to address their unique needs, reduce opioid related deaths and sustain recovery in the community while supporting the consumers' continued stability and recovery throughout the continuum of care. This service is available as an enhancement in all levels of care. This service may be provided face-to-face or via a telehealth platform. Since Medicaid offers Care Management in outpatient, RSCM is excluded from reimbursement for individuals admitted into Ambulatory LOCs in Recovery Care Efficiency (RCE). As of July 19, 2023, 1,186 unduplicated individuals have received RSCM services.

Needs Assessment: Prevention

In December 1993, the SSA was awarded a three-year contract with the Center for Substance Abuse Prevention (CSAP) to conduct studies to assess needs for prevention of alcohol, tobacco, and other drugs misuse and abuse in the state and in its health planning regions. The contract included the Middle School Survey, the Mature Citizen Survey and the Community Leaders Survey. In addition, a social indicators study and companion chart books of social and health indicators for each of New Jersey's 21 counties and selected municipalities were completed. The data generated by these surveys and studies were utilized in policy formulation, resource allocation and the provision of revised data requested within the SUPTRS Block Grant Application process beginning in FFY 1998.

Middle School Survey. Considering the importance of monitoring levels of risk for substance abuse among New Jersey's youth, the SSA has supported continuation of the Middle School Survey beyond the CSAP funding period. The SSA subsequently conducted a Middle School Survey approximately every 3 years. They have been conducted in 2003, 2007, 2010, 2012, 2016 and 2020. The most recent survey was conducted during the 2020-2021 academic year. Because

of constraints necessitated by the COVID-19 pandemic, the survey was largely administered electronically. Response rates exceeded those of previous years, when the survey was conducted in person. The 2023 survey has launched and will be completed in 2023. Analysis and report development will be completed in 2024.

Implementation of the SSA's first High School Survey was completed in June 2008. It used the same survey instrument as the middle school survey (Pride Survey) and is the first New Jersey report at the county level on 9th through 12th grade youth. It was decided to not repeat the survey since the NJ Department of Education (DOE) conducts a High School Student Health Survey. The SSA collaborated with DOE and provided financial assistance for the 2010-2011, 2013 and 2016 surveys. While the DOE does not sample at the county level, the findings still provide important information regarding factors protecting and posing risk to adolescents concerning substance use as well as reported substance use.

Through data obtained in all the prevention studies, the SSA identified risk and protective factors for substance abuse and ranked communities by risk scores. Additionally, the SSA used the data to identify trends in factor scores over the past 18 years. However, one of the state's challenges has been that active parental consent is required for students to participate in these surveys, which impacts response rates. The SSA has supported a change in the legislation to require passive parental consent instead. The state passed new legislation NJ P.L.2021, c.156 that eliminates the need for active parental consent.

<u>Chartbooks.</u> Assessing the well-being of community health through social indicators has been a long-standing concern to the Center for Substance Abuse Treatment (CSAT). To meet this objective, CSAT has encouraged the use of social indicators to assess social and health risks related to substance misuse in order to inform policy makers. Following the *Social Indicators Core Protocol* guidelines provided by CSAT, the SSA developed the *NJ Chartbook of Substance Abuse Related Social Indicators*. The Social Indicators Chartbook is intended to identify social and health problems directly or indirectly related to substance use and to aid in the assessment of needs for treatment and prevention services. This is achieved, in part, by using key social indicators outlined in the core protocol by CSAT, and by identifying risk and protective factors affecting health outcomes. Summary analysis of the core indicators is presented using census data, criminal justice data and substance abuse treatment admissions data.

Additional indicators were identified using guidance from three sources: 1) The U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration's Risk and Protective Factors for Mental, Emotional, and Behavioral Disorders Across the Life Cycle; 2) The Community Anti-Drug Coalition's (CADCA) Assessment Primer: Analyzing the Community, Identifying Problems and Setting Goals; and 3) CADCA's Community Assessment Needs Assessment Data Collection Examples of Local Data worksheet. These documents rely on the Center on Substance Abuse Prevention's (CSAP) Strategic Prevention Framework to guide the identification of individual, family, and community factors that are related to substance abuse. Additionally, CADCA's Assessment Guide is specifically concerned with aiding community coalitions during the needs assessment process and in identifying communities to target for prevention initiatives and the organization of the county and municipal social indicators follow CADCA's conceptualization of domains useful in prevention planning.

The specific objectives of the Chartbook are to: 1) Present an objective profile of New Jersey at the state, county, and municipal levels using key social indicators related to substance abuse; 2) Show the effect of substance use and related health consequences in New Jersey at the state, county, and municipal levels; and 3) Provide information to support needs assessment and prevention, as well as treatment planning, at the community level. Chartbooks have been published for 2003, 2005, and 2013. In early 2016, DMHAS updated its *Chartbooks of Social and Health Indicators*' information which can be used to identify health problems directly or indirectly related to substance use and to aid in the assessment of needs for prevention and treatment services, and further enhanced the database of all prevention services and programs being delivered throughout the State. The 2022 Chartbooks are currently under review.

Prevention Coalitions. In 2012, DMHAS established nineteen prevention coalitions in New Jersey. The regions in which the coalitions are located were identified based the "Prevention Needs Assessment Using Social Indicators: State of New Jersey Substance Abuse Prevention County Level Needs Assessment". The "Prevention Needs Assessment" utilized archival data of social indicators to develop composite indices of risks to estimate the need for prevention services among New Jersey's 21 counties. Criteria including population, substance abuse treatment admissions and rates within the region as well as prevalence of alcohol and prescription drug misuse among middle and high-school students were also considered in identifying the 19 regions. Additional criteria used to determine the regions included that:

- Each region must be comprised of at least one county
- Each region must have reported a minimum of 2000 treatment admissions (according to the latest available data) for the previous year

Relative Needs Assessment Scale. The Relative Needs Assessment Scale (RNAS) was developed for alcohol and drug prevention planning in 1995 and updated in 2008, 2013 and 2016. A report was prepared in September 2017, "Substance Abuse Prevention Needs Assessment Using Social Indicators". Archival data of social and health indicators were used to estimate the relative levels of need for prevention services among NJ counties. The risk indicators for AOD use or abuse are organized by two operational domains, namely, the Community-based Risk Index (CRI) and the Youth Risk Index (YRI). The RNAS employs social indicators of substance use-related mortality and morbidity and calculates relative risk for each county and municipality, thus, permitting comparisons of relative risk among counties across the state and among municipalities within each county. The RNAS is used to target prevention and treatment resources by location and socio-economic characteristics of at-risk populations. It was utilized in the 2008 and 2014 RFP processes for awarding five-year prevention contracts utilizing SAPT Block Grant funding. Work will begin on updating the RNAS during SFY 2024.

Addictions Prevention Strategic Plan. In 2012, the SSA completed an addictions strategic prevention planning process to identify prevention priorities and provide direction regarding the use of environmental management strategies to address those priorities. The planning method relied on the full range of DMHAS' available quantitative data in order to identify meaningful priorities at both the state and community levels for which measurable change could be achieved when prevention efforts employed targeted, evidence-based prevention strategies. It provides direction for all DMHAS-funded prevention services.

In keeping with the aforementioned purpose of the Plan, the priorities identified were included in the RFP entitled, "Funding for Regional Coalitions to Utilize Environmental Strategies to Achieve Population-Level Change". The primary goals of the RFP were to identify and fund regional coalitions to utilize the SPF and undertake a rigorous needs assessment process to identify which of the statewide DMHAS prevention priorities identified in the Plan are the most significant in their region. Nineteen coalitions were awarded contracts. The Plan will be updated during SFY 2024.

State Epidemiological Outcomes Workgroup. The SSA was awarded a Strategic Prevention Framework State Incentive Grant (SPF-SIG) by SAMHSA in October 2006 the purpose of the grant was to develop a comprehensive Prevention Strategy for delivering and implementing effective substance abuse prevention services. The initiative served as a blueprint for state and community partners to apply the federal Center for Substance Abuse Prevention's (CSAP) Strategic Prevention Framework towards creating healthy communities for everyone. The NJ SPF aligned its work around CSAP's framework, providing tools that continue to guide state and local partners in conducting needs assessments, capacity development, strategic planning, plan implementation, and outcome evaluation.

As one requirement of the SPF-SIG, the SSA convened the New Jersey State Epidemiological Outcomes Workgroup (SEOW), comprised of individuals from various state departments including Health, Transportation, Education, Human Services, Juvenile Justice, county offices, universities, community provider agencies and statewide organizations. The SEOW continues to meet monthly to discuss ways to prevent the onset and reduce the progression of substance use disorder in New Jersey.

The SSA also continues to actively recruit for new SEOW members. The past year has seen the addition of members from the NY/NJ High Intensity Drug Trafficking Area (HIDTA), the Department of Health's (DOH) Division of Family Health, the NJ Department of Children and Families, , the New Jersey Hospital Association Behavioral Health Group, Statistical Analysis System (SAS) Institute, the NJ Attorney General's office, Rutgers, and Robert Wood Johnson Medical Schools, representatives from the NJ State Police's Regional Operations Intelligence Center, and representation from the Prescription Drug Monitoring Program.

Originally, the role of SEOW was to conduct a statewide prevention needs assessment to recommend a statewide priority for the SPF-SIG project. Beginning in late 2006, the SEOW developed the New Jersey Epidemiological Profile for Substance Abuse, which it submitted to SAMHSA in April 2007. The plan was updated in 2008 and during SFY 2024 will be updated again.

Examples of datasets reviewed for production of the Epidemiological Profile included:

1. The Behavioral Risk Factor Surveillance System (BRFSS)
2. The Core Alcohol and Drug Survey (CORE)
3. The New Jersey Household Survey on Drug Use and Health (NJHSDUH)
4. The National Survey on Drug Use and Health (NSDUH)
5. The New Jersey Middle School Risk & Protective Factor Survey(MSRPFS)

6. The New Jersey Student Health Survey of High School Students (NJSHS)
7. The Treatment Episode Data Set (TEDS)
8. The Uniform Crime Report (UCR)
9. The New Jersey Youth Tobacco Survey (NJYTS)

Other sources of governmental administrative data used to compile the above mentioned profile included:

1. The New Jersey Substance Abuse Reporting System (NJSAMS)
2. The New Jersey Department of Children and Families (DCF)
3. The New Jersey State Police Regional Operations and Intelligence Center (ROIC)
4. The National Highway Traffic Safety Administration (NHTSA)
5. The New Jersey Center for Health Statistics (NJCHS)
6. The New Jersey Department of Health: Division of HIV/AIDS Services (NJDHSS)
7. Violence, Vandalism and Substance Abuse in New Jersey Public Schools. The Commissioner's Annual Report to the Education Committees of the Senate and General Assembly (CRVV)

Initially, the profile served as the basis for identifying prevention priorities to be addressed through the SPF-SIG grant. The SEOW conducted an extensive review of data from a multitude of sources that describe substance use and its consequences. Using prevalence and incidence rates, severity ratings and trends, the SEOW developed a formula incorporating these variables to produce need scores and ranked the needs in order of importance. "Alcohol use/misuse by 18-25 year olds in the past year", "drug use/misuse among 18-25 year olds in the past year" and "past month use of illicit drugs by 18-25 year olds" were the three highest ranked indicators. Based on these data, the priority "to reduce the harmful consequences of alcohol and drug use among 18-25 year olds," was selected as the guideline for the SPF-SIG project. It was noted that there are very few prevention programs specifically for the 18-25 year old population. In 2008, the SSA awarded 11 community contracts to address this prevention priority. As the projects were implemented, most were focused on the harmful consequences of alcohol consumption and in particular, motor vehicle crashes. SPF-SIG funding ended in 2012, after which, most of the SPF-SIG communities received funding (from the SABG) to continue their coalition work by focusing on the priorities identified in the prevention strategic plan.

The role of the SEOW was expanded in 2010 when the SSA charged the group with developing both treatment and prevention priorities. Upon further review of the data as described above, which included updated information, the SEOW then identified the following statewide prevention priority problems/issues in 2010: 1) Drug use/misuse by 18-25 year-olds in the past year; 2) Binge drinking by college students; 3) Use of illicit drugs by persons under age 25 in the past 30 days; and 4) Use of alcohol by high school students in the last 30 days.

Selecting indicators to describe the consequences of substance use and the consumption patterns associated with those consequences is a critically important aspect of the needs assessment process. The SEOW Epidemiological (Epi) Profile Workgroup identified various dimensions that could describe the extent of a problem, including the size of the problem, its magnitude relative to other states' problems, the severity of the problem's impact on an individual and/or community, trend characteristics, attributable risk to substance abuse, and availability of data. In addition, the

Epi-Profile Workgroup identified additional criteria that could impact efforts to address a problem, including capacity/resources, perceived gap between capacity/resources and need readiness (political will/public concern), economic impact, and social impact. The SEOW Epi-Profile Workgroup compiled a list of the data gaps they identified in their process. Some of the data gaps identified by the SEOW Epi-Profile Workgroup included:

- Medical Examiner data - not all counties report to state; need to search for data on presence of AOD in the bodies of homicide victims; more collaboration / cooperation between New Jersey State Police and New Jersey Medical Examiners on ALL AOD related deaths
- Secondary cause of death due to alcohol
- Pedestrian fatalities and non-fatalities by age and substance
- Current use of ATOD by high school students
- General education referrals to school Student Assistance Counselors
- General education referrals to treatment
- High school dropout rate

In 2022, work began on a new Epi Profile. SEOW Epi Profile Workgroup members assumed responsibility for reviewing relevant data and writing first drafts of the five chapters of the Profile. The chapter topics were determined by a review of epidemiological, law enforcement, and Department of Education data. The review identified the substances that posed the most significant threat of harmful consequences throughout New Jersey. A representative from the Department of Health - Office of Tobacco Control and Prevention was responsible for the Tobacco chapter. The Prescription Drugs chapter was headed up by the Director of New Jersey's Prescription Drug Monitoring Program (PDMP). Staff from the Office of Drug Monitoring & Analysis at the NJ State Police – Regional Operations Intelligence Center (ROIC) prepared the chapter on Illicit Drugs. The ROIC partners with federal, state, and local entities to collect crime, threat, and disaster related information, conduct analysis, develop intelligence products, and provide timely and relevant alerts, warnings, and notifications to law enforcement, public safety and private sector entities to strengthen preparedness, prevention, enforcement, investigative, response, and resiliency efforts.

The Executive Director of the New Jersey Prevention Network guided the work of the Alcohol chapter and a professor/researcher from the Rutgers New Jersey Medical School was responsible for the Marijuana/Cannabis chapter. Workgroup members used the Strategic Prevention Framework (SPF) as a guide when they reviewed and analyzed the data.

Colleagues from the Rutgers School of Social Work, Center for Prevention Science created a draft of the Epi Profile, which included an introduction, methodology, and then introductions and data tables and figures for each chapter. Costs associated with preparing the Profile were covered by New Jersey's Strategic Prevention Framework – Partnerships for Success grant. The final version of New Jersey's Epi Profile will be available by the end of August 2023.

New Jersey Regional Coalition Needs Assessment . The 19 New Jersey Regional Coalitions conducted an update to their needs assessment in 2018. Building on their initial needs assessment conducted five years prior, the Regional Coalitions built on that process to update their logic

models and plans in order to capture current substance abuse prevention needs and trends. Using the Strategic Prevention Framework (SPF), the coalitions work on all steps (i.e., needs assessment, building capacity, implementation, etc.) at different times. Given the length of time that had passed since the coalitions' original needs assessment, an update was needed to assess their accomplishments so far and determine any changes in community needs.

The primary goals of these community needs assessment updates were to assess what the coalitions accomplished in the first several years of the statewide initiative, assess current community needs and readiness, prioritize strategies, and update logic models to reflect any changes in their plans to address current needs. The Rutgers Center for Prevention Science (RU-CPS) and New Jersey Prevention Network (NJPN) provided guidance, technical assistance, and training as the coalitions moved through their community needs assessment updates.

The overall needs assessment questions guiding the coalitions' process included the following:

- Which substance use problems (i.e., overdoses, alcohol poisoning) and related behaviors (i.e., prescription drug misuse and underage drinking) are occurring in your community?
- How often are these problems and related behaviors occurring?
- Where are these substance use problems and related behaviors occurring (i.e., at home or in vacant lots; in small groups or during big parties)?
- Who is experiencing more of these substance use issues and related behaviors? (i.e., are they males, females, youth, adults, or members of certain cultural groups?)

The final step for all coalitions was to update their regional logic models based on their needs assessment update process. Across all coalitions, logic models were developed for the following substance priorities: underage drinking, marijuana, prescription drug misuse, illegal drugs, and tobacco. Coalition Needs Assessments will be updated during SFY 2024.

Prevention Initiatives Based on Need

Regional Coalitions. Effective January 1, 2012, 19 regional substance abuse prevention coalitions were funded under an RFP that was issued by the Division of Mental Health and Addiction Services in the fall of 2011. The goals of this project are to engage community stakeholders to address prevention priorities identified by DMHAS' Prevention Strategic Planning Committee in 2010 and to complement and reflect the first of the Substance Abuse and Mental Health Services Administration's (SAMHSA) Eight Strategic Initiatives. The prevention priorities are:

- Reduce underage drinking
- Reduce the use of illegal substances – with a special focus on the use of opioids among young adults 18-25 years of age
- Reduce prescription medication misuse across the lifespan
- Reduce the use of new and emerging drugs of abuse across the lifespan

The SSA identified 19 coalition regions in New Jersey. These regions were selected based the "Prevention Needs Assessment Using Social Indicators: State of New Jersey Substance Abuse Prevention County Level Needs Assessment." The "Prevention Needs Assessment" utilized archival data of social indicators to develop composite indices of risks to estimate the need for

prevention services among New Jersey's 21 counties. Criteria including population, substance abuse treatment admissions and rates within the region as well as prevalence of alcohol and prescription drug misuse among middle and high-school students were also considered in identifying the seventeen regions.

The coalitions collaborate with Municipal Alliances in their region, which are funded and overseen by the Governor's Council on Alcoholism and Drug Abuse (GCADA). Coalitions also coordinate their efforts with those of the 30 Federally-funded Drug Free Community Support Programs in New Jersey. This initiative seeks to achieve an enhanced level of communication and collaboration among all groups and organizations that are working to reduce the misuse and the harmful consequences of alcohol and drug use among the citizens of New Jersey.

Strategic Prevention Enhancement Grant. In May 2011, the SSA received a Strategic Prevention Enhancement (SPE) grant from SAMHSA. New Jersey's SPE Project served six high-need counties: Bergen, Camden, Essex, Hudson, Middlesex, and Monmouth. Archival data of social indicators were used to develop composite indices of risks to estimate need for prevention services among the 21 New Jersey counties. Risk factors related to alcohol and drug misuse in these identified counties were far more prevalent than in other counties throughout the State.

In addition to serving these high-need communities, New Jersey utilized SPE funding to make numerous enhancements to its prevention infrastructure by: addressing gaps in data regarding older adults and binge drinking rates among young adult women of child bearing age (21-29 years), expanding the capacity of the Prevention Outcomes Monitoring System (POMS), which DMHAS' prevention management information system, and to collect data on environmental strategies and programs. Additionally, DMHAS was able to update its *Chartbooks of Social and Health Indicators*, the information in which can be used to identify health problems directly or indirectly related to substance use and to aid in the assessment of needs for prevention and treatment services. Funding was also used to create a database of all prevention services and programs delivered throughout the State.

The training and services that DMHAS provided to high-need communities as well as the enhancements to its prevention infrastructure better enabled New Jersey to support more strategic, comprehensive systems of community-oriented care.

Partnership for Success. In October 2013, DMHAS received a five-year Strategic Prevention Framework - Partnerships for Success (SPF-PFS) cooperative agreement from CSAP. The goals of New Jersey's SPF-PFS initiative were threefold: 1) to strengthen and enhance the work of 19 DMHAS-funded regional prevention coalitions; 2) to further develop the prevention data infrastructure and information systems capacity at the state level; and 3) in collaboration with state partners and community stakeholders, to continue work in developing a unified statewide prevention planning and service delivery system. Specifically, New Jersey's SPF-PFS sought to 1) reduce underage drinking among persons aged 12 to 20; and 2) reduce prescription drug misuse and abuse among persons aged 12 to 25. As additional components of its PFS programming, New Jersey also focused on unhealthy drinking patterns and prescription drug abuse among adults age sixty and older; and served military families with prevention education, addressing military community risk levels, striving to mitigate the risk factors, and enhancing the protective factors to

support military members and their families in making responsible parenting and individual choices in regards to drug and alcohol use.

DMHAS utilized these funds for numerous prevention infrastructure developments and enhancements. For instance, New Jersey took advantage of emerging technologies to better promote prevention messaging, and developed a prevention-focused mobile app called “Be the One”.

The Division was awarded another Strategic Prevention Framework Partnerships for Success Grant (PFS) in 2018. The focus of New Jersey’s newest Partnership for Success is twofold. First, the Department of Human Services, Division of Mental Health and Addiction Services (DHS/DMHAS) is focusing its efforts on providing prevention education and services to youth who are involved with the Department of Children and Families, Children’s System of Care (DCF/CSOC). New Jersey has a fully-developed, organized statewide children’s system of care, the Division of Children’s System of Care (CSOC), under the auspices of the Department of Children and Families (DCF), that provides a single point of entry 24/7, for youth (under 21) and their families, with behavioral health challenges, substance use challenges, intellectual/developmental disabilities, and autism. The Division of Mental Health and Addiction Services (DMHAS), within the Department of Human Services (DHS), provides services to adults who seek behavioral health and substance abuse treatment.

The Departments and their respective Divisions (CSOC and DMHAS) partner to implement prevention strategies that include outreach, education and training services to communities and families throughout the entire state of New Jersey. Concurrent with these services, the DMHAS-funded county coalitions provide community-based prevention services throughout their counties, resulting in a cohesive, unified statewide prevention system.

Prevent Drug Overdose. In September 2016, DMHAS was awarded a Prevent Prescription Drug/Opioid Overdose-Related Deaths (PDO) grant of $1 million annually for five years. DMHAS used PDO funds to develop the Opioid Overdose Prevention Network (OOPN). DMHAS receives real-time, statewide information about drug overdoses, naloxone administrations, and opioid-related arrests and seizures from the NJ State Police Regional Operations Intelligence Center. This capability allows DMHAS to almost immediately alert front-line practitioners and to make data-driven decisions about where to deploy prevention interventions, which includes community education and distribution of naloxone.

OOPN implemented an Early Warning and Rapid Response System (EWRRS) that includes an extensive network of practitioners and community workers in a variety of healthcare settings (e.g., FQHCs, EDs, hospitals) who were informed when their communities were affected. The alerts mobilized opioid overdose prevention practitioners who provided emergency response training and distributed naloxone to at-risk individuals and their families, as well as disseminated information about addiction treatment services to the local communities that were affected. This grant ended in September 2021.

Prevent Drug Overdose Grant 2023. DMHAS was awarded a Grant to Prevent Prescription Drug/Opioid Overdose-Related Deaths (PDO), which will begin in the fall of 2023.

The goal of the PDO-NJ is to reduce the number of prescription drug/opioid overdose-related deaths and adverse events among individuals 18 years of age and older by training first responders and other key community sectors on the prevention of prescription drug/opioid overdose-related deaths and implementing secondary prevention strategies, including the purchase and distribution of naloxone to first responders and other target groups. Goals include:

1. Provide increased access to services such as overdose education and naloxone distribution.
2. Promote use of best opioid prescribing practices among health care providers.
3. Identify and implement innovative strategies that reduce the risk of overdose to individuals and diverse communities that are disproportionately impacted by the opioid epidemic.
4. Develop prevention and treatment strategies aimed at reducing prescription drug abuse and its harmful consequences on college campuses.
5. Use existing data and enhance data collection efforts to identify the need for and effectively target Naloxone distribution and other overdose prevention activities.

Strategic Prevention Framework Rx. In September 2016, NJ was awarded a Strategic Prevention Framework for Prescription Drugs (SPF Rx) grant for $371,616 per year for five years. The SPF Rx provided an opportunity for states that completed a Strategic Prevention Framework State Incentive Grant (SPF SIG) to target the priority issue of prescription drug misuse. Called NJAssessRx, the grant expanded interagency sharing of the state's prescription drug monitoring program, data and gave DMHAS the capability to use data analytics to identify prescribers, prescriber groups and patients at high risk for inappropriate prescribing and nonmedical use of opioid drugs. Informed by the data, DMHAS and its prevention partners strategically targeted communities and populations needing services, education or other interventions.

The target population was youth (ages 12-17) and adults (18 years of age and older) who were prescribed opioid pain medications, controlled drugs, or HGH, and are at risk for their nonmedical use. A major component of New Jersey's SPF Rx project focused on young athletes. A toolkit called "Tackling Opioids through Prevention for Athletes" (TOP) was developed by the New Jersey Prevention Network for use by providers. Literature suggests that when young athletes are prescribed opioid pain relievers for sports-related injuries, there is a risk of addiction and medication misuse. The 19 county coalitions that were established by DMHAS used the TOP to provide education regarding this issue to coaches, parents, prescribers, and young athletes.

DMHAS conducted an epidemiological analysis on NJPMP data and employed geographic information systems (GIS) to identify communities and issues that required targeted interventions and public health initiatives. One of the goals of this project was to build capacity to strategically utilize the PMP to inform our prevention strategies. DMHAS purchased SAS® Visual Analytics software to analyze Prescription Drug Monitoring data. The product enabled us to identify suspicious or problematic patterns and develop targeted prevention strategies. The SAS® Analytics tool was used for anomaly detection and predictive modeling. This helped us achieve our goal of identifying drug misuse trends and developing appropriate prevention strategies. Reports identified those populations, practice settings and geographic areas, with the highest rates of nonmedical use of opioids and opioid prescriptions. The reports developed from DMHAS data analysis was shared with other state agencies and with DMHAS' Prevention Coalitions to inform

planning in local communities, such as, targeting locales for naloxone distribution to prevent drug overdoses.

In September 2021, DMHAS received a second SPF-Rx grant, which enabled it to continue work with young athletes as well as the other ongoing projects described above.

Prevention Statewide Request for Proposals. A Request for Proposals (RFP) for Statewide Services and Special Projects for Substance Abuse Prevention was released in September 2014 for community-based substance abuse prevention services and two special prevention projects described below. The guidelines and requirements of the RFP were developed by DMHAS in accordance with the DMHAS Substance Abuse Prevention Strategic Plan. Funding for all services is provided by the SUPTRS Block Grant. Each county in the state was assigned a funding allocation from the total funds available based on its relative need. The funding allocation was determined based on the presence and intensity of social indictors, past 30-day use rates, treatment admission rates, as well as need and risk factors within each county. Bidders responding to the RFP were required to utilize evidence-based programs and address the risk and protective factors specific to the prevention priority as well as the population (e.g. families, middle or high school students, older adults, workplaces, etc.) they propose to serve. In addition, bidders were required to provide quantitative data to substantiate the need for the substance abuse prevention services within the community and population they intend to target. From the 98 proposals that were received, 51 community-based contracts and two special project contracts were awarded totaling $5,700,200.

Prevention Services to Families of Military Veterans and First Responders. Working with the New Jersey National Guard Family Program and its eight Family Assistance Centers based at armories around the state, the SSA funds the New Jersey Prevention Network to provide programs to serve returning military personnel and their families through two evidence-based programs, Coping with Work and Family Stress and the Strengthening Families Program. Both programs are designed to enhance protective factors to support military members and their families in making responsible parenting and individual choices in regards to drug and alcohol use. In 2022, the program was expanded to provide services to older veterans and first responders.

Prevention Services to Gay, Lesbian, Bisexual, Transgendered and Questioning Youth. The SSA provides prevention services to Gay, Lesbian, Bisexual, Transgendered, and Questioning (LGBTQ) youth. The SSA awarded funding to the North Jersey Community Research Initiative to expand their existing programs for high-risk LGBTQ youth of color by using a "Street Smart" prevention model developed by the Centers for Disease Control and Prevention, as well as early intervention services, social marketing, and structured recreational activities. During SFY 2023, two additional programs, to serve LGBTQ youth in Central and South New Jersey, were established.

Prevention Services to Older Adults. Originally as part of the STR grant, then continued with the SOR grants, primary prevention efforts are focused on community education programs for older adults with the goal of reducing demand for opiate prescriptions by familiarizing them with alternative means of addressing pain other than opioid analgesics. Programs are available in 20 of the 21 counties. Most of the providers who are delivering the Approaches to Pain Management for

Older Adults (AAPMOA) program use the evidence-based Wellness Initiative for Senior Education (WISE) program. WISE is a wellness and prevention program targeting older adults, which is designed to help them celebrate healthy aging, make healthy lifestyle choices and avoid substance abuse. It provides educational services to older adults on topics including medication management, stress management, depression, and substance misuse. Created by the New Jersey Prevention Network and implemented locally by prevention agencies across the country, WISE promotes health through education concerning high-risk behaviors in older adults. Since the program was launched in 1996, prevention programs presented by WISE facilitators have reached over 40,000 individuals.

Opioid Overdose Prevention Program. DMHAS issued a Request for Proposals (RFP) in June 2015 to establish three annually renewable regional opioid overdose prevention programs.

North: Bergen, Essex, Hudson, Morris, Passaic, Sussex and Warren Counties
Central: Hunterdon, Mercer, Middlesex, Monmouth, Somerset, and Union Counties
South: Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester, Ocean and Salem Counties.

The statewide program provides education to individuals at risk for an opioid overdose, their families, friends and loved ones to recognize an opioid overdose and includes the distribution of naloxone kits and information on how to access treatment, including MAT, which is the best practice for someone living with an OUD. Federal funding received through STR, then continued with SOR, helped to expand these trainings and distribution of kits to populations including, but not limited to residential substance use disorder treatment agencies, schools, jails, prisons, fire departments, homeless shelters, offices of emergency management and HIV clinics. In addition to distributing naloxone, as of August 2022, the OOPPs can now also provide Fentanyl Test Strips (FTS), as a harm reduction strategy, to those who request during the trainings.

Opioid Overdose Prevention Network. The Opioid Overdose Prevention Network (OOPN) was established by DMHAS in 2016 using funds from New Jersey's Prescription Drug Overdose ("PDO" grant). The purpose of OOPN is to reduce the number of prescription drug/opioid overdose-related deaths and adverse events among individuals 18 years of age and older by training first responders and other key community sectors on the prevention of prescription drug/opioid overdose-related deaths and implementing secondary prevention strategies, including the purchase and distribution of naloxone to first responders. DMHAS provides funds to the Robert Wood Johnson Medical School, which conducts all OOPN trainings and accompanying naloxone distribution.

In 2019, OOPN staff developed a training of trainers specifically for Recovery Specialists (peers) who work in the hospital based DMHAS Opioid Overdose Recovery Network programs that operate in fifty-six hospital emergency departments in New Jersey and those who are employed in Support Teams for Addiction Recovery that operate in all 21 New Jersey counties. The training provides recovery specialists the knowledge and skills that enable them to train the clients with whom they work (and the client's family) how to recognize and overdose and administer naloxone.

Since its beginning in 2016, the OOPN has trained more than three thousand individuals (in-person and virtually) annually and provided naloxone kits to all trainees.

Opioid Overdose Recovery Program. A Request for Proposals (RFP) was issued in June 2015 to develop an Opioid Overdose Recovery Program (OORP) to respond to individuals reversed from opioid overdoses and treated at hospital emergency departments as a result of the reversal. This two-year initiative was funded by DMHAS, the Governor's Council on Alcoholism and Drug Abuse (GCADA) and the Department of Children and Families (DCF), funded programs in Atlantic, Camden, Essex, Monmouth and Ocean Counties. Since then, using monies appropriated by the Governor, as well as STR and SOR funds, the program is now provided in all 21 NJ counties, and in 73 percent of hospital EDs throughout the state. All programs are now funded by the SSA. The Opioid Overdose Recovery Program utilizes recovery specialists and patient navigators to engage individuals reversed from an opioid overdose to provide non-clinical assistance, recovery supports and appropriate referrals for assessment and substance use disorder treatment. The recovery specialists and patient navigators also maintain follow-up with these individuals. It is expected that, at minimum, recovery specialists will be accessible and on-call from Thursday evenings through Monday mornings. This initiative commenced in the fall of 2015. Additional OORP RFPs were released in 2016 and 2017. As of March 31, 2023, 25,072 individuals have been served by the OORP. While overdose and relapse prevention are key goals, the program is also intended to help individuals achieve recovery.

3. Planning Processes

County Planning

The county AEREF comprehensive planning process detailed under "Step 1: Assessing the strengths and needs of the service system...." contributes significantly to the SSA's planning for services across the full continuum of care by 1) applying state needs assessment data to four substate regions, the 21 counties and 565 municipalities, 2) comparing long term trends in statewide need, admissions, and gaps with trends in sub-state regional and county need, admissions, and gaps, 3) analyzing state, substate regional and county trends by level of care, primary drug, eight special subpopulations, and locational access, 4) and supplementing state-provided data analysis with needs assessment data developed at the community level. The counties obtain local data from 1) key informant and stakeholder focus group data, and 2) quantitative data produced from locally-funded research or made available to county planners from multiple health and behavioral health care planning initiatives occurring in their counties. The county level planning process is most informative regarding the identification of gaps in the delivery of services and recommendations for system level changes that can close these gaps. In addition to independent local planning and investment in local systems development, the SSA also relies on county level planning to provide "feedback" regarding the functioning of New Jersey's behavioral health care delivery system and policy recommendations regarding improvement of its performance.

In the past county planning cycle, 2016-2019, there were several changes that lead to challenges in planning amongst the counties. With the approval by CMS of New Jersey's 1115 Comprehensive Waiver permitting Medicaid billing for SUD residential treatment in an IMD,

issued in July of 2018, Medicaid is now available to cover many of these expenses for most county residents enrolled in Medicaid. As the funder of last resort, the counties are trying to redirect their funding from clinical treatment to prevention, early intervention and post-treatment, and recovery support services. The addition of federal and state initiatives to the fight against the opioid epidemic has reduced the number of county residents that must rely on county funding to afford outpatient and intensive outpatient care.

Continuing in the upcoming 2024-2027 planning cycle, each county will be required to report on its quarterly progress implementing and measuring the outcomes of each year's objectives as well as monitoring of system level changes following upon the state's Medicaid expansion, the state's move to managed care for substance abuse treatment and the waiver of the IMD exclusion. These developments have begun to change the demand for the use of county dollars to subsidize access to care for the medically indigent and this in turn is expected to permit counties to emphasize the development of prevention, early intervention and recovery support services and foster innovative programming to meet the needs of their constituents. Each county planning cycle is limited to four years with the current cycle beginning in calendar year 2024 and ending in calendar year 2027. New county comprehensive plans were received by DMHAS by the end of 2022. Despite the challenges of the COVID-19 pandemic that began in 2020, the counties have been able to continue through their planning cycle, implementing their plans by using technology to allow for virtual meetings and events when needed and create their new plans for the 2024-2027 cycle.

The State Outcomes Measures (SOMs) is a system created to help County Directors evaluate the performance of contracted providers. The SOMs scores were created to provide county directors with a tool to help them review providers for their programs in the AEREF. The county directors use the scoring to evaluate the performance of their current contracted providers. In addition, they also to help them choose which providers they would like to purchase for new programming in their planning. On occasion, counties have discontinued contracts with providers, influenced by poor performances seen in their SOMs scoring over a span of a couple years. The SOMs scores range from 1-4, worst to best. The system uses the percentiles of five categories which are the following:

- Alcohol Abuse: Absolute Percentage change of clients abstinent from alcohol at admission vs. discharge
- Drug Abuse: Absolute Percentage change of clients abstinent from other drugs at admission vs. discharge
- Employed: Absolute Percentage change of clients employed at admission vs. discharge
- Job Training: Absolute Percentage change of clients enrolled in school or job training at admission vs. discharge
- Arrested: Absolute Percentage change of clients arrested in prior 30 days at admission vs discharge
- Homeless: Absolute Percentage change of clients homeless at admission vs. discharge

The SSA collaborates with the County Alcohol and Drug Abuse Directors in the administration of the aforementioned AEREF program. In 2023, the states' 21 counties received $10,406,953 from the AEREF program, based on county population size, per capita income and estimated treatment need. Additionally, each county received a $20,000 planning grant, totaling $10,826,953. The SSA

supplemented these awards with an additional $6,908,369 for a total state investment of $17,735,322 in county provision of services. Further, each county is required to contribute 25% of its AEREF award to the program. In 2023, counties contributed an additional $2,601,738 to this program for a total combined state and county investment of $20,337,060.

According to the AEREF enabling legislation, each participating county is required to submit "an annual [county] comprehensive plan (CCP) for the provision of community services to meet the needs of alcoholics and drug abusers."[4]..Further, this plan "shall…demonstrate linkages with existing resources which serve alcoholics and drug abusers and their families." The law also stipulates that counties pay "special attention" to the needs of youth, drivers-under-the-influence, women, persons with disability, workers, and offenders committing crimes related to substance abuse. Thus, the counties are mandated by statute to develop unified, data-informed, comprehensive plans for the coordinated provision of community-based prevention, early intervention, treatment, and recovery support services for all county residents at both state and local levels. The SSA provides counties with quality assurance planning protocols and is responsible to review each CCP to determine: 1) whether the plan complies in form and function with the requirements of Chapter 51 by rationally relating county resources with the needs of county residents, and 2) whether it is designed and developed in a manner consistent with the state's quality assurance standards for county planning.

Local Citizen Advisory Planning Boards. A key component of the county comprehensive planning system is the county Local Advisory Committee on Alcoholism and Drug Abuse (LACADA), an independent, citizen's advisory group. The LACADA is required to assist the governing authority to develop and present to the County Board of Commissioners the aforementioned CCP for adoption. The LACADA is also required to establish a County Alliance Steering Subcommittee (CASS). The CASS is the county-level planning body for each county's GCADA municipal alliance which, in turn, is a coalition of municipal level residents and other stakeholder volunteers that recommend a set of local prevention priorities to the LACADA based on their own data analyses and prevention service inventories. Municipal alliance plans are coordinated by the CASS with a county's comprehensive plan through a process known as Unification Planning. The SSA works closely with GCADA to prepare for and implement the Unification process. Additionally, the counties are required to allocate approximately 11% of the county AEREF dollars to support prevention education services.

Length of County Planning Cycle. In 2004, the SSA established a three-year planning cycle for the county AEREF program that allowed counties to submit multi-year plans for the period 2006-2008. In 2008, the SSA lengthened the planning cycle to four years from 2009 through 2012, in order to establish the principle that county RFPs for substance abuse services were to be published subsequent to SSA certification of the county comprehensive plan and in accordance with its goals and objectives. In January of 2011, the SSA extended the effective period of the current CCPs to a fifth year, through 2013, in order to coordinate with the scheduled implementation of federal health care reform. As a consequence of the devastating impacts of "Superstorm Sandy" in October 2012, the SSA, in collaboration with the county planners, extended the current planning cycle for an additional year through the end of 2014. An additional one-year extension was

[4] Chapter 51, Laws of 1989, paragraph 14 incorporating Section 4 of P.L.1983, c.531 (C.26:2b-33 as amended).

implemented in spring 2014 for reasons related to the storm's impact and the focus of many counties on the implementation of Federal Disaster Relief Funds. The prior CCP governed the four-year period from January 1, 2020 through December 31, 2023. The upcoming planning cycle, which is four years, encompasses January 2024 to December 2027.

SSA Planning Standards. Additionally, in 2008, the SSA established planning processes and quality standards that required: 1) state certification of CCP compliance with all Chapter 51 and the SSA planning requirements as a condition of recommending the release of county AEREF and other state discretionary funding; 2) engagement of community stakeholders in a formal community needs assessment based upon state and local data describing substance abuse treatment needs and gaps in the delivery of services required to meet those needs; 3) a logic model of the interrelationships of needs, goals, objectives, strategies, resource allocations and outcomes for prevention, early intervention, treatment, and recovery services; 4) one system-level change to enhance the local continuum-of-care; 5) an action and resource allocation plan that implements the CCP according to its goals, objectives, strategies and intended outcomes; 6) a draft RFP for the provision of those services that would implement the CCP in accordance with its corresponding planned resource allocation; and 7) establishment of an annual plan implementation and outcomes monitoring procedure to document plan implementation obstacles encountered and corrective actions taken to overcome them.

Thus, the SSA, in collaboration with its partner county governments has established planning standards intended to produce rational, goal-oriented, data-driven county plans for the development of the full continuum of care from primary prevention through recovery support. The SSA supplies counties with data from the SSA's needs assessment program. For instance, the counties review: a) primary data obtained from the household survey, b) secondary social indicator data from the county and municipal chart books, c) administrative data from sources like NJ-SAMS and facility licensure. The SSA's County Planning Guidelines also encourage county behavioral health planners to incorporate local perceptions of substance abuse issues and treatment system capacity by means of county focus groups and other encouragements to citizen participation. The SSA provides planning education, training, and technical assistance to the county directors throughout the process.

Future Developments in the State-County Collaborative Planning Process. For the current 2020-2023 and upcoming 2024 – 2027 planning cycle, the SSA will continue to assist counties with planning data and analyses as well as understanding of federal and state level changes to health care delivery that will affect access to care for their residents. It will continue to help counties identify and implement a greater number of evidence-based prevention education programs and encourage counties to participate in planning environmental approaches to prevention at the county and municipal levels. It will encourage counties to increase their investments in recovery support services in order to help treated individuals maintain the benefits of clinical services, forestall relapses, and when necessary, return to treatment sooner before clinical treatment needs become severe.

Naloxone Saturation Plan

The drug epidemic is a significant problem in New Jersey with 2,893 individuals dying from drug overdose in 2022. DMHAS has developed a Naloxone Saturation Plan to address this crisis. The programs NJ utilizes to distribute Naloxone target multiple end users and use multiple methods to increase the access to naloxone while an individual is experiencing an overdose.

Amount of Annual Naloxone Needed to Reach Saturation in NJ and the Estimated Gap in the Current Supply. Naloxone is an important tool in preventing overdose deaths and many studies have demonstrated the value of naloxone distribution[5] and that increased saturation in communities reduces overdose deaths.[6] New Jersey is following research from Scotland[7] that suggests "Take Home Naloxone" (THN) plans should aim to issue 20 times as many THN kits as there are opiate-related deaths per annum and at a minimum, 9 kits. Their study was based on opiate-related deaths with prison release as a 4-week antecedent and estimated plausible effectiveness was 20-30% reduction in opiate related deaths.

For NJ this would be 2,893*20=57,860 at the recommended level, but no less than 2,893*9=26,037 at the minimum level. For the state overall we achieved saturation in 2022. However, when data are examined by county, 10 counties did not achieve saturation. We will implement a protocol to ensure gaps are closed for every county and saturation achieved. Our priority will be to first focus on the counties that fall in the top five overdose deaths category, then address the other indictors. Another article published in Lancet[13] indicates that 4.5 deaths can be averted in New Jersey with 500 kits per 100,000 population.

Targeted Distribution and Communication Strategy to get Naloxone into the Hands of Those Most Likely to Witness an Overdose and in the Locations where they are Most Likely to Occur. NJ will be using three major distribution points: community organizations, pharmacies and a web-based portal. Attention will also focus on providing kits to individuals who are most likely to witness an overdose event. Intended community groups include: Harm Reduction Centers, SUD and Mental Health Treatment Programs, Homeless Shelters, EMS, OORP, STAR, Recovery Centers, FSCs, Jails, Re-Entry Programs, Mobile Outreach Vans, Law Enforcement and Fire Departments, and Libraries. Additionally, the Scotland research suggests key 4-week periods recognized as high risk for opioid fatalities are: soon after prison release, hospital discharge, opioid substitution therapy and leaving abstinence-oriented drug treatment.

Our two community providers, the OOP and OOPN, distributed 7,602 kits during CY 2022. NJ-DHS announced in April 2022 a new initiative to allow for the delivery of naloxone kits directly

---

[5] Walley AY, Xuan Z, Hackman HH, Quinn E, Doe-Simkins M, Sorensen-Alawad A, Ruiz S, Ozonoff A. Opioid overdose rates and implementation of overdose education and nasal naloxone distribution in Massachusetts: interrupted time series analysis. BMJ. 2013 Jan 30; 346: f174.

[6] Irvine MA, Oller D, Boggis J, Bishop B, Coombs D, Wheeler E, Doe-Simkins M, Walley AY, Marshall BDL, Bratberg J, Green TC. Estimating naloxone need in the USA across fentanyl, heroin, and prescription opioid epidemics: a modelling study. Lancet Public Health. 2022 Mar;7(3):e210-e218. doi: 10.1016/S2468-2667(21)00304-2. Epub 2022 Feb 10. PMID: 35151372.

[7] Bird SM, Parmar MK, Strang J. Take-home naloxone to prevent fatalities from opiate-overdose: Protocol for Scotland's public health policy evaluation, and a new measure to assess impact. Drugs (Abingdon Engl). 2015 Feb;22(1):66-76. doi: 10.3109/09687637.2014.981509. Epub 2014 Nov 18. PMID: 26045638; PMCID: PMC4438351.

to eligible agencies and entities responsible for administering, distributing or leaving behind naloxone. To meet the ongoing needs of agencies across the State, NJ-DHS has developed an online portal where: (1) agencies will be able to register their entity to participate in the program and (2) utilize the order page to request naloxone. The program is called *Naloxone Direct*. *Naloxone Direct* is a website where approved agencies register through a website and request direct shipments of naloxone free of charge. After approval, the drug is shipped directly from the manufacturer to the provider organization. Orders are for naloxone cases (there are 12 kits to a case). It is paid for with grant funds sent to the state from the federal government. In CY 22, 53,985 kits were distributed through the portal.

Opioid addiction and overdoses continue to impact communities throughout New Jersey and across the country at an alarming rate. Since 2018, tens of thousands of New Jerseyans have experienced an overdose and more than 15,000 died of a suspected drug-related death. To combat and curb this epidemic, New Jersey has worked to bolster harm reduction efforts throughout the state including expanding the availability of naloxone through statewide distribution days. In 2023, New Jersey took the next steps to make naloxone readily available every day of the year for free. The newest program, *Naloxone 365*, is a pharmacy-based distribution program which provides naloxone for free, anonymously, without prescriptions to whoever asks for it.

In January 2023, Governor Murphy announced a nation-leading program to allow anyone 14 years or older to acquire naloxone anonymously and at no cost at participating pharmacies across New Jersey. The Department of Human Services partnered with the New Jersey Board of Pharmacy and its Medicaid division to craft and implement this unique program. Since the program's launch in January 2023, the number of naloxone kits dispensed is 46,852 kits. Currently 636 pharmacies are participating and include national chains. To bolster efforts, the Regional Coalitions are engaged in the Help Everyone Reverse Overdoses (HERO) campaign to encourage local independent pharmacies to participate. The website can be found at https://nj.gov/humanservices/stopoverdoses.

Partnerships with Existing Public and Private Efforts External to SOR such as through Medicaid, "Buyers' Clubs", and Recent Court Settlements. In CY 2022, NJ-DHS received waiver approval for a Supplemental Waiver of Advertising necessary from the Division of Purchase and Property to provide a large amount of funding for the purchase of naloxone. NJ-DHS conducted a search of State contracts and the price for Narcan from Emergent Biosolutions (Emergent), was significantly lower than the equivalent item from other vendors. Specifically, the cost for a kit of the equivalent brand of Narcan containing two units was $120.34. Emergent provided New Jersey a public interest rate of $47.50 per carton, each containing two 4 mg. intranasal devices. This is a substantial savings and gives NJ-DHS the opportunity to make a larger quantity of this life-saving medication to entities across the State.

Other partnerships include our OOPN program with RWJ, and our OOPP program. In addition, NJ Medicaid reimburses the cost of Narcan for its beneficiaries.

Gambling Strategic Plan

In 2014, the New Jersey Legislature enacted legislation directing that $250,000 be collected from each casino located in Atlantic City or their internet gaming affiliate(s) that were issued a permit to conduct internet gaming. The purpose of the legislation is to increase/enhance the scope of disordered gambling treatment services in New Jersey. There are currently 9 internet gaming licenses.

With the introduction of legalized sports betting in 2018, DMHAS now receives $100,000 as a portion of the licensing fee each gaming establishment is required to pay. These funds are also directed to the further development or enhancement of prevention programs or treatment services for gambling disorder. There are 12 licenses.

The compulsive gambling contract that DMHAS funds provides statewide assessment, treatment, prevention, and helpline services through the Council on Compulsive Gambling of New Jersey. The Council offers counseling by certified treatment providers; a helpline (1-800-GAMBLER) that provides information on problem gambling and connects callers to treatment programs and Gamblers Anonymous/Gam-Anon meetings; ongoing public awareness activities; and educational materials for compulsive gamblers, families, and others affected by gambling problems.

A workgroup was formed consisting of representatives from different areas of DMHAS to develop a Gambling Strategic Plan to best utilize these new state resources. The plan covers prevention, early intervention, treatment and recovery.

One of the projects includes developing a GAMBIRT program, modelled after SBIRT. An RFP is in preparation. Some of the groups intended to be reached include: seniors, high school and college students, veterans and ethnically diverse groups. Other projects include: peer gambling training; reviewing the existing gambling treatment network; outreach to underserved populations, such as LGBTQ; providing services to those in prison or jail; providing training to SUD providers on gambling treatment; and outreach to more groups, such as faith-based organizations, recreation centers, schools, etc.

Alcohol Use Disorder Strategic Plan

With all the emphasis on the opioid crisis, there still remains a need to address alcohol use disorder. In fact, in CY22, the primary drug at admission was alcohol (37%) exceeding heroin by 1%. This is the first time that alcohol was reported as the primary drug of use at the time of admission to a withdrawal management or treatment program. Due to problem-drinking and diagnosed cases of Alcohol Use Disorder (AUD) within New Jersey showing an increasing trend following the COVID-19 pandemic, a workgroup of Division staff was convened to develop a strategic outline that would identify and prioritize areas of concern and objectives for January 2022 – December 2023. Emphasis was given to objectives considered important for overall systems change, but that are also achievable in the short term and able to show a direct impact on positive client outcomes. For organizational purposes, the workgroup recognized priority areas across the prevention, early intervention, treatment and recovery continuum of care. The workgroup agreed that this strategic outline remains a fluid document that is revisited as new data is made available for analysis and updated accordingly. With the impact of COVID-19 on substance use within the state only now

starting to take shape, flexibility in addressing issues must remain on the table. As such, an additional priority area is for on-going data and needs assessment.

The purpose of the AUD Strategic Outline is to provide a broad plan of action for the Division to deliver system level interventions during the designated timeframe with identified areas of focus carried out by separate DMHAS units to achieve their various objectives. The AUD Strategic Outline only includes the broad goals that are independent of other on-going projects. While it is noted that there will be overlapping and sharing of resources with other Division initiatives, the intent of the strategic outline is to define these distinct activities for further detailed and individual project management. It is noted that to accomplish the areas of focus, additional staffing and stakeholder involvement beyond what is indicated will be required to meet the desired objectives. The outline provides the general strategic and priority areas, target dates, expected Division units and external stakeholders involved to carry out tasks and deliverables.

New Jersey Prevention Unification Process

The NJ Prevention Collaborative, previously called Prevention Unification, re-activated a committee in July 2018. The NJ Prevention Collaborative includes members from the New Jersey Division of Mental Health and Addiction Services (DMHAS), New Jersey Prevention Network (NJPN), Rutgers Center for Prevention Science (RU-CPS), and the Governor’s Council on Alcoholism and Drug Abuse (GCADA). The Prevention Technology Transfer Center operated by RU-CPS provided state-level technical assistance to this state-level group as well. It was decided to re-brand “Prevention Unification” and now this workgroup is referred to as the NJ Prevention Collaborative. The overall aim of the NJ Prevention Collaborative was to align all state-funded substance abuse prevention initiatives. The primary goals include the development of state-level logic models for underage drinking, prescription drug misuse, marijuana, and tobacco. These logic models will be used to integrate with the coalition logic models and then more locally, the alliances would use these to fit in their efforts.

During the earlier meetings in the summer and fall of 2018, the team created a list of objectives, action steps, and an overall plan that included milestones through the end of 2019. In the early planning, some of the expectations for what the state-level logic model included: Minimize service duplication and complement each other’s work; build upon past success of prevention unification processes; continue alignment of regional coalitions, “B” grant providers, Municipal Alliances, and Division Substance Abuse Directors; determine state-wide priorities and solidify desired outcomes for prevention system; and support a state-wide cohesive message about what effective prevention looks like. The NJ Prevention Collaborative decided on a scope for the state-level logic models, which included the 19 Regional Coalitions, all Municipal Alliances, individual and family program providers, and Drug Free Communities grantees. These are also the entities that would act as primary users of the state-level logic models.

RU-CPS initial step was to review data from the regional coalitions for inclusion in the state-wide logic models. This process began by examining problem statements, root causes, local conditions, strategies, and outcomes from all regional coalition logic models and organized databases with frequencies for each of the substance priorities: underage drinking, prescription drug misuse,

marijuana, and tobacco. Once all of these data sources were integrated, the group began to populate a state-wide logic model.

Throughout the process, the members presented on the NJ Prevention Collaborative to different constituents in order to involve stakeholders in the process and to solicit feedback throughout the process. NJPN made multiple presentations to the regional coalitions; GCADA presented to the county municipal coordinators and alliances; and DMHAS presented at their meetings.

In June 2019, the NJ Prevention Collaborative provided a statewide logic model presentation followed by a focus group. Participants included regional coalition coordinators and municipal alliance coordinators whose agencies were representative of the state geographically and in terms of size (e.g. number of municipal alliances, funding resources, community partnerships, etc.). The statewide logic model was presented as an opportunity to acknowledge efforts at the state, regional, and municipal level while incorporating important factors cited in prevention literature. The logic model was also cited as a useful tool for identifying any gaps in the work being done and serve as a resource for coalitions to strategically address health disparities in their communities at the local level. The presentation was followed by a focus group in which participants expressed overall impressions of the logic models, identified potential challenges to successful implementation, and communicated their expectations for their agency's role going forward.

The final steps of the state-level logic models included gathering state level data to complete the problem statement for each of the four logic models. The goal was to include multiple data points for consumption patterns and consequences (i.e., crime indicators, injuries, ER visits, overdoses) for each logic model. These are state-level data points.. RU-CPS led this step and built a database of over 300 outcome measures. Each data point was tracked for a minimum of three years in order to observe trends across time. Data points were collected for New Jersey as well as for the US, in order to compare New Jersey and national trends.. The NJ Prevention Collaborative reviewed all data elements and trends and created a prioritization process.. Indicators were ranked: high, medium, and low priority based on the prevalence of the problem, trends over time, and how NJ compared to the nation. in order for the group to make final decisions on which high and medium priority measures to include in the final state-level logic models.

The group finalized the prioritization process and created a list of interventions to include in the final logic models. The NJ Prevention Collaborative completed the four state-level logic models in the summer of 2019 and shared them with the various state-funded groups and stakeholders. The efforts of the Prevention Collaborative were shared with the regional coalitions for their continued assessment, planning, and evaluation processes for their regionally based prevention strategies and with the municipal alliances as they conducted their needs assessment process in the Fall and Winter of 2019. Currently, the group is working on a systems-level logic model for the state.

4. Data Gaps

Older Adult Survey. During its strategic planning processes, DMHAS determined that one of the top data gaps in New Jersey was the lack of information on the older adult population and the prevalence of substance use, misuse, and mental health issues within this group. The first New

Jersey Older Adult Survey was conducted in 2012, with a total of 800 individuals living in New Jersey who were age 60 and older responding.

DMHAS was awarded the Partnerships for Success grant by SAMHSA in 2013, and allocated funding to address the need for further research on this population relating to substance use and mental health issues. The overall goals of the New Jersey Older Adult Survey (NJOAS) were three-fold: (1) to assess the prevalence, risk, and protective factors of substance misuse and mental health issues among New Jersey older adults; (2) to obtain enough data to create small-area estimates of the prevalence of substance abuse and mental health for the target population in specific geographic areas; and (3) to analyze the results of the survey with the aim of providing policy suggestions to the state of New Jersey that would help better allocate resources for New Jersey older adults. In February 2014, Avalon Health Economics was contracted by Rutgers University School of Social Work and the New Jersey Division of Mental Health and Addiction Services (NJ DMHAS) to conduct a needs-based survey among the New Jersey older adults. New Jersey was divided into four sections; Central, Metro, Northern, and Southern. The survey respondents represent each area equally (23%, 32%, 25%, 21%, respectively).

The NJOAS instrument was developed and then implemented through telephone interviews, using random digit dialing sampling methods and stratified by four New Jersey regions. The survey instrument included items based on commonly used and validated subscales, to measure the prevalence of substance use and misuse, mental health issues, consequences of use, risk and protective factors, and basic demographic information (race, ethnicity, education, job status, etc.). The sample was randomly selected from a database of over 600,000 New Jersey residents who were age 60 and older (older adults) at the time of the interview. A total of 3,701 responses were collected during October and December 2015. New Jersey was divided into four geographic sections; Central, Metro, Northern, and Southern. The survey respondents represent each area equally (23%, 32%, 25%, and 21%, respectively).

The PFS team worked with the Technical Assistance Team through SAMHSA's Center for the Application of Prevention Technologies (CAPT) to meet with an expert in small-area estimation techniques. The CAPT team arranged for consultation with Dr. Robert E. Fay. Dr. Fay is a Westat Senior Statistician with more than 40 years of experience in multiple aspects of sample surveys to include survey design, estimation, variance estimation, imputation and analysis of missing data, statistical modeling of data from complex samples and small area estimation. As a consultant to the CAPT and in collaboration with the CAPT Epidemiology Team, Dr. Fay provided expert guidance on small area estimation to the state of New Jersey.

Veteran's Survey. New Jersey continues to focus on returning Veterans as a priority population. This is another population for which there were limited data. DMHAS has reached out to the New Jersey Department of Military and Veteran's Affairs as well as the New Jersey National Guard to solicit their active participation on the SEOW and Advisory Council in light of this priority. DMHAS collaborated with its partners at Rutgers University and Avalon Health Economics to conduct a survey of returning Veterans in order to gather information about behavioral health issues and concerns within this population in New Jersey. Interviews were completed in late 2015. Almost 1,200 New Jersey veterans responded to the survey.

Young Adult Survey. In early 2023, DMHAS engaged the Center for Research and Evaluation on Education and Human Services (CREEHS) at Montclair State University to develop and conduct an online survey of 18–25-year-olds in New Jersey. The survey will gather information about both substance use within this population as well as attitudes and beliefs regarding substance use/misuse. The survey will provide invaluable data about this population for which, currently, there is a paucity of information.

Municipal Level Data. A critical challenge for the 19 county prevention coalitions, as well as County Drug and Alcohol Directors, and Municipal Alliance Coordinators in New Jersey, has been the lack of available data at very specific and detailed geographic units of analysis (e.g., municipal, census tract, neighborhood, etc.). A social indicator database project was completed under the SPE grant which used a variety of methods to acquire new data and merge information from existing systems to provide a foundation for an integrated data infrastructure. Purposes of this database are: to help identify high need communities; promote data-driven planning; support funding allocation methods based on need; enhance capacity in local communities and strengthen their ability to identify meaningful local indicators; and to help produce community-level epidemiological profiles. Presently, the County Chartbooks contain a wealth of municipal level data.

5. Current Gaps in the Substance Use Disorder Continuum of Care

In order for clients who have or are at risk for a substance use disorder it is critical that there are recovery supports in place so clients can realize their full potential and clients have access to evidence-based treatment. The following areas have been identified by the SSA as areas that need enhancement.

Relapse Prevention. Drug and alcohol rehab statistics show that the percentage of people who will relapse ranges from 50% to 90%. Data from NJSAMS for CY 2022 indicated that of 45,914 individuals, 9,684 (21%) individuals experienced two admissions during the year and 9,059 (20%) had 3 or more admissions. Of these, 2,191 (11.7%) returned to care between 31 and 90 days, and 1,736 (9.3%) had a readmission 91 or more days later (within CY 2022). We define a new episode of care when admission to treatment exceeds 30 days, i.e., not within the existing episode where there may be movement to other LOCs within the continuum of care for that episode. Our goal is to provide recovery supports to help these individuals move to and remain in recovery for longer periods of time. Currently the Opioid Overdose Recovery Program, the Support Team for Addiction Recovery, Telephone Recovery Support and Peer Recovery Centers are helping to fill the gap. A new initiative was implemented in SFY 2023 to further support this effort: Recovery Management Check-Up (RMC).

Housing. Studies cited by the Corporation for Supportive Housing (CSH) indicate that supportive housing has positive impacts on reducing or ending substance use. Once people with histories of substance use achieve sobriety, their living situation is often a factor in their ability to maintain their recovery. According to the Kentucky Interagency Council on Homelessness (KICH), a one-year follow-up study of 201 graduates of the Eden Programs chemical dependency treatment programs in Minneapolis found that 56.6% of those living independently remained sober, 56.5% of those living in a halfway house remained sober, while 90% of those living in supportive housing remained sober.

There are also studies that documented positive impacts on health with decreases of more than 50% in tenants' emergency room visits and hospital inpatient days; decreases in tenants' use of emergency detoxification services by more than 80%; and increases in the use of preventive health care services. Positive impacts on employment have also been found, with increases of 50% in earned income and 40% in the rate of participant employment when employment services are provided in supportive housing.

Stable, affordable housing is a crucial component of recovery for individuals with substance use disorders. Supportive housing combines affordable housing with services that help people who face the most complex challenges to live with stability, autonomy and dignity. Supportive housing has been proven as an effective solution to ending homelessness for active substance users; barrier-free housing provides a necessary platform to access a variety of services, participate in long-term recovery and give individuals the opportunity to engage in important community roles.

DMHAS only has 273 supported housing slots for individuals with a substance use disorder: two programs in Camden (31 beds) and Atlantic (32 beds) counties, a 10-bed program for women in Somerset County, and 200 supportive housing subsidies for those with an OUD. Supportive housing is a successful, cost-effective, combination of affordable housing with services that help people live more stable, productive lives. It offers permanent housing with services that work for individuals and families who face complex challenges such as homelessness and/or have serious and persistent issues that may include substance use, mental illness, and HIV/AIDS.

DMHAS awarded contracts in 2019 to provide individualized case management and supportive services to up to 200 individuals with an OUD, on average, up to 8 hours per month, billable in 15 units, based on individual needs. These services will assist individuals in seeking and connecting with behavioral health and or physical healthcare needs. DMHAS provides 200 rental subsidies, up to the fair market rate (FMR) as defined by the Department of Community Affairs (DCA) for lease-based housing. One-time funding will be available to consumers for security deposits, utility start-up costs and furnishings. Contracts were awarded four agencies to serve individuals in five counties: Atlantic, Burlington, Camden, Mercer and Monmouth. Since the awarding of the OUD contracts the number of referrals have reached approximately 225 referrals with a total of 95 subsidies currently occupied, and an additional 24 in housing search phase. The turnover of the OUD vouchers is approximately 10%, with consumers surrendering the subsidies. The onset of the COVID-19 Pandemic has resulted in the full payment of rent for some of the OUD consumers since they lost employment.

Contracts were awarded in 2019 for three pilot recovery-based housing residences (a minimum of five individuals in each residence), one in each region (North, Central and South), for individuals with an OUD who are homeless or at risk of homelessness. Individuals are in or recently discharged from treatment and are seeking a drug free, sober and supportive living environment, with access and linkage to recovery community resources. Individualized case management and recovery-based housing services is provided for 15 individuals (a minimum of five individuals in each region) who have been identified as needing a safe, healthy, peer-lead, recovery-oriented environment. The housing provided must be licensed as a Class F, Cooperative Sober Living Residence (NJAC § 5:27). Accordingly, individuals are responsible for providing their own food

and taking care of their own laundry. Treatment and counseling may not be provided in the residence; however, non-clinical recovery support services may be provided at the site and the agency may require, at its discretion, drug or alcohol testing of residents. (NJAC § 5:27-2.1). Although increased funded sober housing slots are needed, the pilots are thriving and continue to benefit those individuals seeking a stable recovery environment.

With the award of ARPA funding, DMHAS issued an RFP for an Interim Housing Program for individuals experiencing SUD challenges. The program would have allowed individuals an opportunity to have temporary stable housing for up to two months while the provider tried to arrange for more stable permanent housing. Unfortunately, the RFP issued in October 2022 had to be withdrawn for technical issues.

It is an urgent issue to create housing opportunities for individuals with SUD. One of the negative outcomes is that homeless who individuals who have overdosed and are in our OORP program are then discharged to costly inpatient care due to the lack of suitable community housing options.

DMHAS continues to explore potential residential opportunities for SUD clients. A possibility is implementing ASAM Level 3:1: Clinically Managed Low-Intensity Residential Services. Examples of this level is a halfway house, group home or other Supportive Living Environment (SLE) with 24-hour staff and close integration with clinical services. It only requires 5 hours of treatment per week. This level is suited for homeless individuals while their issue of homelessness is addressed. It is an appropriate setting for individuals who need time and structure to practice and integrate their recovery and coping skills in a residential, supportive environment.

Recovery Centers. There is a need for DMHAS to continue expanding services at Recovery Centers. There were only two state funded centers prior to 2019, one in the northern region of the state, Eva's Village in Paterson, and one location in the southern region of the state, Living Proof in Voorhees. From 2019 to 2023 DMHAS was able expanded Recovery Centers to every county in New Jersey through the SOR funding. Funding was issued through Request for Proposals (RFP) to develop small scale Community Peer Recovery Centers (CPRC) in every county with $100,000 startup funding. Recovery support is an essential part of the continuum of care since addiction is a chronic biologically based disease of the brain and as such requires a system of care designed to treat a chronic condition rather than an acute illness. With other chronic conditions, e.g., diabetes, hypertension, heart disease, that are characterized by periods of wellness and acute episodes of care, the care system and intervention are designed to manage the illness in order to promote sustained periods of wellness and eliminate or minimize the need for acute care. Similarly, the addiction treatment system must adapt so as to support the process of sustained recovery. The New Jersey Recovery Centers has been effective with many individuals seeking recovery.

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

During 2022, there were 84,437 discharges from substance abuse treatment in New Jersey. Of these, 24,555 or 29%, dropped out of treatment. While all clients can benefit from recovery support services, those clients who did not complete treatment may find recovery support beneficial and a gateway back into treatment and/or sustained recovery. It is clear that there are significant numbers of people who could benefit from ongoing recovery programs. While these figures are drawn from those who enter the formal treatment system, there is a group of people of unknown size who have never accessed formal treatment who could also benefit from recovery services. This will also be an opportunity for those for whom access to treatment is not possible or delayed. The DMHAS Recovery Centers offer training, social, educational and recreational opportunities. There are classes focused on wellness, nutrition and illness management, including classes on self-care, stress management, financial management, literacy education, job, and parenting skills. Housing assistance (e.g., finding apartments and roommates) is provided, and telephone support is available to Recovery Center participants. It is expected that this peer-delivered service will result in improved social functioning, reduced substance abuse and an improved quality of life, including more social connectedness.

DMHAS has expanded Recovery Centers through the SOR funding in the amount of $100,000 each for start-up small-scale Recovery Centers to provide peer-to-peer recovery support services to prevent recurrent of substance use and promote sustained recovery. All activities and services through the CPRCs are led and driven by "peers", individuals who have experienced addiction and recovery, either directly or indirectly as a family member or friend. The overall goal of the CPRC is to provide a safe place for recovering individuals to gather in support of one another and experience recovery-oriented living in a community setting. The CPRC is a place where those in recovery can have the opportunity to give back to their community thereby fostering senses of empowerment and independence.

Since March 2020, CPRCs have found creative new ways to keep individuals engaged with their centers. They keep track and report quarterly of Traditional In-Person Groups and Individual Recovery Support Service as well as Virtual and Hybrid Services. Some centers also offer Community Activities In-Person, Virtual or Hybrid. 50% of the centers use the Recovery Data Platform to document individuals served. The biggest barriers reported by CPRCs is limited funding for Transportation, Recovery Support Housing, Harm Reduction Supplies, and Recruiting and Retention of workforce.

Recovery Case Management. There were no formal case management services in the NJ addiction service system. Research indicates that substance-dependent individuals who have prompt access to a full continuum of services that address individual client needs and co-morbidities experience improved recovery outcomes. Kirk (2007) describes a client-centered service delivery model that promotes access to a broad array of services, reduces the frequency and duration of acute care episodes, and facilitates client stabilization in the "recovery zone". The term "recovery zone" refers to a state of sustained recovery characterized by long periods of abstinence, gainful employment, stable housing, and supportive and rewarding social and spiritual connectedness. Recovery case management (RCM) interventions that support clients' entrance into and maintenance within the recovery zone not only improves the quality of life for substance-dependent individuals but reduces the cost of their care by promoting access to non-residential

treatment and recovery support services which are less costly than acute residential care. A client's movement into the recovery zone varies depending on individual needs; successful recovery case management depends upon a strength-based approach that recognizes client competencies.

RCM seeks to encourage a client's mastery over their substance use disorder, thus increasing the likelihood of an individual's sustained engagement in the recovery zone. DMHAS proposes the inclusion of recovery case management within our current system of care to reduce service fragmentation, promote service continuity, and increase clients' capacity to manage their chronic health condition.

With State Targeted Response (STR) funding, DMHAS was able to initially create 10 Support Teams for Addiction Recovery (STAR). Additional SOR funding allowed the creation of two more STAR programs, which transitioned to SOR funding. Additional SOR funding allowed the development of 11 more STAR programs. This resulted in statewide coverage.

DMHAS has been able to create two new recovery support services, described below, with the award of SABG Supplemental and ARPA funding.

Recovery Management Check-Up (RMC). RMC is a service for discharged clients to support their independent living and success with recovery. This program provides more methods of outreach to clients that include virtual face-to-face visits, text messaging and chat features, and the opportunity for in-person contacts. This check-up service will help provide local recovery supports, including information about local resources such as self-help meetings, food pantries, and sober houses, if needed. RMC aims to identify and alleviate client problems before they undermine recovery. Monthly contact forms the core of RMC. During these contacts, staff will assess clients using a brief assessment tool to evaluate the individual's progress, current needs and check on recovery status. Problems will be addressed using motivational interviewing techniques, connecting clients to appropriate community resources and/or treatment, if needed. The conceptual framework of RMC is to treat addiction as a chronic disease, with long-term management to minimize the number of acute episodes of substance abuse and with prompt treatment when episodes occur to prevent them from becoming more severe and consequential.

Recovery Support Care Management (RSCM). RSCM provides direct and comprehensive assistance to consumers to ensure access to the necessary treatment, rehabilitative and recovery services with the intent of reducing psychiatric and addiction symptoms, connect consumers with services, improve transitions between levels of care, implement strategies to address their unique needs, reduce opioid related deaths and sustain recovery in the community while supporting the consumers' continued stability and recovery throughout the continuum of care. This service is available as an enhancement in all levels of care and has been incorporated into the SUD fee-for-service system. This service may be provided face-to-face or via a telehealth platform. One unit of service is 15 minutes. The rate is $24.97 per unit. The limits of this service are 4 units per diem and 16 units per month, with no annual limit per consumer.

Medication Assisted Treatment. NJSAMS data indicated while heroin plus other opiates were the primary drugs accounting for 44%, or 37,486, of New Jersey's treatment admissions during 2022, the use of either methadone (16%) or buprenorphine (12%), a total of just 28%, was in the

treatment plan for these admissions, a difference of 16%. The number of people who entered either opioid maintenance -outpatient or -intensive outpatient was only 15% (12,420). This difference of 29% for a level of care that uses MAT, demonstrates a large gap between the number of people using heroin and other opiates admitted to treatment vs. the number receiving the most effective, evidence-based treatment available.

Based on our data and experience with our Opioid Overdose Recovery Program the greatest treatment need is for ambulatory substance use disorder treatment programs that offer Medication Assisted Treatment (MAT) in the forms of methadone, buprenorphine and Vivitrol. Increasing this capacity could significantly reduce the demand for Inpatient Withdrawal Management (IWM) as well as other residential treatment services.

Ambulatory Withdrawal Management. Currently there are 18 licensed providers in NJ that provide Ambulatory Withdrawal Management (AWM). This is a service that has been a great benefit to individuals with an opioid use disorder (OUD), and has been used as an option to the costlier, and not always clinically indicated, Inpatient Withdrawal Management (IWM). A requirement for AWM agencies is that they minimally have to offer outpatient programming at their agencies.

Public Awareness Campaign. DMHAS, with the support of the Department Human Services (DHS) Central Office, Office of Public Relations, secured a vendor that has been delivering a public awareness campaign to help reduce stigma and discrimination around the use of MAT. The campaign was initially launched in the Spring of 2020 and continually refreshes its campaign.. Most messaging continues around opioid use with the goal to bring public awareness that medication can support recovery and encourages viewers of the advertisements to call ReachNJ, the 24/7 Addiction Hotline in New Jersey. Messaging has continued to target multiple resident groups, such as student-athletes, pregnant women, older adults and prescribers. Various forms of messaging include TV ads, radio commercials, social media and billboards in the community.

Family Support Services. Three regional Family Support Centers (FSC) continue to be funded through SOR Funding to provide peer to peer family support services to families in each region whose loved ones suffer from an opioid use and/or stimulant us disorder. FSCs were the first formal family support service in the New Jersey's Substance Use Disorder continuum of care that offered direct family support, education, resources and advocacy in a safe and non-stigmatizing environment. Each regional center is staffed with Family Support Coordinators with lived experiences who are specially trained in the Community Reinforcement and Family Training (CRAFT) Model which teaches families self-protection along with non-confrontational skills to help empower their loved one to seek treatment; as well as helping each family member develop and work on their own Individualized Wellness Recovery Plan. The overall goal of the FSC Coordinator is to provide compassionate support to empower family members to have a better quality of life, improve their psychological health, reduce levels of stress, feel less isolated, and gain skills needed to cope with their loved one's use. Families who receive FSC services also receive Naloxone Training and Kits to assist their loved ones at risk of opioid overdose.

In 2021, each regional FSC expanded due to the increased numbers of referrals coming from OORPS, STARS, Connect4Recovery Call Center, Division of Children and Families, and Families, and Drug Court, Probation, and Treatment Providers to assist family members of loved ones with or without an opioid use and/or *s*timulant use disorder. While the FSCs have seen an

increase in referrals, one the main barrier continues to be difficulty recruiting multi-lingual family support peers who can connect and engage family members who speak other languages.

Narcan Reversals and Follow-up Treatment. One of the gaps identified through the SSA's data is the need to engage individuals who have undergone a naloxone reversal to enter treatment. The data clearly demonstrates that most individuals who experience a reversal do not enter treatment.

Despite 15,452 Narcan administrations in New Jersey from January 1, 2022 to December 31, 2022, NJSAMS data indicated that during that same period, there were only 1,035 admissions who reported a Narcan administration "in the past 30 days." This difference of 14,417 demonstrates that: a) very few persons who undergo a Narcan reversal access treatment and b) closing this gap will require effort to reach out to such individuals and encourage them to enter substance use disorder treatment, ideally at programs providing MAT. As a result, DMHAS is developing strategies to reduce this gap. Using STR funding, brochures were printed which were given to individuals who refuse transport to the hospitals by EMS that provides a list of resources for follow-up help. The brochures are tailored by county. Using SOR funding, additional brochures were printed. DMHAS is also working with the Department of Health (DOH) to better connect our OORP teams with local EMS providers; a meeting was held between these two groups in February 2021. Also, several of our OORP staff attended the "Five Minutes to Help" training that was developed by the DOH for EMS providers.

Linkage from Withdrawal Management to Other Levels of Care. One of DMHAS' concerns is the movement of clients from withdrawal management (WM) to the next appropriate level of care. Data for CY 2022 indicated that of 17,217residential WM discharges, only 9,653 (56%) were linked to another level of care. The Single State Authority on Substance Abuse (SSA) is considering different strategies to improve the connection to treatment, such as the inclusion of peers in these programs, incentives for agencies and motivational interviewing to help reduce client refusal for continuing treatment.

Peers in Treatment Services. While the SSA has expanded the role of peers in prevention and recovery services, work is needed to incorporate peers in treatment settings. To address this gap, the DMHAS issued an RFP in March 2023 for residential providers to expand the peer workforce to include peer services in inpatient withdrawal management, short-term and long-term residential and halfway house settings. The successful bidders will hire peers who will assist with issues that often occur concurrently with SUD, such as homelessness, legal issues, employment, child care, documentation, etc. In addition to linking individuals with the appropriate community resources, peers will also encourage individuals to remain in treatment as recommended in the treatment plan and modeling strategies on how to manage addiction successfully. Awards were made in June 2023 for 26 Peer Recovery Specialists in residential treatment settings.

Climate Change. An issue recently discussed at a DMHAS Executive staff meeting was the impact climate change is having on behavioral health conditions. DMHAS plans to begin a program of education for our providers in their approach to clinical and non-clinical substance use treatment and prevention services.

Buprenorphine Bridge Clinics. The Bridge model is a clinical model in which ED practitioners screen patients for opioid use disorder (OUD), provide short-term prescriptions for buprenorphine and then provide patients with warm handoff directly to a co-located, outpatient bridge clinic that provides medications for opioid use disorder. The Bridge model may be modified to establish a virtual bridge clinic utilizing telehealth.

School-Based Educational Prevention. Utilizing certified recovery specialists, individuals would share personal stories of their struggles and identify when they began using substances and how their substance use disorder escalated.

Screening for Substance Use Disorders and Adverse Childhood Experiences (ACEs) in Pediatric and Primary Care. Programs that provide interventions that are culturally responsive and resilience-focused to children impacted by addiction and that have ACEs are a key strategy in disrupting intergenerational SUDs and providing targeted services to arguably one of the most at-risk populations of children. Preventing ACEs can lead to a significant reduction in chronic health conditions and socioeconomic challenges, including obesity, depressive disorder, substance use, medically uninsured people and unemployment.

Gaps Observed by the New Jersey Behavioral Health Planning Council. The New Jersey Behavioral Health Planning Council (BHPC) previously developed a white paper expressing concerns with the wait to admission into residential withdrawal management. The SSA invested a significant amount of funding into residential withdrawal management in FY 17. Funds were added to the SAPTI fee-for-service initiative for this level of care and a new STORI treatment initiative was developed using STR funds which included residential withdrawal management. In addition, ambulatory withdrawal management was added to this initiative once the rates were finalized. While STR has ended, several of the SUD FFS initiatives now fund this level of care, which has made it very accessible. Four initiatives reimburse (DUII, Drug Court, SJI and MAP-SPB) both AWM and IWM. AWM is also available in NJSI; MATI and SAPT both fund IWM.

At the June 2019 BHPC meeting, gaps identified were: 1) a key barrier to MAT for opioid SUD is transportation and homelessness and 2) services for older adults with opioid addictions. With regards to older adults, DMHAS has made 20 awards for programs to educate older adults on alternate strategies for opioid prescriptions .

At the July 2021 meeting, gaps were once again addressed. The issue of transportation came up and we are exploring whether our FFS programs can provide transportation. The issue of homelessness and services was raised. We are currently in the process of developing programs in homeless shelters to deliver MAT in the shelters. A final issue was that housing is a number one priority. We will be expanding our Oxford House program to help address this issue.

At the July 2022 meeting, gaps were again addressed. One focused on the issue of older adults and the need to increase services to this population. DMHAS has been making progress in this area. We have a prevention-focused Adult Education program in 20 of 21 counties. We recently issued an RFP for treatment services to underserved populations and one provider is focusing on serving older adults. Another concern is addressing feelings of isolation among our consumers and the negative impact this can have.

6. Addressing Needs and Gaps of Services of Special/Target Populations

Pregnant Women and Women with Dependent Children. In 2014, as a SAMHSA Prescription Drug Abuse Policy Academy State, New Jersey was eligible to apply for a unique technical assistance opportunity through the SAMHSA supported National Center on Substance Abuse and Child Welfare (NCSACW) to address the multi-faceted problems of Substance Exposed Infants (SEI) and Neonatal Abstinence Syndrome (NAS). New Jersey DHS/DMHAS as the lead State agency partnered with DCF and Department of Health (DOH) and submitted a successful application for In-Depth Technical Assistance (IDTA) (no funding attached). The IDTA goal was to develop uniform policies/guidelines that address the entire spectrum of NAS and SEI from pre-pregnancy, prevention, early intervention, assessment and treatment, postpartum and early childhood. The IDTA would also provide assistance to New Jersey to strengthen collaboration and linkages across multiple systems such as addictions treatment, child welfare, and medical communities to improve services for pregnant women with opioid and other substance use disorders and outcomes for their babies. The New Jersey IDTA Core Team included over sixty (60) individuals representing multiple State Departments and Divisions, community stakeholders, treatment providers, and the medical community.

The IDTA established three goals: (1) Increase perinatal SEI screening at multiple intervention points (Health system, SUD/MH system); (2) Leverage existing programs and policy mechanisms to collaboratively increase the rate at which women screening positive on the 4P's Plus get connected for a comprehensive assessment by establishing formal warm-handoffs and other safety net measures; (3) Leverage existing programs and policy mechanisms to collaboratively increase the rate at which women delivering SEIs and their babies and any other eligible children, receive early support services for which they are eligible.
Three workgroups convened:

(1) *Data Workgroup* looked at statewide data systems (Medicaid ICD codes and DOH) that capture prenatal screening, linkage to treatment services, follow-up for parenting women, prevalence of NAS and associated costs. During the initiative, the team analyzed 2013 and 2014 Medicaid data to establish prevalence and costs of treatment NAS.

(2) *Prenatal Screening, Early Identification of Infants & Referral to Service Workgroup* focused on how to increase connections to appropriate treatment and supportive services such as Central Intake and Perinatal Cooperatives, by mapping out current screening and referral practices across the state using Pregnancy Risk Assessment (PRA) data; New Jersey implemented the 4Ps+ across the State and embedded the tool within the PRA. The workgroup found high utilization (over 80%) of 4Ps+ within doctors serving pregnant women on Medicaid. The mapping allowed the team to target low utilization areas to increase the prevalence of prenatal screening.

(3) *Labor, Delivery and Engagement (Infants) Workgroup* developed a comprehensive survey with input from the medical community and perinatal cooperatives. The Hospital Birth Survey was disseminated statewide March 2017 to the labor and delivery hospitals. The survey sought to understand how pregnant women with SUD and substance-exposed infants are identified, treated, and triaged with partners at discharge, and if treatment for NAS was explored. The Hospital Birth

Survey results was intended to guide Departments in establishing statewide guidelines for best practice; aid in the development of cross system models to ensure families get access to services; establish education needs on issues of SEI/NAS and identify high risk areas.

The IDTA commenced in 2017. DMHAS as the IDTA lead state agency, requested modified technical assistance from the NCSACW to support New Jersey to interpret the key findings from the *Birthing Hospital Survey*, and apply these findings to the Project ECHO (Extension for Community Outcomes) program design. Robert Wood Johnson and the Nicholson Foundation, in partnership with the three Departments (Health, Human Services, and Children and Families) and other stakeholders began planning to launch Project ECHO for SEIs. The New Jersey Project ECHO is aimed at Statewide adoption of best practice clinical care and community-based interventions to support SEIs and their parents to support recovery, family formation, and child development through a multidisciplinary case-based learning platform. Project ECHO for SEI and parents focuses on prevention, birth, and the infant's first year of life.

In 2020, DMHAS collaborated with Rutgers/Robert Wood Johnson Medical School to implement Project ECHO for Maternal Child Health. Pregnant and Parenting Women with Opioid Use Disorder (MCH PPW OUD). This ECHO provides education and training to primary care practitioners, SUD treatment providers, behavioral health practitioners, and other stakeholders in multiple clinic settings and at home, utilizing a web-based video collaboration between a multi-disciplinary team of specialists and primary care practitioners on best practices for the assessment, case management, intervention, treatment and recovery support services for PPW with an OUD. The ECHO's goal is to increase the capacity and competency of providers, community support organizations and clinical teams to support prevention, treatment and recovery of PPW with OUD. ECHO continues to position communities to reduce the NAS birth rates, improve use of medication assisted treatment, family formation and early infant development; improve access to physical and mental health care by educating more providers, midwives, doulas, and other health care professionals on best practices during prenatal and perinatal periods and inform the ECHO participants on Plans of Safe Care.

The anticipated start date for the program was set for March 2020. However, with the advent of the global COVID-19 pandemic, and the national and state orders to shelter in place effective late March 2020, limitations on who could go to the hospital added a level of complexity to care for those mothers expecting to give birth during this time or in recovery at home. These events required an immediate response to address the public health emergency. March, 2020 the DMHAS agreed to postpone the traditional MCH PPW-OUD ECHO Series until such time that the providers could return to a focus on pregnant and parenting women with an OUD. The ECHO team (DMHAS, Rutgers/RWJ and Hub members) refocused resources to provide COVID-19 MCH & OUD ECHO sessions. This temporary change in scope enabled the MCH PPW-OUD ECHO team to address treatment issues, access to healthcare services and how to meet the needs of specific populations of women during this crisis. The MCH PPW-OUD Hub team completed a 7 COVID-19 maternal child health and OUD sessions between April and the first week of June 2020. The MCH PPW-OUD ECHO with COVID-19 (included as a discussion topic) will reconvene 2021 for two series of 12 bi-weekly sessions.

DMHAS extended the MCH PPW-OUD ECHO through SFY24 for two educational/training (series 3 and series 4) commencing March 2023. Series 3 included eight (8) sessions held in the evening time for practitioners to learn and discuss the latest FDA approved techniques for MAT, integrated care and wraparound services. Series 4 will include ten (10) sessions with a curriculum that focuses on areas such as reducing stigma of mental health and substance use, screening protocols, improving access to substance use treatment, Plans of Safe Care, coordination of care for pregnant women with OUD and their newborns, MAT, etc.

SFY23 New Jersey Department of Health successfully applied for In-Depth Technical Assistance (IDTA) – *Advancing Collaborative Practice and Policy: Promoting Healthy Development and Family Recovery for Infants, Children, Parents, and Caregivers Affected by Prenatal Substance Exposure.* The Departments of Health, Children and Families, and Human Services, DMHAS, representative from the Governor's Office and an individual with lived experience comprise the State team. This new round of IDTA will build on the previous IDTA. Several goals have been established: conduct a statewide landscape analysis of resources targeted at individuals and the families of individuals with SUD: establish a comprehensive and seamless system of care among state agencies, healthcare providers, and community level and non-profit organizations to address SUD during and after pregnancy; increase the percentage of prenatal Plans of Safe Care that community partners develop; develop and update protocols and policies that aim to prevent NAS, SEI and SUD to implement care coordination through the NJ Plans of Safe Care model.

In November 2021, a Memorandum of Agreement with the Rowan University, School of Osteopathic Medicine (SOM) was developed for Screening, Brief Intervention and Referral to Treatment (SBIRT) for persons receiving services at their internal medicine, family care, OB/GYN clinics, and the Rowan University Student Health Center. Utilizing national best-practice standards for substance use screening, Rowan SOM has developed and implemented a fully sustainable, integrated SBIRT model as part of routine medical care. Additionally, Rowan SOM will implement annual, universal screening protocol, and office-based risk interventions, as part of patient intake services in all OB/GYN clinical settings.

<u>Child Welfare/Parents with Dependent Children Programs.</u> On July 1, 2015, the treatment contracts for parents with substance use disorders via a Memorandum of Understanding between the SSA and DCF Division of Child Protection & Permanency (DCP&P) transitioned over to DCF. DCF is the lead State agency on Plans of Safe Care for SEI, mothers and their families and has developed protocols for integrating Plans of Safe Care into child protection services and child welfare and child welfare assessments. DCF and DMHAS collaborate on multiple initiatives targeted to pregnant and parenting women with substance use disorders. This partnership focuses on a coordinated multisystem approach to enhance and integrate service delivery that will ultimately improve the outcomes for the women, their infants and families. This cross-system collaboration ensures that services are coordinated, and information is shared appropriately to facilitate better communication, maximize resources and address barriers.

Currently, 12 of New Jersey's 21 counties have monthly DCP&P Child Welfare Substance Use Disorder Consortia meetings which are held at the local DCP&P offices. Child welfare staff, DMHAS, Division of Family Development, Substance Use Disorder Provider Agencies, Work First New Jersey, Substance Abuse Initiative (WFNJ SAI) providers, and Boards of Social

Services meet each month and plan on how to better serve families, leading to more effective policies and practices to meet the needs of infants, children and families. The Consortia also addresses ASFA timelines and reunification for children in out of home placement. Through collaboration, multiple agencies working with the same family can improve communication to reduce the gaps in service delivery and improve coordination of services. The Consortia allow for cross systems collaboration with local treatment programs and other community partners who can provide the expertise needed to better serve families in the child welfare system.

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

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

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

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

The overall goal with the M-WRAP is to alleviate barriers to services for pregnant opioid dependent women through comprehensive care coordination implemented within the five major timeframes when intervention in the life of the substance exposed infants (SEI) can reduce potential harm of prenatal substance exposure: pre-pregnancy, prenatal, birth, neonatal and early

childhood. Care coordination also addresses screening, early intervention, assessment, treatment and recovery supports.

To ensure that the needs of the mother, infant and family receive coordination, access to and engagement in services, providers are required to develop Plans of Safe Care. Plans of Safe Care are developed prior to the birth event, whenever possible and in collaboration with treatment providers, health care providers, early childhood service providers and other members of the multidisciplinary team as appropriate. The M-WRAP model is intended to promote maternal health, improve birth outcomes for women, their infants and families, and reduce the risks and adverse consequences of prenatal substance exposure.

The onset of the COVID-19 pandemic resulted in many significant safety precautions at the national and state level. The stay-at-home orders, such as closures of businesses, schools, restrictions in gatherings has had an impact on the social determinants of health (food, security, employment, income, access to medical care, etc.). Pregnant and parenting women with a history of substance use disorder could be at risk for increase in substance use or experience relapse due to feelings of isolation, lack of family supports, or social support systems. Their mental health could be adversely affected exhibiting depression during pregnancy and postpartum July, 2021 the M-WRAP statewide initiative eligibility criteria was expanded to include pregnant women with substance use disorder, not exclusive to opioid dependency.

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

Integrated Opioid Treatment Services and Substance Exposed Infants (IOT-SEI). In December 2017, the Department of Health (DOH) awarded funding through a Request for Applications (RFA) for the expansion of integrated opioid treatment services and substance exposed infants (IOT-SEI). DMHAS manages the IOT-SEI Initiative. The IOT-SEI initiative focuses on three of the five major timeframes when intervention in the life of a SEI can reduce potential harm of prenatal substance exposure: the prenatal phase, the birth event, and neonatal phase. The IOT provides an array of services for opioid dependent pregnant women, their infants and family ranging from substance use disorder treatment, prenatal and postpartum medical/obstetric services, care coordination, recovery-based living arrangements, wraparound services such as intensive case management and recovery supports. Providers are required to develop Plans of Safe Care. The overall goal is intended to improve outcomes for pregnant women with opioid use disorder, their infant and families. This initiative promotes maternal health, improve birth outcomes and reduce the risks and adverse consequences of prenatal substance exposure. Five agencies across the State are contracted to participate in this initiative. In SFY2021, one of the awardees located in the Northern counties chose not to renew their contract. DMHAS rebid these services in SFY 2022 and awarded a provider to provide services in one of the northern counties

Tuberculosis (TB) Services. In New Jersey, all substance use disorder treatment facilities receiving contracts are required to conduct TB testing as part of the patients' admissions process. A provision of the guidelines requires that patients with TB, who were not admitted for treatment because the funded capacity at that facility had been exceeded, be referred to another treatment provider for services. DMHAS continues to have discussions with the NJ Department of Health, Division of HIV/AIDS, STDs and Tuberculosis Services (DHSTS) to consider the latest best practices for this effort.

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

Persons Who Inject Drugs (PWID). In CY 2021, 23,313 (24%) of 87,745 admissions used drugs intravenously. This particular group is at high risk for other infectious diseases such as HIV and hepatitis, indicating the need for linkage to primary care. One attempt to address this need was applying for, and being awarded, a Promoting Integration of Primary and Behavioral Health (PIPBHC) grant. The two awardees provide models of integration to serve individuals with opioid use disorder (OUD) and other health co-morbidities. Sterile Syringe Programs, called Harm Reduction Programs in New Jersey, are an integral part of this program and provide an additional referral source.

Another activity to address the need of PWID has been our partnership with Department of Health, the National Alliance of State and Territorial AIDS Directors (NASTAD) and the JSI Research & Training Institute, Inc. (JSI). One-time funds were provided to support activities related to the Strengthening Systems of Care for People with HIV and Opioid Use Disorder (SSC) project. These funds were designated to support concrete, time-based activities focused on enhancing systems of care for people with HIV and OUD and in alignment with state technical assistance plans developed for the project. Stigma and its effects contribute to the syndemics of HIV and opioid use disorder (OUD), acting as a barrier to care for people seeking services. An area that has been explored is data sharing among the two Departments to determine the number of individuals in substance use disorder (SUD) treatment who have HIV and the number of individuals who have HIV that are in SUD treatment. If a plan can be executed for the data sharing, information could be utilized by both Departments to help improve health outcomes for this population by better engaging individuals to seek either HIV or SUD treatment.

The SSA requires all substance use disorder treatment agencies providing treatment to persons who inject drugs (PWID) to provide outreach activities to encourage PWID clients to seek and undergo treatment. The SSA incorporates a provision within the requirements section of each contract with the agencies providing treatment to PWID to ensure that these entities: 1) admit all individuals who request and are determined to be in need of treatment for intravenous drug use within 14 days of their request; or 2) make interim services available to the individuals within 48 hours of the request, and should the individual actively remain on the waiting list, admit the clients

within 120 days. To address the need for interim services for PWID, DMHAS utilizes funding to support individuals requiring interim services through its Fee-for-Service (FFS) initiatives.

DMHAS has implemented a low-threshold buprenorphine induction program at all seven of the existing Harm Reduction Centers (HRCs), utilizing SOR funding. The intent has been to address the needs of PWID, who visit these centers, and encourage them to engage in treatment, when appropriate.

Another initiative to promote low induction medication is through mobile medication programming. Currently, DMHAS contracts with seven agencies to facilitate low induction medication, case management and other ancillary services for individuals with an OUD, which includes PWID, in counties with low access to MAT, as well as areas of the State with individuals who are homeless or at higher risk for homelessness.

Medication Assisted Treatment is the gold standard of care for individuals who suffer from an OUD. Data from NJSAMS for CY 2022 indicated that 15% methadone and 12% buprenorphine was planned for use in treatment, despite the fact that heroin and other opiates accounted for 45% of primary drug admissions. DMHAS is committed to reducing the gap between the use of MAT for people with OUD, particularly PWID. DMHAS, in partnership with the Department Human Services (DHS), Office of Public Relations, secured a vendor that has been delivering a public awareness campaign to help address stigma and discrimination around the use of MAT for OUD. The campaign was initially launched in the Spring of 2020 and continues to refresh with new ads. Various forms of messaging including TV ads, radio commercials, social media and billboards have been utilized.

In addition, DMHAS offers extensive training on the use of MAT in efforts to make this the standard of care. In CY 2023, DMHAS contracted with Cooper Medical School of Rowan University (CMSRU), the State's Southern Center of Excellence (COE), to provide tailored training and technical assistance on Addiction Medicine, specifically buprenorphine induction, throughout New Jersey. This includes various training topics, formats, office hour sessions, and "elbow to elbow" on-site consultation services. The training is aimed at increasing the use of buprenorphine to treat opioid use disorders, specifically at Emergency Departments, Federally Qualified Healthcare Centers and Primary Care offices.

Lesbian, Gay, Bisexual, Transgendered, and Questioning. The SSA provides prevention services to Gay, Lesbian, Bisexual, Transgendered, and Questioning (LGBT) youth. The SSA awarded funding to the North Jersey Community Research Initiative (NJCRI) to expand their existing programs for high-risk LGBT youth of color by using a "Street Smart" prevention model developed by the Centers for Disease Control and Prevention, as well as early intervention services, social marketing, and structured recreational activities. NJCRI providers services covering the northern NJ counties. In the spring of 2023, DMHAS (by means of a competitive RFP process) identified two additional organizations to provide services to LGBT persons in their communities: Prevention Resources in Central NJ and the Robert Wood Johnson-Barnabas Health Institute for Prevention and Recovery, in the south.

NJ State Tribal Nations. In 2023 DMHAS developed a Memorandum of Agreement (MOA) with the New Jersey Commission on American Indian Affairs, within the New Jersey Department of State. New Jersey is home to three state (not federally) recognized tribes: Nanticoke Lenni-Lenape Indians, Powhatan Renape Indians, and the Ramapough Lenape Indian Nation.

To date, DMHAS has not collaborated with the Commission on Indian Affairs. But, under this MOA, DMHAS will provide funds (Block Grant Supplement and ARP) to enable the tribes to implement evidence-based primary prevention programs. Tribes will be instructed in the use of the Strategic Prevention Framework and will identify prevention programs or strategies that were developed by or for Native American communities. DMHAS will offer guidance and support to the tribes at their request.

Special Populations. DMHAS issued an RFP to providers to identify an underserved special population(s) to whom they would provide direct mental health and SUD services. The services are intended to assist those who have experienced difficulties and challenges accessing critical services when they may be in crisis. Funding attached to the special population initiative is aimed at ensuring that services provided will include diversity, inclusion, equity, cultural and linguistic competence to the target population identified by each provider. Providers awarded this funding are committed to continually assessing and utilizing the demographic data collected from participants' service areas to continue the development and delivery of programming, evaluation, and program outcomes to their targeted underserved population. The analyze data collected will be used to help implement strategies to increase program participation and provide resources to this underserved population.

Providers are required to show the specific detail on how they've identified their underserved population and how their provided services will focus on the outreach techniques used to help minimize the negative impact of a crisis and how their direct clinical services have benefited the underserved population. These targeted services should be consumer-driven and planned with the specific needs of the individual and their special population in mind. Providers must also present with the capacity to accommodate consumers who present or are referred with legitimately prescribed medications. This can be accomplished either through direct provision of services associated with the provision or dispensing of medications and/or via development of viable networks/referrals/consultants/sub-contracting with those who are licensed and otherwise qualified to provide medications.

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Pregnant Women/ Women with Dependent Children

Priority Type: SUT

Population(s): PWWDC

Goal of the priority area:

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

Strategies to attain the goal:

• Provider Meetings. Biannual meetings are held with the Maternal Wrap Around (MWRAP) providers, Integrated Opioid Treatment and Substance Exposed Infants (IOT-SEI) providers, and the Department of Children and Families (DCF). A variety of topics such as information sharing, data collection, best practices, continuum of care, medication assisted treatment, referrals and access to services, recovery supports, Plans of Safe Care, systems collaboration, program accomplishments, challenges, and training needs are addressed.

• Professional Development. Contracted licensed women's treatment providers receiving funding through the women's set aside block grant are required to address the full continuum of treatment services. Services include family-centered treatment, evidence-based parenting programs, trauma-informed and trauma-responsive treatment using Seeking Safety, Strengthening Families, evidence-based parenting classes, recovery supports, etc. and to provide assistance with housing supports by linking women to transitional, permanent and/or supportive or sober living homes such as an Oxford House. Providers with DMHAS contracts for pregnant and parenting women including specialty services that addresses the continuum of care from prevention, treatment and recovery supports as per contract requirements are required to have new staff successfully complete the National Center on Substance Abuse and Child Welfare (NCSACW) online tutorials "Understanding Child Welfare and the Dependency Court: A Guide for Substance Abuse Treatment Professionals" and document completion of tutorials in their employee personnel files.

• Plans of Safe Care. All women's treatment and pregnant and parenting specialty services including the MWRAP and IOT-SEI Initiatives) provider contract language requires Plans of Safe Care for pregnant and postpartum women (PPW). Plans of Safe Care will address the needs of the mother, infant and family to ensure coordination of, access to, and engagement in services. For a pregnant woman, the Plan shall be developed prior to the birth event whenever possible and in collaboration with treatment providers, health care providers, early childhood service providers, and other members of the multidisciplinary team as appropriate. Documentation of the Plan must be included in the woman's file. The DMHAS Monitoring Unit has updated their monitoring site review document to include Plans of Safe Care under the women's set aside section for the block grant funded treatment providers.

• Interim Services. In 2019 NJ DMHAS added language to Fee for Service (FFS) Network Annex A's to ensure all FFS funded treatment agencies provide Interim Services as an engagement service at all levels of care to ensure priority PPW consumers awaiting admission to their assessed level of care anywhere in the state could receive interim services within 48 hours at facilities closer to home. Interim services for PPW consumers is designed to reduce the adverse health effects of substance use, promote individual health, and reduce the risk of transmitting disease to sexual partners and their infants by providing individualized education, case management, referrals and MAT if needed, while awaiting admission. Statewide technical assistance on interim services was provided to all provider contractees.

• In Depth Technical Assistance (IDTA) Neonatal Abstinence Syndrome and Substance Exposed Infants (NAS SEI). As a SAMHSA Prescription Drug Abuse Policy Academy State, in 2014 NJ applied for a unique technical assistance opportunity through the SAMHSA supported NCSACW to address the multi-faceted problems of NAS and SEI. NJ DHS/DMHAS as the lead State agency, partnered with DCF and DOH, and submitted a successful application (no funding attached). The IDTA goal was to develop uniform policies/guidelines that address the entire spectrum of NAS and SEI from pre-pregnancy, prevention, early intervention, assessment and treatment, postpartum and early childhood. The IDTA provided technical assistance to NJ to strengthen collaboration and linkages across multiple systems such as addictions treatment, child welfare, and medical communities to improve services for pregnant women with opioid and other substance use disorders and outcomes for their babies. The Core Team included over 60 individuals representing multiple State Departments and Divisions, community stakeholders, treatment providers, and the medical community. Three goals were established: (1) Increase perinatal SEI screening at multiple intervention points; (2) Leverage existing programs and policy mechanisms to collaboratively increase the rate at which women screening positive on the 4P's Plus get connected for a comprehensive assessment by establishing formal warm-handoffs and other safety net measures; and (3) Leverage existing programs and policy mechanisms to collaboratively increase the rate at which women delivering SEIs and their babies and any other eligible children, receive early support services for which they are eligible. Workgroups were formed. New Jersey was recently awarded technical assistance through the National Center on Substance Abuse and Child Welfare's (NCSACW) 2023 Policy Academy: Advancing Collaborative Practice and Policy: Promoting Healthy Development and Family Recovery for Infants, Children, Parents, and Caregivers Affected by Prenatal Substance Exposure. The Department of Health is the lead State Department and NJ Policy Academy State representatives include the Departments of Children and Families, Human Services, and the Governor's Office. The DMHAS Women's Treatment

Coordinator represents the Department of Human Services. The overall goal is to increase awareness of pregnant women and SUD, through increased education and maximizing messaging through the perinatal work force, increase awareness and access to treatment, Plans of Safe Care, and improving screenings in hospitals and healthcare providers.

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

• Project ECHO Maternal Child Health. The Pregnant and Parenting Women with Opioid Use Disorder (MCH PPW OUD) ECHO provides education and training to primary care practitioners, SUD treatment providers, behavioral health practitioners, and other stakeholders in clinic settings and at home, utilizing a web-based video collaboration between a multi-disciplinary team of specialists and primary care practitioners on best practices for the assessment, case management, intervention, treatment and recovery support services for PPW with an OUD. The goal is to increase the capacity and competency of providers, community support organizations and clinical teams to support prevention, treatment and recovery of PPW with OUD. ECHO will position communities to reduce the NAS birth rates, improve use of medication assisted treatment, family formation and early infant development; improve access to physical and mental health care by educating more providers, midwives, doulas, and other health care professionals on best practices during prenatal and perinatal periods. The anticipated start date for the Program was set for March 2020. However, with the advent of the global COVID-19 pandemic, and the national and state orders to shelter in place effective late March 2020, limitations on who could go to the hospital added a level of complexity to care for those mothers expecting to give birth during this time or in recovery at home. These events required an immediate response to address the public health emergency. In late March, 2020 the DMHAS agreed to postpone the traditional MCH PPW-OUD ECHO Series until such time that the providers could return to a focus on pregnant and parenting women with an OUD. The ECHO team (DMHAS, Rutgers/RWJ and Hub members) refocused resources to provide COVID-19 MCH and OUD ECHO sessions. This temporary change in scope enabled the MCH PPW-OUD ECHO team to address treatment issues, access to healthcare services and how to meet the needs of specific populations of women during this crisis. The MCH PPW-OUD Hub team completed seven (7) COVID-19 maternal child health and OUD sessions between April and the first week of June. The MCH PPW-OUD Hub team completed seven (7) COVID-19 maternal child health and OUD sessions between April and the first week of June, 2020, and MCH PPW-OUD ECHO with COVID-19 (included as a discussion topic) reconvened June 15, 2020 through December 2020. MCH PPW-OUD ECHO series is scheduled after July of 2021. Each series was designed as 12 bi-weekly sessions. Project ECHO series with the new curriculums took place early Spring 2022 and concluded late summer.

DMHAS renewed the MCH PPW-OUD ECHO series with 18 sessions scheduled through 2023. The curriculum covers the following areas: screening for SUD; new guidelines for prescribing buprenorphine; starting treatment: the patient contract, pharmacy partner and social services; managing buprenorphine treatment and follow-up; opioid dependency reporting guidelines; and hot topics. In an effort to reach out to practitioners and prescribers, the first ECHO 8 sessions were scheduled for a special evening time with a focus on the latest FDA approved techniques for MAT, integrated care, and wraparound services.

• Maternal Wrap Around Program (MWRAP). MWRAP is a statewide program located in seven regions. MWRAP was awarded through an RFP in 2018 and services included intensive case management and recovery support services for opioid dependent pregnant and postpartum women. Opioid dependent women were eligible for services during pregnancy and up to one year after the birth event. MWRAP served thirty (30) unduplicated women in each region. The MWRAP goal was to alleviate barriers to services for pregnant opioid dependent women through comprehensive care coordination implemented within the five major timeframes when intervention in the life of the SEI can reduce potential harm of prenatal substance exposure: pre-pregnancy, prenatal, birth, neonatal and early childhood. MWRAP is intended to promote maternal health, improve birth outcomes, and reduce the risks and adverse consequences of prenatal substance exposure.

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

Improving maternal child health outcomes is a major agenda for NJ through the adoption of NurtureNJ, led by First Lady Tammy Murphy. NurtureNJ is a statewide, multi-agency campaign dedicated to this issue. Reach NJ, the central call-in line for NJ residents who are looking for help with a SUD dedicated their public service announcement campaign to pregnant women during late Fall 2022. MWRAP provided training to ReachNJ who will now offer MWRAP as a resource and provide warm hand-offs. MWRAP services provides the support needed to help pregnant and parenting women with SUD maintain a healthy recovery, resulting in less overdoses, and improved birth outcomes and maternal child health. SFY2024 MWRAP will receive another expansion, with each MWRAP region required to provide services to sixty (60) unduplicated women. A total of 420 unduplicated pregnant women will be eligible for services.

• Integrated Opioid Treatment and Substance Exposed Infants (IOT-SEI) Initiative. Five awards across the State, funded with the Governor's State Opioid funds. This Initiative provides an array of integrated services for opioid dependent pregnant women, their infants and family. Providers are required to

ensure a full continuum of services and to establish mechanisms to develop a coordinated and cohesive approach for working together across systems that include, SUD treatment, medical community, maternal child health, and child welfare. Initiative focuses on alleviating barriers to services. Services range from: mother's medical/prenatal and obstetrical care, SUD treatment for OUD including MAT, new born/infant medical care, child welfare services as identified, intensive case management, recovery supports, assistance with housing, case management and other wraparound services. Providers must ensure that there is comprehensive care coordination from prenatal through the birth event, postpartum, and early childhood.

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

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

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

• Sober Living. New Jersey contracts with Oxford House Inc. which has dedicated women's homes and women with children homes. The contract has been expanded to develop additional homes for special populations including women with children. Women and Children Oxford Houses are required to provide lockboxes to each for medication storage. Residents in Oxford Houses is responsible for their individual medication lock boxes. Outreach staff conduct annual training (Overdose Specific) at each Chapter meeting at the annual state workshop. Currently, there are 14 Oxford House Chapters throughout the state. This is in response to the heroin overdose epidemic in the state of New Jersey and its effects related to Oxford House. Each home is required to maintain Naloxone kits on site. In 2022 Oxford House continued to see an increase in members applying for membership with OUD. This increase created a more significant need for naloxone training and information on access to Medical Assisted Recovery (MAR) options. The New Jersey Oxford House outreach team continues to educate members on MAR and the importance of being an active member of their recovery community.

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

• Advertising Campaign. New Jersey continues its statewide advertising campaign centered around opioid use and bringing public awareness to call ReachNJ, the 24/7 Addiction Hotline, for treatment. New messaging, beginning in August 2022, has added pregnant women, along with student athletes and older adults, as target groups. This is a statewide campaign that utilizes television and radio advertisements, bus wraps, billboards and social media to encourage New Jerseyans to access treatment. Recently the TV ad aired on NBC during the Macy's Thanksgiving Day Parade and later that evening during an NFL football game.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Increase the number of pregnant women or women with children entering substance use treatment.
Baseline Measurement:	SFY 2023: 23,272 admissions
First-year target/outcome measurement:	Increase number of pregnant women or women with children entering substance use treatment in SFY 2024 by .5 %.
Second-year target/outcome measurement:	Increase number of pregnant women or women with children entering substance use treatment by .5 % by the end of SFY 2025. The change in SFY 2025 will be measured by calculating the percent difference from SFY 2023 to SFY 2025.
Data Source:	

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

Description of Data:

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

Data issues/caveats that affect outcome measures:

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

Priority #: 2

Priority Area: Persons Who Inject Drugs (PWID)

Priority Type: SUT

Population(s): PWID

Goal of the priority area:

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

Strategies to attain the goal:

• Low Threshold Buprenorphine Program at Harm Reduction Centers. Continue to implement low threshold buprenorphine induction programming at all statewide Harm Reduction Centers (HRCs) while also continuing to encourage collaboration and affiliation agreements between the HRCs and substance use disorder agencies to ensure referral to comprehensive treatment programs, when clinically indicated.

• Mobile Medication Units. Providing services in convenient locations, specifically through existing and new mobile medication programming, in order to reduce barriers and engage individuals in care as easily as possible.

• Expanded Hour OTPs. Continuance of an expanded hour Opioid Treatment Program (OTP) initiative in efforts to provide increased (i.e. evening) hours that are not typically provided in efforts to assist individuals with easier access to services.

• Public Awareness Campaign. Educating providers and reducing stigma and discrimination for individuals with an OUD, family members and the public about the benefits of medications for Opioid Use Disorder (MOUD) through its public awareness campaign that was initially launched in 2020.

• Opioid Overdose Prevention Trainings. Contracts with three regional Opioid Overdose Prevention Program (OOPP) providers and an Opioid Overdose Prevention Network (OOPN) provider to continue to offer community education and trainings for individuals at-risk for an opioid use disorder, their families, friends and loved ones to recognize an opioid overdose and to subsequently provide naloxone kits to individuals in attendance. A component of these trainings have been and will continue to be to discuss treatment, including MOUD. In addition to populations listed above, training will continue to be inclusive of, but not limited to other populations such as schools, jails, licensed Substance Use Disorder (SUD) agencies, Office of Emergency Management, Emergency Medical Services (EMS), teams, fire departments, homeless shelters and community health clinics.

• Opioid Overdose Recovery Programs. Linking individuals reversed from an opioid overdose, who are seen bedside by recovery specialists and patient navigators at emergency departments, via the 21 county Opioid Overdose Recovery Programs (OORPs) to treatment and/or recovery support services in their communities.

• Support Teams for Addiction Recovery. Statewide contracts awarded to providers in all 21 counties for a Support Team for Addiction Recovery (STAR) program to provide case management and wraparound services for individuals with an OUD. Goals include linking clients to needed services, housing, primary care and treatment to include MOUD.

• Telephone Recovery Supports. Telephone Recovery Support (TRS) is a statewide program to assist individuals to reduce relapse and to enhance the recovery experience. The service calls high risk participants with an OUD, for up to four months, longer if needed, to provide encouragement, support and information.

• Maternal Wrap Around Program. Maternal Wrap Around Program (MWRAP), is a statewide program that was awarded through an RFP in 2018. MWRAP has had several expansions and is located in seven regions throughout the state, all counties provide MWRAP, with each region serving approximately 60 unduplicated pregnant women with substance use disorder, their infants and families. MWRAP provides intensive case management

and recovery support services. Services are available to pregnant women and up to one year after the birth event. The MWRAP goal is to alleviate barriers to services for pregnant opioid dependent women through comprehensive care coordination that is implemented within the five major timeframes when intervention in the life of the SEI can reduce potential harm of prenatal substance exposure: pre-pregnancy, prenatal, birth, neonatal and early childhood. MWRAP is intended to promote maternal health, improve birth outcomes, and reduce the risks and adverse consequences of prenatal substance exposure. Improving maternal child health outcomes is a major agenda for NJ through the adoption of NurtureNJ, led by First Lady Tammy Murphy. NurtureNJ is a statewide, multi-agency campaign dedicated to this issue. Reach NJ, the central call-in line for NJ residents who are looking for help with a SUD dedicated their public service announcement campaign to pregnant women during late Fall 2022. MWRAP provided training to ReachNJ who will now offer MWRAP as a resource and provide warm hand-offs. MWRAP services provides the support needed to help pregnant and parenting women with SUD maintain a healthy recovery, resulting in less overdoses, and improved birth outcomes and maternal child health.

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

• Strategic Prevention Framework for Prescription Drugs: In September 2021, DMHAS was awarded its second "Strategic Prevention Framework for Prescription Drugs (SPF Rx)" five-year grant from SAMHSA to implement the NJAssessRx initiative. NJAssessRx expands interagency sharing of the state's Prescription Drug Monitoring Program data and gives DMHAS the capability to use data analytics to identify prescribers, prescriber groups and patients at high risk for inappropriate prescribing and nonmedical use of opioid drugs. Informed by the data, DMHAS and its prevention partners will strategically target communities and populations needing services, education or other interventions. The target population is youth (ages 12-17) and adults (18 years of age and older) who are being prescribed opioid pain medications, controlled drugs, or human growth hormone (HGH), and are at risk for their nonmedical use.

• State Opioid Response (SOR) Grant. In FY 2023, New Jersey received just over $133 million through SOR for a two-year period. The goal of the SOR is to address the State's opioid crisis as well as a rising issue of stimulant use disorder by providing treatment, family and peer recovery support, community prevention and education programs and training. The key objectives of funding are to increase access to medication-assisted treatment (MAT), reduce unmet treatment need, reduce opioid-related deaths, and provide services to address individuals who have a stimulant use disorder.

• Jail MAT and Technical Assistance. As part of SOR and state funding, DMHAS collaborates with all 21 counties in NJ who have established Medication Assisted Treatment (MAT) programs or enhanced existing MAT services for inmates with OUD at county correctional facilities. DMHAS utilizes funds to have its two Centers of Excellence (COEs) provide technical assistance to correctional facilities to assist them in the provision of these services. In addition, DMHAS has worked with county correctional facilities to establish justice involved re-entry services for detainees where case managers at county jails conduct intake assessments and establish pre-release plans for needed services in the community.

• Interim Services. Interim Services is a requirement of DMHAS provider contracts. An initiative developed in October 2019 has allowed DMHAS to pay for these services through a fee-for-service (FFS) mechanism. The Interim Services initiative provides funding to all contracted FFS agencies to support individuals awaiting admission to treatment following a substance use disorder (SUD) assessment. Interim Services are an engagement level of service intended to link individuals to services they may not be able to access due to lack of provider capacity. This service has been designed to be provided by agencies contracted for any licensed ASAM level of care. Interim services have been made available to any individual eligible for treatment within the public system who cannot be admitted for the assessed level of care within 72 hours. Prior to this initiative, agencies enrolled in the Block Grant initiatives were required to provide this service.

• Homeless Shelter Initiative. DMHAS continues to increase access to buprenorphine and other ancillary services for individuals with a substance use disorder through current programming available at homeless shelters. Contracted providers will continue to develop the capacity to provide low threshold medication as well as other support services for individuals who reside or drop in at the shelters, linking them to treatment and recovery services, when appropriate.

• Community Training. DMHAS will continue a train-the-trainer program through Rutgers University to educate the community on medications that can be utilized to support recovery and provide NJ-specific treatment and recovery resources. The goal of this project is to educate, support, and mentor graduate students to provide these free educational talks to community groups throughout the State.

• Cultural Competency Training and Practice for Opioid Treatment Providers. DMHAS contracts with a provider whose goal is to help narrow the treatment gap experienced by Black/African Americans (AA) who are diagnosed with opioid and stimulant use disorders and who are statistically less likely to receive or access services. Another significant goal of this initiative is to increase the prescribing of Medication for Opioid Use Disorders (MOUD) among the Black/AA community.

• Paramedicine Initiative. DMHAS continues to develop a pilot program to fund one of its university partners to develop pilot paramedicine programs in the State to administer buprenorphine for opioid withdrawal symptoms and provide next day linkage to care to community providers.

• Office Based Addiction Treatment. The Division of Medical Assistance and Health Services (DMAHS), in collaboration with DMHAS, continues a program to cover and support medications for opioid use disorder at Office Based Addiction Treatment (OBAT) providers. This program coordinates the

delivery of multiple reimbursable services provided by primary care providers and community behavioral health specialists to NJ FamilyCare members with an addiction diagnosis. OBAT providers link patients to OTPs or other treatment services, when appropriate.

• Long-Term Residential Incentive Payment. A new innovation is paying Long Term Residential agencies for providing Medication Assisted Treatment (MAT) to clients. Effective June 1, 2020, the Long-term Residential (LTR) reimbursement rate was increased, as well as the ability to pay for MAT and MAT-related services. On August 20, 2021, the Department of Health (DOH) issued Guidance 7-2021 that reported Long Term Residential (LTR) facilities do not need to seek approval from DOH to prescribe medication, other than Methadone, for the treatment of substance use disorders. As a result, effective October 15, 2021, the base rate for Long Term Residential [H0019HF] includes the MAT add-on of $5.00 per unit and increased to $152.60 per day inclusive of Room and Board. Beginning July 1, 2020, additional incentive payments became available for the utilization of MAT and MAT capacity in LTR. The incentive rate creates the capacity to prescribe and administer MAT, which minimally includes Buprenorphine, but also may include Naltrexone and other FDA-approved products for Opioid Use Disorder (OUD) and for Alcohol Use Disorder (AUD). The rates and incentives are structured as follows:
1) The increased base LTR treatment rate with the MAT add-on plus Room and Board per diem.
2) When an LTR provider site has least 40% of eligible clients receiving an approved medication for treatment of an OUD or an AUD, the provider's rate will increase by $10.00 per unit of service. This incentive threshold applies to medications arranged for using an external provider (e.g., Methadone from an OTP; Buprenorphine from OBAT) and provided by the LTR Provider.
3) The LTR provider can bill for medications inclusive of administration costs in addition to the new rates.

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

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

• Expanded Outpatient Hours. An RFP was issued in August 2022 to expand outpatient treatment services and enhance access to treatment by removing barriers such as traditional service hours. Ten SUD outpatient treatment providers were awarded a contract to provide these services in October 2022. These expanded hours will provide increased access to outpatient treatment for individuals with an SUD. The purpose of this expansion for outpatient services is to support, enhance and encourage the emotional development and the development of consumer's life skills in order to maximize their individual functioning during alternate times from standard business hours (after hours and weekends). Providers are required to expand their hours at a minimum of six (6) days per week with the goal of extending hours into the evening and admitting new consumers for these services during these times. This program is funded with ARPA SUBG funds.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase the number of PWID entering treatment.

Baseline Measurement: SFY 2023: 16,741 admissions

First-year target/outcome measurement: Increase the number of PWID entering treatment by 1%.

Second-year target/outcome measurement: Increase the number of PWID entering treatment by 2% by the end of SFY 2025. The change in SFY 2025 will be measured by calculating the percent difference from SFY 2023 to SFY 2025.

Data Source:

The number of PWID in SFY 2023 through SFY 2025 will be tracked by the SSA's New Jersey Substance Abuse Monitoring System (NJSAMS).

Description of Data:

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

Data issues/caveats that affect outcome measures:

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

Indicator #: 2

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

Baseline Measurement: SFY 2023: 35,589 admissions

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

Second-year target/outcome measurement: Increase number of opiate dependent individuals entering treatment by 2% by the end of SFY 2025. The change in SFY 2025 will be measured by calculating the percent difference from SFY 2023 to SFY 2025.

Data Source:

The number of opiate dependent individuals from SFY 2023 - 2025 will be tracked by the SSA's New Jersey Substance Abuse Monitoring System (NJSAMS).

Description of Data:

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

Data issues/caveats that affect outcome measures:

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

Priority #: 3

Priority Area: Heroin/Opioid Users

Priority Type: SUT

Population(s): Other

Goal of the priority area:

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

Strategies to attain the goal:

• Public Awareness Campaign. Continue to utilize a public awareness campaign focusing on reducing stigma/discrimination for individuals with an OUD, family members and the public about the benefits of utilizing medications to support recovery for an Opioid Use Disorder (MOUD).

• Building Capacity Initiative. Initiative focuses on addressing challenges faced by both licensed mental health and substance use disorder programs that require start-up funds to increase their capacity to offer MAT, specifically buprenorphine to their clients. Contracted MH and SUD programs are expected to build capacity to offer MAT in compliance with all federal and New Jersey state regulations.

• Vivitrol Enhancement. DMHAS will continue the Vivitrol Enhancement through its Fee-for-Service (FFS) Network. This enhancement allows providers to be reimbursed for the provision of Vivitrol as well as other ancillary services in FFS initiatives. Licensed SUD agencies can be enrolled in the enhancement if have proper approval of policies and procedures from the Department of Health, Certificate of Need & Licensing (CN&L).

• Buprenorphine Enhancement. DMHAS will continue the Buprenorphine Enhancement, similar to the one created for Vivitrol, that reimburses FFS Network providers for the provision of buprenorphine at their agencies. Licensed SUD agencies are able to participate in the enhancement with proper approval (MAT Waiver) issued by CN&L.

• Jail MAT and Case Management Initiative. DMHAS collaborates with the State's 21 county jails that established MAT programs or enhanced existing MAT services for inmates. In addition, DMHAS works with county correctional facilities and have established justice involved re-entry services for detainees where case managers at county jails conduct intake assessments and establish pre-release plans for needed services in the community, which

include linking individuals to community MAT services.

• American Society of Addiction Medicine Booklets. DMHAS will continue to provide a statewide distribution of American Society of Addiction Medicine (ASAM) booklets entitled "Opioid Addiction Treatment: A Guide for Patients, Families and Friends" which provide facts about treatment, including MAT as a best practice, and provides NJ-specific resources to accessing treatment and recovery services. These guides are provided in English, Spanish and Braille and goal is to provide in additional languages that are prevalent in New Jersey. In addition, DMHAS worked with the NJ Division of Deaf and Hard of Hearing (DDHH) to create a video link in American Sign Language (ASL).

• Community Training. DMHAS will continue its Memorandum of Agreement (MOA) with Rutgers University, Robert Wood Johnson Medical School for a train-the-trainer program on Medications for Opioid Use Disorder (MOUD), the opioid epidemic (specific to New Jersey) and concepts of SUD (specific to OUD) for a minimum of 40 graduate students at Rutgers University. This project will continue to educate, support, and mentor graduate students to give free educational talks, through use of PowerPoint presentations, to community businesses and organizations in efforts to reduce stigma/discrimination around medication to support an individual's recovery.

• Low Threshold Buprenorphine Induction at Harm Reduction Centers. Continue low threshold buprenorphine induction programming at all statewide Harm Reduction Centers (HRCs) while also continuing to encourage collaboration and affiliation agreements between the HRCs and substance use disorder agencies to ensure referral to comprehensive treatment programs, when clinically indicated.

• Expanded Hour Opioid Treatment Program. Continuance of an expanded hour Opioid Treatment Program (OTP) initiative which provides increased (i.e. evening) hours that are not typically provided in efforts to assist individuals with easier access to services/care.

• Cultural Competency Training and Practice for Opioid Treatment Providers. DMHAS contracts with a provider whose goal is to help narrow the treatment gap experienced by Black/African Americans (AA) who are diagnosed with opioid and stimulant use disorders and who are statistically less likely to receive or access services. Another significant goal of this initiative is to increase the prescribing of Medication for Opioid Use Disorders (MOUD) among the Black/AA community.

• Long-Term Residential Incentive Payment. A new innovation is paying long term residential providers for providing MAT to clients. Effective June 1, 2020, the Long-term Residential (LTR) reimbursement rate was increased, as well as the ability to pay for Medication Assisted Treatment (MAT) and MAT related services. On August 20, 2021, the Department of Health (DOH) issued Guidance 7-2021 that reported Long Term Residential (LTR) facilities do not need to seek approval from DOH to prescribe medication, other than Methadone, for the treatment of substance use disorders. As a result, effective October 15, 2021, the base rate for Long Term Residential [H0019HF] includes the MAT add-on of $5.00 per unit and increased to $152.60 per day inclusive of Room and Board. Beginning July 1, 2020, additional incentive payments became available for the utilization of MAT and MAT capacity in LTR. The incentive rate creates the capacity to prescribe and administer MAT, which minimally includes Buprenorphine, but also may include Naltrexone and other FDA-approved products for Opioid Use Disorder (OUD) and for Alcohol Use Disorder (AUD). The rates and incentives are structured as follows:

1. The increased base LTR per diem rate for treatment plus Room and Board.
2. When an LTR provider site has least 40% of eligible clients receiving an approved medication for treatment of an OUD or an AUD, the provider's rate will increase by $10.00 per unit of service. This incentive threshold applies to medications arranged for using an external provider (e.g., Methadone from an OTP; Buprenorphine from OBAT) and provided by the LTR Provider.
3. The LTR provider can bill for medications inclusive of administration costs in addition to the new rates.

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

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

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

• Homeless Shelter Initiative. DMHAS continues to increase access to buprenorphine and other ancillary services for individuals with a substance use disorder through current programming available at homeless shelters. Contracted providers will continue to develop the capacity to provide low threshold medication as well as other support services for individuals who reside or drop in at the shelters, linking them to treatment and recovery services, when appropriate.

• Mobile Medication Units. Providing services in convenient locations, specifically through existing and new mobile medication programming, in order

to reduce barriers and engage individuals in care as easily as possible.

• DMHAS worked with the Department of Health, Certificate of Need & Licensing (CN&L) to eliminate the need for a MAT Waiver that was previously required at residential SUD treatment agencies.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase the number of heroin/other opiate admissions for whom MAT was planned.

Baseline Measurement: SFY 2023: 20,402 heroin/other opiate admissions for whom MAT was planned.

First-year target/outcome measurement: Increase the number of heroin/other opiate admissions for whom MAT is planned by 1%.

Second-year target/outcome measurement: Increase the number of heroin/other opiate admissions for whom MAT is planned by 2%. The change in SFY 2025 will be measured by calculating the percent difference from SFY 2023 to SFY 2025.

Data Source:

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

Description of Data:

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

Data issues/caveats that affect outcome measures:

None

Priority #: 4

Priority Area: TB

Priority Type: SUT

Population(s): TB

Goal of the priority area:

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

Strategies to attain the goal:

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

Annual Performance Indicators to measure goal success

Indicator #: 1

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

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

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

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

Data Source:

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

Description of Data:

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

Data issues/caveats that affect outcome measures:

None

Priority #: 5

Priority Area: Tobacco

Priority Type: SUP

Population(s): PP

Goal of the priority area:

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

Strategies to attain the goal:

Beginning in January 2012, DMHAS funded 19 Regional Prevention Coalitions covering NJ's 21 counties, all of whom utilize the SPF model to guide their work. These coalitions are all required to address tobacco use among youth. The coalitions use, primarily, environmental strategies along with occasional individual approaches as appropriate. Below is a listing of approaches used by the coalitions to address tobacco use among adolescents in their regions.

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

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

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

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

• DMHAS, the Department of Health, and the Department of Treasury collaborated in 2023 to develop strategies to reduce underage tobacco sales in New Jersey. One strategy that has been implemented in February 2023 is the addition of information on Treasury's online cigarette licensing application regarding the consequences of underage sales (fines, and/or suspension or revocation of tobacco license) and ways tobacco retailers can avoid underage sales at. Links to merchant education materials were also added to the licensing application's front page.

Annual Performance Indicators to measure goal success

Indicator #: 1

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

Baseline Measurement: According to 2021 NSDUH data, 1.97 percent of the target population reported tobacco product use (any) during the month prior to participating in the survey.

First-year target/outcome measurement: A reduction of .10% below the baseline measure.

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

Data Source:

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

Description of Data:

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

Data issues/caveats that affect outcome measures:

None

Priority #: 6

Priority Area: Alcohol

Priority Type: SUP

Population(s): PP

Goal of the priority area:

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

Strategies to attain the goal:

Beginning in January 2012, DMHAS funded 19 Regional Prevention Coalitions covering NJ's 21 counties, all of whom utilize the SPF model to guide their work. These coalitions are all required to address underage drinking among youth. The coalitions use, primarily, environmental strategies along with occasional individual approaches as appropriate. Below is a listing of approaches used by the coalitions to address underage drinking among adolescents in their regions.

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

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

Annual Performance Indicators to measure goal success

Indicator #: 1

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

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

First-year target/outcome measurement: A reduction of .50% below the baseline measure.

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

Data Source:

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

Description of Data:

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

Data issues/caveats that affect outcome measures:

None

Priority #: 7

Priority Area: Marijuana

Priority Type: SUP

Population(s): PP

Goal of the priority area:

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

Strategies to attain the goal:

Beginning in January 2012, DMHAS funded 19 Regional Prevention Coalitions covering NJ's 21 counties, all of whom utilize the SPF model to guide their work. These coalitions are all required to address marijuana use among youth. The coalitions use, primarily, environmental strategies along with occasional individual approaches as appropriate. Below is a listing of approaches used by the coalitions to address marijuana use among adolescents in their regions.

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

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

Annual Performance Indicators to measure goal success

Indicator #: 1

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

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

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

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

Data Source:

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

Description of Data:

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

Data issues/caveats that affect outcome measures:

None.

Priority #: 8

Priority Area: Prescription Drugs

Priority Type: SUP

Population(s): PP

Goal of the priority area:

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

Strategies to attain the goal:

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

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Opioid Prescriptions in New Jersey.

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

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

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

Data Source:

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

Description of Data:

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

Data issues/caveats that affect outcome measures:

None

Priority #: 9

Priority Area: Heroin

Priority Type: SUP

Population(s): PP

Goal of the priority area:

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

Strategies to attain the goal:

Beginning in January 2012, DMHAS funded 19 Regional Prevention Coalitions covering NJ's 21 counties, all of whom utilize the SPF model to guide their work. These coalitions are all required to address the use of illegal substances (including heroin) among youth. The coalitions use, primarily, environmental strategies along with occasional individual approaches as appropriate. Below is a listing of approaches used by the coalitions to address perceptions of risk regarding heroin use among adolescents in their regions.

Environmental Strategies

• Enhance Access/Reduce Barriers – Enhance access to effective prevention strategies and information through the use of a social media campaign and

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

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

Annual Performance Indicators to measure goal success

Indicator #: 1

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

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

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

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

Data Source:

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

Description of Data:

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

Data issues/caveats that affect outcome measures:

None

Priority #: 10

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

Priority Type: MHS

Population(s): SED

Goal of the priority area:

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

Strategies to attain the goal:

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

Annual Performance Indicators to measure goal success

Indicator #: 1

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

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

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

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

Data Source:

The New Jersey Pediatric Psychiatry Collaborative

Description of Data:

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

Data issues/caveats that affect outcome measures:

None.

Priority #: 11

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

Priority Type: MHS

Population(s): SED

Goal of the priority area:

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

Strategies to attain the goal:

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

Annual Performance Indicators to measure goal success

Indicator #: 1

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

Baseline Measurement: 0

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

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

Data Source:

Internal Data

Description of Data:

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

Data issues/caveats that affect outcome measures:

None.

Priority #: 12

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

Priority Type: MHS

Population(s): SED

Goal of the priority area:

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

Strategies to attain the goal:

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

Annual Performance Indicators to measure goal success

Indicator #: 1

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

Baseline Measurement: 0

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

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

Data Source:

Internal Data

Description of Data:

the number of clinicians who successfully completed the training.

Data issues/caveats that affect outcome measures:

None.

Priority #: 13

Priority Area: Housing Services in Community Support Services

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

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

Strategies to attain the goal:

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

The SMHA will utilize a number of strategies to help attain the objective.
1. The Office of Planning, Research, Evaluation, Prevention and Olmstead works collaboratively with provider agencies, state hospital key personnel, DMHAS staff and other Divisions across the state to implement an overall paradigm of community integration.
2. Continued use of the Individual Needs for Discharge Assessment (INDA) facilitates the treatment and discharge planning processes. The INDA serves as both an assessment tool geared toward evaluating needs or barriers that the consumer may face upon discharge and a mechanism by which to assign state hospital consumers to prospective community service providers. The INDA will be continually used by the SMHA to facilitate transition into the community and anticipate and address any barriers that may hinder or preclude placement within the community.
3. Separation of Housing and Services in service delivery has enabled consumers to choose a housing provider and a different service provider.

Consumers will no longer be restricted to the same agency. This separation will also enable the SMHA to track expenditures, utilization, outcomes, and demands for services.
4. The Bed Enrollment Data System (BEDS)/Vacancy Tracking System was developed to help DMHAS manage and track vacancies. The system has replaced the process of cold calls to agencies and the utilization of quickly outdated paper tracking sheets. Utilization of a web-based system provides real-time access to vacancy information and helps facilitate assignments and avoid outdated spreadsheets. Analysis of the utilization of Supportive Housing vs. supervised settings (e.g. group homes and supervised apartments) allows for assessment of the Division's progress toward community integration. The system will also enable planning at both the individual consumer level for placement purposes and system-wide for purposes of enhancements in community resources.
5. Assignment Process - In May 2015, New Jersey DMHAS revised its Administrative Bulletin 5:11 directing engagements of consumers by community providers. Under this revision, assignments of consumers replaced the concept of referrals to community providers by hospital treatment teams, requiring providers to either accept the assigned consumer or communicate their needs to DMHAS for additional supports necessary to serving the assigned consumer. The goal of this new policy was the early familiarity of consumers and providers through mandatory provider participation in the discharge planning process and engagements such as recreational day trips; visits to prospective apartments for rent; discharge preparations; and overnight visits (upon request of the consumer and/or hospital treatment team).

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

Annual Performance Indicators to measure goal success

Indicator #: 1

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

Baseline Measurement: The total number of clients served in CSS in SFY 2022 was 5575. The total number of individuals terminated (including individuals who left voluntarily, agency-initiated terminations and individuals who transitioned to a different level of care or service) in SFY 2022 was 808. Therefore, the percentage of consumers who remain in Community Support Services is 85.5%

First-year target/outcome measurement: The percentage of consumers who remain in Community Support Services during SFY 2024 will be no less than 88% of total consumers served in Community Support Services.

Second-year target/outcome measurement: The percentage of consumers who remain in Community Support Services during SFY 2025 will be no less than 88% of total consumers served in Community Support Services.

Data Source:

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

Description of Data:

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

Data issues/caveats that affect outcome measures:

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

Priority #: 14

Priority Area: Early Serious Mental Illness (ESMI)

Priority Type: MHS

Population(s): ESMI

Goal of the priority area:

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

Strategies to attain the goal:

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

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

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

New Jersey plans to continue utilizing the 10% set-aside funding in the FY 2024-25 to support the CSC teams in providing evidence-based services for individual with ESMI. The CSC programs serve up to 70 individuals per agency with clinical staff at 6.6 FTE levels in FY 2023.

Annual Performance Indicators to measure goal success

Indicator #: 1

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

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

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

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

Data Source:

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

Description of Data:

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

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

Data issues/caveats that affect outcome measures:

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

Priority #: 15

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

Priority Type: BHCS

Population(s): BHCS

Goal of the priority area:

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

Strategies to attain the goal:

The objective of this project will be achieved through increasing capacity and expanding operations in current 988 Lifeline centers as well as establishing additional 988 Lifeline centers in the state.
NJ currently has five (5) 988 Lifeline centers certified by Vibrant Emotional Health (Vibrant) for meeting the minimum clinical, operational and performance standards. Those centers are: Contact of Burlington County, CONTACT of Mercer County (COMC), Caring Contact, Mental Health Association in New Jersey (MHANJ), and Rutgers University Behavioral Health Care (R-UBHC). Collectively, these centers offer statewide coverage for incoming calls to NJ's 21 counties. R-UBHC is the only center in NJ that currently offers 24/7 call services. Carelon Behavioral Health (Carelon) was recently awarded the NJ 988 Managing Entity contract. Carelon's responsibilities will include collecting, recording, and analyzing all 988 data from the NJ Lifeline centers.
In 2021, the National Suicide Prevention Lifeline in NJ received 45,819 calls. In the first eleven months of 988, NJ has received approximately 53,000 calls. By the end of year one, NJ is projected to surpass the number of calls received in 2021 by over 10,000. So far, these increases in volume have occurred without statewide messaging. Since the transition to 988, NJ's monthly in-state call answer rate has fluctuated between 70% and 85%, reaching a recent high of 85%. As a statewide Public Awareness Campaign is scheduled for the coming months, it is anticipated that the statewide answer rate will drop in response to higher call volumes. To reach the goal of at least 90% annually, additional capacity is needed (staffing, technology, IT, space, overhead, etc.) and gaps in coverage hours (evenings, nights and weekends) must be filled.

The State Fiscal Year (SFY) 2024 budget includes $10 million for 988 Lifeline operations. NJ DMHAS plans to expand 988 Lifeline center operations (for current and/or future centers) through a competitive procurement process to allocate these funds. This expansion will add capacity to the NJ 988 system and allow a higher rate of response to calls 24 hours a day, every day of the year. This funding opportunity is anticipated to be published and awarded in the Fall of 2023.
NJ DMHAS also recently applied for the SAMHSA 988 State and Territory Improvement Grant. If awarded, it would provide the state with approximately $12 million over the next three (3) years to improve the response to 988 contacts originating in NJ. Funding from this grant would be used to build/expand the NJ 988 workforce to answer at least 90% of total calls routed to NJ Lifeline centers. Award notification is expected from SAMHSA in August 2023. If awarded, a funding opportunity for current and incoming 988 Lifeline centers is expected to be published and awarded in the Spring of 2024.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	988 Suicide and Crisis Lifeline statewide answer rate percentage
Baseline Measurement:	In SFY 2022, before the transition to the 988 Suicide and Crisis Lifeline, NJ's five National Suicide Prevention Lifeline centers answered approximately 77% of calls statewide. Post-transition, in the first eleven months of SFY 2023, the annual average in-state answer rate is approximately 79%. Since the transition to 988, NJ's monthly in-state call answer rate has steadily improved from 70%, reaching a recent high of 85%.
First-year target/outcome measurement:	In SFY 2024, it is anticipated that at least 85% of calls coming into the 988 Suicide and Crisis Lifeline from NJ will be answered by a center in-state.
Second-year target/outcome measurement:	In SFY 2025, it is anticipated that at least 90% of calls coming into the 988 Suicide and Crisis Lifeline from NJ will be answered by a center in-state.

Data Source:

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

Description of Data:

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

Data issues/caveats that affect outcome measures:

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

Footnotes:

Priority Area #3 Population: Individuals who use heroin/opioids

Planning Tables

Table 2 State Agency Planned Expenditures [SUPTRS]

States must project how the SSA will use available funds to provide authorized services for the planning period for state fiscal years FFY 2024/2025.
SUPTRS BG – ONLY include funds expended by the executive branch agency administering the SUPTRS BG.

Planning Period Start Date: 7/1/2023 Planning Period End Date: 6/30/2025

Activity (See instructions for using Row 1.)	Source of Funds									
	A. SUPTRS BG	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. COVID-19 Relief Funds (MHBG)[a]	I. COVID-19 Relief Funds (SUPTRS BG)[a]	J. ARP Funds (SUPTRS BG)[b]
1. Substance Use Prevention[c] and Treatment	$78,036,872.00		$0.00	$106,495,423.00	$284,291,537.00	$0.00	$0.00		$33,402,980.00	$0.00
a. Pregnant Women and Women with Dependent Children[c]	$13,953,656.00				$2,136,614.00				$1,050,000.00	
b. Recovery Support Services	$20,050,886.00			$44,518,082.00					$1,550,000.00	
c. All Other	$44,032,330.00			$61,977,341.00	$282,154,923.00				$30,802,980.00	
2. Primary Prevention[d]	$22,818,948.00		$0.00	$36,987,571.00	$16,458,507.00	$0.00	$0.00		$8,646,986.00	$0.00
a. Substance Use Primary Prevention	$22,818,948.00			$36,987,571.00	$16,458,507.00				$8,646,986.00	
b. Mental Health Prevention										
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)										
4. Other Psychiatric Inpatient Care										
5. Tuberculosis Services										
6. Early Intervention Services for HIV										
7. State Hospital										
8. Other 24-Hour Care										
9. Ambulatory/Community Non-24 Hour Care										
10. Crisis Services (5 percent set-aside)										
11. Administration (excluding program/provider level) MHBG and SUPTRS BG must be reported separately	$3,211,006.00			$6,183,709.00	$2,296,272.00				$1,239,977.00	
12. Total	**$104,066,826.00**	**$0.00**	**$0.00**	**$149,666,703.00**	**$303,046,316.00**	**$0.00**	**$0.00**	**$0.00**	**$43,289,943.00**	**$31,792,369.00**

[a] The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[b] The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. Per the instructions, the planning period for standard MHBG/SUPTRS BG expenditures is July 1, 2023 – June 30, 2025. Please enter SUPTRS BG ARP planned expenditures for the period of July 1, 2023 through June 30, 2025

[c] Prevention other than primary prevention

[d] The 20 percent set-aside funds in the SUPTRS BG must be used for activities designed to prevent substance misuse.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [MH]

Table 2 addresses funds to be expended during the 24-month period of July 1, 2023 through June 30, 2025. Table 2 now includes columns to capture state expenditures for COVID-19 Relief Supplemental and ARP funds. Please use these columns to capture how much the state plans to expend over a 24-month period (July 1, 2023 - June 30, 2025). Please document the use of COVID-19 Relief Supplemental and ARP funds in the footnotes.

Planning Period Start Date: 7/1/2023 Planning Period End Date: 6/30/2025

Activity (See instructions for using Row 1.)	Source of Funds										
	A. SUPTRS BG	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. COVID-19 Relief Funds (MHBG)[a]	I. COVID-19 Relief Funds (SUPTRS BG)[a]	J. ARP Funds (MHBG)[b]	K. BSCA Funds (MHBG)[c]
1. Substance Use Prevention and Treatment											
a. Pregnant Women and Women with Dependent Children											
b. Recovery Support Services											
c. All Other											
2. Primary Prevention											
a. Substance Use Primary Prevention											
b. Mental Health Prevention[d]		$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	$0.00
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)[e]		$5,319,081.00	$1,821,208.00	$0.00	$0.00	$0.00	$0.00	$5,010,000.00		$6,277,455.00	$367,177.00
4. Other Psychiatric Inpatient Care											
5. Tuberculosis Services											
6. Early Intervention Services for HIV											
7. State Hospital											
8. Other 24-Hour Care		$14,840,737.00	$803,189,760.00	$0.00	$120,877,462.00			$500,000.00		$444,444.00	$0.00
9. Ambulatory/Community Non-24 Hour Care		$27,711,912.00	$1,472,738,018.00	$8,734,000.00	$770,276,747.00		$800,000.00	$8,309,195.00		$11,917,404.00	$2,921,968.00
10. Crisis Services (5 percent set-aside)[f]		$2,659,541.00	$22,408,601.00	$2,521,698.00	$155,701,973.00			$4,916,729.00		$12,772,017.00	$183,589.00
11. Administration (excluding program/provider level) MHBG and SUPTRS BG must be reported separately[g]		$2,659,541.00	$2,764,000.00	$266,000.00	$38,487,446.00			$679,203.00		$1,738,727.00	$119,026.00
12. Total	**$0.00**	**$53,190,812.00**	**$2,302,921,587.00**	**$11,521,698.00**	**$1,085,343,628.00**	**$0.00**	**$800,000.00**	**$19,415,127.00**	**$0.00**	**$33,150,047.00**	**$3,591,760.00**

[a]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the "standard" MHBG. Columns H should reflect the state planned expenditure period of July 1, 2023– June 30, 2025, for most states. Note: If your state has an approved no cost extension, you have until March 14, 2024, to expend the COVID-19 Relief supplemental funds.

[b]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" MHBG. Columns H should reflect the state planned expenditure period of July 1, 2023– June 30, 2025, for most states.

[c]The expenditure period for the 1st allocation of Bipartisan Safer Communities Act (BSCA) supplemental funding is from **October 17, 2022 thru October 16, 2024** and the expenditure for the 2nd allocation of BSCA funding will be from September 30, 2023 thru September 29, 2025 which is different from the expenditure period for the "standard" MHBG. Column J should reflect the state planned expenditure period of July 1, 2023– June 30, 2025, for most states.

[d]While the state may use state or other funding for prevention services, the MHBG funds must be directed toward adults with SMI or children with SED.

[e]Column 3 should include Early Serious Mental Illness programs funded through MHBG set aside.

[f]Row 10 should include Behavioral Health Crisis Services (BHCS) programs funded through different funding sources, including the MHBG set aside. States may expend more than 5 percent of their MHBG allocation.

[g]Per statute, administrative expenditures cannot exceed 5% of the fiscal year award.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Planning Tables

Table 3 SUPTRS BG Persons in need/receipt of SUD treatment

To complete the Aggregate Number Estimated in Need column, please refer to the most recent edition of SAMHSA's National Survey on Drug Use and Health (NSDUH) or other federal/state data that describes the populations of focus in rows 1-5.

To complete the Aggregate Number in Treatment column, please refer to the most recent edition of the Treatment Episode Data Set (TEDS) data prepared and submitted to SAMHSA's Behavioral Health Services Information System (BHSIS).

	Aggregate Number Estimated In Need	Aggregate Number In Treatment
1. Pregnant Women	12,006	692
2. Women with Dependent Children	23,139	8,184
3. Individuals with a co-occurring M/SUD	138,497	44,478
4. Persons who inject drugs	31,788	17,773
5. Persons experiencing homelessness	3,239	6,047

Please provide an explanation for any data cells for which the state does not have a data source.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

1. The aggregate number in treatment is based on served client number reported in NJSAMS in year 2021.

2. Aggregate number estimated in need for Pregnant women: Number of Pregnant women is based on NJ Annual Estimates of the Resident Population, CDC Centers for Disease Control and Prevention, NJ House hold survey, and NJSAMS data.

3. Aggregate number estimated in need for Women with dependent children, Individuals with a co-occurring M/SUD, and Persons who inject drugs: Capture and Recapture estimation based NJSAMS 2020 and 2021 data.

4. Aggregate number estimated in need for Persons experiencing homeless: 2021 Point-In-Time Count On the night of January 26th, 2021 and NIH study of Alcoholism, drug abuse, and the homeless.

Planning Tables

Table 4 SUPTRS BG Planned Expenditures

States must project how they will use SUPTRS BG funds to provide authorized services as required by the SUPTRS BG regulations, including the supplemental COVID-19 and ARP funds. Plan Table 4 must be completed for the FFY 2024 and FFY 2025 SUPTRS BG awards. The totals for each Fiscal Year should match the President's Budget Allotment for the state.

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

	FFY 2024		
Expenditure Category	**FFY 2024 SUPTRS BG Award**	**COVID-19 Award[1]**	**ARP Award[2]**
1 . Substance Use Disorder Prevention and Treatment[3]	$28,992,993.00	$31,852,980.00	$8,560,259.00
2 . Substance Use Primary Prevention	$11,409,474.00	$8,646,986.00	$3,019,782.00
3 . Early Intervention Services for HIV[4]			
4 . Tuberculosis Services			
5 . Recovery Support Services[5]	$10,025,443.00	$1,550,000.00	$1,077,163.00
6 . Administration (SSA Level Only)	$1,605,503.00	$1,239,977.00	$794,129.00
7. Total	**$52,033,413.00**	**$43,289,943.00**	**$13,451,333.00**

[1]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19

Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the FY 2024 "standard" SUPTRS BG, which is October 1, 2023 - September 30, 2024. The SUPTRS BG ARP planned expenditures for the period of October 1, 2023 - September 30, 2024 should be entered here in the first ARP column, and the SUPTRS BG ARP planned expenditures for the period of October 1, 2024, through September 30, 2025, should be entered in the second ARP column.

[3]Prevention other than Primary Prevention

[4]For the purpose of determining which states and jurisdictions are considered "designated states" as described in section 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 45 CFR § 96.128(b) of the Substance use disorder Prevention and Treatment Block Grant (SUPTRS BG); Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the AtlasPlus HIV data report produced by the Centers for Disease Control and Prevention (CDC,), National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention (NCHHSTP). The most recent AtlasPlus HIV data report published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective SUPTRS BG allotments to establish one or more projects to provide early intervention services regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a “designated state” in any of the three years prior to the year for which a state is applying for SUPTRS BG funds with the flexibility to obligate and expend SUPTRS BG funds for EIS/HIV even though the state’s AIDS case rate does not meet the AIDS case rate threshold for the fiscal year involved for which a state is applying for SUPTRS BG funds. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance will be allowed to obligate and expend SUPTRS BG funds for EIS/HIV if they chose to do so and may elect to do so by providing written notification to the CSAT SPO as a part of the SUPTRS BG Application.

[5]This expenditure category is mandated by Section 1243 of the Consolidated Appropriations Act, 2023.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Planning Tables

Table 5a SUPTRS BG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

	A	B		
Strategy	IOM Target	FFY 2024		
		SUPTRS BG Award	COVID-19 Award[1]	ARP Award[2]
1. Information Dissemination	Universal			
	Selected			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
2. Education	Universal			
	Selected			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
3. Alternatives	Universal			
	Selected			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
4. Problem Identification and Referral	Universal			
	Selected			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
	Universal			

5. Community-Based Processes	Selected			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
6. Environmental	Universal			
	Selected			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
7. Section 1926 (Synar)-Tobacco	Universal	$0	$0	$0
	Selected	$0	$0	$0
	Indicated	$0	$0	$0
	Unspecified	$0	$0	$0
	Total	**$0**	**$0**	**$0**
8. Other	Universal			
	Selected			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
Total Prevention Expenditures		**$0**	**$0**	**$0**
Total SUPTRS BG Award[3]		**$52,033,413**	**$43,289,943**	**$13,451,333**
Planned Primary Prevention Percentage		**0.00 %**	**0.00 %**	**0.00 %**

[1]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 1, 2025**, which is different from the expenditure period for the "standard" SUPTRS BG. Per the instructions, the standard SUPTRS BG expenditures are for the planned expenditure period of October 1, 2023 – September 30, 2025.

[3]Total SUPTRS BG Award is populated from Table 4 - SUPTRS BG Planned Expenditures

Footnotes:

Planning Tables

Table 5b SUPTRS BG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2023   Planning Period End Date: 9/30/2024

Activity	FFY 2024 SUPTRS BG Award	FFY 2024 COVID-19 Award[1]	FFY 2024 ARP Award[2]
Universal Direct	$2,611,866		
Universal Indirect	$3,811,192		
Selected	$0		
Indicated	$3,544,675		
Column Total	**$9,967,733**	**$0**	**$0**
Total SUPTRS BG Award[3]	**$52,033,413**	**$43,289,943**	**$13,451,333**
Planned Primary Prevention Percentage	**19.16 %**	**0.00 %**	**0.00 %**

[1]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the “standard” MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 1, 2025**, which is different from the expenditure period for the “standard” SUPTRS BG. Per the instructions, the standard SUPTRS BG expenditures are for the planned expenditure period of October 1, 2023 – September 30, 2025.

[3]Total SUPTRS BG Award is populated from Table 4 - SUPTRS BG Planned Expenditures

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Planning Tables

Table 5c SUPTRS BG Planned Primary Prevention Priorities (Required)

States should identify the categories of substances the state BG plans to target with primary prevention set-aside dollars from the FFY 2024 and FFY 2025 SUPTRS BG awards.

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

	SUPTRS BG Award	COVID-19 Award[1]	ARP Award[2]
Prioritized Substances			
Alcohol	☑	☑	☑
Tobacco	☑	☑	☑
Marijuana	☑	☑	☑
Prescription Drugs	☑	☑	☑
Cocaine	☑	☑	☑
Heroin	☑	☑	☑
Inhalants	☑	☐	☐
Methamphetamine	☑	☑	☑
Fentanyl	☐	☑	☑
Prioritized Populations			
Students in College	☑	☑	☑
Military Families	☑	☑	☑
LGBTQI+	☑	☑	☑
American Indians/Alaska Natives	☑	☑	☑
African American	☑	☑	☑

Hispanic	☑	☑	☑
Persons Experiencing Homelessness	☑	☑	☑
Native Hawaiian/Other Pacific Islanders	☐	☐	☐
Asian	☑	☑	☑
Rural	☐	☑	☑
Underserved Racial and Ethnic Minorities	☑	☑	☑

[1]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 1, 2025**, which is different from the expenditure period for the "standard" SUPTRS BG. Per the instructions, the standard SUPTRS BG expenditures are for the planned expenditure period of October 1, 2023 – September 30, 2025.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Planning Tables

Table 6 Non-Direct-Services/System Development [SUPTRS]

Please enter the total amount of the SUPTRS BG, COVID-19, or ARP funds expended for each activity.

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

	FFY 2024				
Expenditure Category	**A. SUPTRS BG Treatment**	**B. SUPTRS BG Prevention**	**C. SUPTRS BG Integrated[1]**	**D. COVID-19[2]**	**E. ARP[3]**
1. Information Systems	$1,721,299.00	$11,284.00		$2,000,000.00	$570,000.00
2. Infrastructure Support	$226,200.00			$1,800,000.00	$933,333.00
3. Partnerships, community outreach, and needs assessment	$215,849.00				
4. Planning Council Activities (MHBG required, SUPTRS BG optional)					
5. Quality Assurance and Improvement					
6. Research and Evaluation	$2,950,398.00	$1,430,458.00			
7. Training and Education	$408,004.00			$1,550,000.00	$333,333.00
8. Total	**$5,521,750.00**	**$1,441,742.00**	**$0.00**	**$5,350,000.00**	**$1,836,666.00**

[1]Integrated refers to non-direct service/system development expenditures that support both treatment and prevention systems of care.

[2]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[3]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" SUPTRS BG. Per the instructions, the standard SUPTRS BG expenditures are for the federal planned expenditure period of October 1, 2023 - September 30, 2025. Please list ARP planned expenditures for each standard FFY period.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Planning Tables

Table 6 Non-Direct-Services/System Development [MH]

Please enter the total amount of the MHBG, COVID-19, ARP funds, and BSCA funds expended for each activity

MHBG Planning Period Start Date: 07/01/2023 MHBG Planning Period End Date: 06/30/2025

Activity	FY 2024 Block Grant	FY 2024[1] COVID Funds	FY 2024[2] ARP Funds	FY 2024[3] BSCA Funds	FY 2025 Block Grant	FY 2025[1] COVID Funds	FY 2025[2] ARP Funds	FY 2025[3] BSCA Funds
1. Information Systems	$600,000.00				$600,000.00			
2. Infrastructure Support		$2,000,000.00	$1,782,500.00	$129,000.00			$1,782,500.00	$129,000.00
3. Partnerships, community outreach, and needs assessment								
4. Planning Council Activities (MHBG required, SUPTRS BG optional)	$23,740.00				$23,740.00			
5. Quality Assurance and Improvement								
6. Research and Evaluation			$700,000.00				$700,000.00	
7. Training and Education				$12,000.00				$12,000.00
8. Total	**$623,740.00**	**$2,000,000.00**	**$2,482,500.00**	**$141,000.00**	**$623,740.00**	**$0.00**	**$2,482,500.00**	**$141,000.00**

[1] The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG. Per the instructions, the standard MHBG expenditures captured in Columns A - G are for the state planned expenditure period of July 1, 2023 - June 30, 2025, for most states. Note: If your state has an approved no cost extension, you have until March 14, 2024 to expend the COVID-19 Relief supplemental funds.

[2] The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" MHBG. Per the instructions, the standard MHBG expenditures captured in Columns A - G are for the state planned expenditure period of July 1, 2023 - June 30, 2025, for most states.

[3] The expenditure period for the 1st allocation of Bipartisan Safer Communities Act (BSCA) supplemental funding is **October 17, 2022** thru **October 16, 2024** and for the 2nd allocation will be **September 30, 2023** thru **September 29, 2025** which is different from the expenditure period for the "standard" MHBG. Column D should reflect the spending for the state reporting period. The total may reflect the BSCA allotment portion used during the state reporting period.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Environmental Factors and Plan

1. Access to Care, Integration, and Care Coordination – Required

Narrative Question

Across the United States, significant percentages of adults with serious mental illness, children and youth with serious emotional disturbances, and people with substance use disorders do not access needed behavioral health care. States should focus on improving the range and quality of available services and on improving the rate at which individuals who need care access it. States have a number of opportunities to improve access, including improving capacity to identify and address behavioral needs in primary care, increasing outreach and screening in a variety of community settings, building behavioral health workforce and service system capacity, and efforts to improve public awareness around the importance of behavioral health. When considering access to care, states should examine whether people are connected to services, and whether they are receiving the range of needed treatment and supports.

A venue for states to advance access to care is by ensuring that protections afforded by MHPAEA are being adhered to in private and public sector health plans, and that providers and people receiving services are aware of parity protections. SSAs and SMHAs can partner with their state departments of insurance and Medicaid agencies to support parity enforcement efforts and to boost awareness around parity protections within the behavioral health field. The following resources may be helpful: **https://store.samhsa.gov/product/essential-aspects-of-parity-training-tool-for-policymakers/pep21-05-00-001**; **https://store.samhsa.gov/product/Approaches-in-Implementing-the-Mental-Health-Parity-and-Addiction-Equity-Act-Best-Practices-from-the-States/SMA16-4983**. The integration of primary and behavioral health care remains a priority across the country to ensure that people receive care that addresses their mental health, substance use, and physical health problems. People with mental illness and/or substance use disorders are likely to die earlier than those who do not have these conditions.[1]Ensuring access to physical and behavioral health care is important to address the physical health disparities they experience and to ensure that they receive needed behavioral health care. States should support integrated care delivery in specialty behavioral health care settings as well as primary care settings. States have a number of options to finance the integration of primary and behavioral health care, including programs supported through Medicaid managed care, Medicaid health homes, specialized plans for individuals who are dually eligible for Medicaid and Medicare, and prioritized initiatives through the mental health and substance use block grants or general funds. States may also work to advance specific models shown to improve care in primary care settings, including Primary Care Medical Homes; the Coordinated Care Model; and Screening, Brief Intervention, and Referral to Treatment.

Navigating behavioral health, physical health, and other support systems is complicated and many individuals and families require care coordination to ensure that they receive necessary supports in and efficient and effective manner. States should develop systems that vary the intensity of care coordination support based on the severity seriousness and complexity of individual need. States also need to consider different models of care coordination for different groups, such as High-Fidelity Wraparound and Systems of Care when working with children, youth, and families; providing Assertive Community Treatment to people with serious mental illness who are at a high risk of institutional placement; and connecting people in recovery from substance use disorders with a range of recovery supports. States should also provide the care coordination necessary to connect people with mental and substance use disorders to needed supports in areas like education, employment, and housing.

[1]Druss, B. G., Zhao, L., Von Esenwein, S., Morrato, E. H., & Marcus, S. C. (2011). Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. Medical care, 599-604.Avaiable at: **https://journals.lww.com/lww-medicalcare/Fulltext/2011/06000/Understanding_Excess_Mortality_in_Persons_With.11.aspx**

1. Describe your state's efforts to improve access to care for mental disorders, substance use disorders, and co-occurring disorders, including detail on efforts to increase access to services for:

a) Adults with serious mental illness

b) Pregnant women with substance use disorders

c) Women with substance use disorders who have dependent children

d) Persons who inject drugs

e) Persons with substance use disorders who have, or are at risk for, HIV or TB

f) Persons with substance use disorders in the justice system

g) Persons using substances who are at risk for overdose or suicide

h) Other adults with substance use disorders

i) Children and youth with serious emotional disturbances or substance use disorders

j) Individuals with co-occurring mental and substance use disorders

Please see attached.

2. Describe your efforts, alone or in partnership with your state's department of insurance and/or Medicaid system, to advance parity enforcement and increase awareness of parity protections among the public and across the behavioral and general health care fields.

   Please see attached.

3. Describe how the state supports integrated behavioral health and primary health care, including services for individuals with mental disorders, substance use disorders, and co-occurring mental and substance use disorders. Include detail about:

   a) Access to behavioral health care facilitated through primary care providers

   b) Efforts to improve behavioral health care provided by primary care providers

   c) Efforts to integrate primary care into behavioral health settings

   Please see attached.

4. Describe how the state provides care coordination, including detail about how care coordination is funded and how care coordination models provided by the state vary based on the seriousness and complexity of individual behavioral health needs. Describe care coordination available to:

   a) Adults with serious mental illness

   b) Adults with substance use disorders

   c) Children and youth with serious emotional disturbances or substance use disorders

   Please see attached.

5. Describe how the state supports the provision of integrated services and supports for individuals with co-occurring mental and substance use disorders, including screening and assessment for co-occurring disorders and integrated treatment that addresses substance use disorders as well as mental disorders. Please describe how this system differs for youth and adults.

   Please see attached.

   Please indicate areas of technical assistance needed related to this section.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Access to Care, Integration, and Care Coordination – Required

1. Describe your state's efforts to improve access to care for mental disorders, substance use disorders, and co-occurring disorders, including detail on efforts to increase access to services for:

a) Adults with serious mental illness

NJ DMHAS used Mental Health Block Grant COVID Supplemental and ARPA to fund a number of initiatives that help improve access to care for adults with SMI and children with SED. Here is the list of the initiatives.

<u>ESMI Coordinated Specialty Care (CSC) and CSC Community Integration</u>

<u>Coordinated Specialty Care (CSC)</u>

Since its inception in November 2016, NJ CSC programs have gone through a rapid expansion. This initiative, which is covered statewide by three providers, was designed to serve a caseload of 35 clients per team. The programs have doubled in size and each CSC team now can manage a caseload of 70 individuals. The three teams combined serve over 210 clients annually with some clients receiving service after two years in the program. Some of the programs have reached or exceeded their caseload capacity of 70 individuals at each site due to the demand for services. Each agency currently covers 7 counties. This presents a challenge for providers in covering the vast territory as well as for individuals receiving services because of the time spent traveling to the provider agency. Telehealth has been very helpful in the ability to serve individuals with psychosis and keeping clients engaged. All of the agencies offer a hybrid approach to treatment which meets the needs of the individuals served. DMHAS will be enhancing access to CSC services across the state by funding up to six (6) programs which will enhance coverage across the state and increase access for youth and young adults in remote and underserved areas. Additionally, DMHAS will be expanding the target population to also include affective psychosis and the development of step-down programs based upon the identified gap in services.

<u>CSC Community Integration</u>

The DMHAS has identified a need for CSC Community Integration (CI) since Coordinated Specialty Care (CSC) originally opened in the state. DMHAS will be developing six (6) CSC CI programs which will be able to provide treatment and supports to individuals after they complete the CSC program. There has been a rapid expansion of CSC services in the first few years due to demand for services; however, most outpatient programs do not specifically fit the programmatic needs of an individual discharged from a CSC program. Service needs should be flexible and comprehensive to meet the individual's needs. The need for a community integration program comes with the increasing number of individuals with early psychosis in need of a transitional support program post-CSC intensive treatment. Consumers that need fewer intensive services will be able to move to the transitional program and titrate services according to their need. Treatment and supports will be geared toward reintegration of the individual into the community, return to school/work, symptom stabilization, diversion from inpatient services and a reduction of screening

center utilization. The step-down program will provide the opportunity to maintain a supportive environment where the person can access an array of services and remain connected in the community, thus reducing hospital recidivism, integration of health and behavioral health via continuity of care between the CSC APN and the client's primary care practitioner, reduction in duration of untreated illness, increase in medication adherence, and increase in functioning.

Crisis Receiving and Stabilization

NJ DMHAS will develop up to five crisis receiving stabilization centers which will advance the development of the crisis continuum based on the National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit. The target population is individuals 18 years of age and older with a primary SMI who are experiencing acute psychiatric symptoms that could interfere with community tenure. DMHAS will be using the "no wrong door" concept and partnering with community crisis responders. The goal is to develop an appropriate alternative to the use of local hospital emergency services and in-patient psychiatric hospitalization by providing crisis services and placement support for those in need of permanent housing. Crisis Receiving Stabilization Centers (CRSCs) will be open for referrals, walk-ins, and drop-offs by first responders 24 hours per day, 7 days per week, 365 days per year. At a minimum, services will include access to trained staff who can provide intensive supports, including assessment, crisis stabilization, engagement, psycho-education, identification of strengths, collaborative problem solving, and individualized crisis planning. Services will be offered in a safe, clean, home-like environment conducive to the recovery process. Medication management, administration, and education will also be offered. Clinical staff in the program will strive to stabilize individuals and address mental health needs. The program will offer continuity of care promoting continued stability and ensuring linkages are arranged that meet the needs of the individual. Overall, the aim of this program is to decrease the utilization of local hospital emergency services and in-patient psychiatric hospitalization, while maintaining crisis stabilization treatment.

Psychiatric Emergency Screening Services (PESS) Peer Support Diversion

Diversionary efforts will be developed to target individuals who frequently use acute care / crisis services. DMHAS will be looking at a similar model piloted by the Camden Coalition with promising outcomes. The goal of this initiative is to reduce emergency room admissions. Interdisciplinary care coordination teams will serve SMI adults 18 years and older in the community who require care coordination services, linkages and/or follow up to services such as primary care and specialist care, mental health services, and peer supports. Service recipients will be assisted with navigating the mental health network and linking to treatment and appropriate supports and services. Treatment will be provided by licensed providers who will expand services to reach underserved populations in their service areas.

Many of these consumers have co-occurring mental health issues, including co-existing medical conditions, co-occurring substance use disorders, co-occurring ID/DD issues, complex service needs and/or housing-related needs. Consumers are expected to be full partners in planning their own treatment and will identify and direct the types of activities that would help them maximize opportunities for successful community living. Staff support shall be provided through a flexible schedule, which must be adjusted as consumers' needs or interests change.

DMHAS provides this funding to contracted Psychiatric Designated Screening Center providers and Affiliated Emergency Services providers in each County. Providers submit a plan to DMHAS to prioritize the hiring of peer staff to work with individuals presenting to psychiatric screening services via the emergency room or via mobile outreach by screening staff, multiple times throughout the course of the year. Non-peer staff can be hired if the organization is unable to hire peer staff. Staff work with hospitals and systems partners to provide follow up services to high utilizers of the psychiatric screening services including to provide follow up calls, linkages to needed services, in person visits as needed, collateral contact and information services to family members and enhanced case management services to individuals presenting to the emergency rooms frequently utilizing psychiatric screening services, with the goal of decreasing emergency room visits and inpatient hospitalizations. Some medication services through the use of a prescriber may be provided as part of this initiative for follow up services. Through enhanced case management services linkages with services and supports, including mental health and other co-occurring needs will be provided.

Web-based Electronic Referral System

Funding will enable DMHAS to procure a web-based data system that provides a registry for behavioral health beds and services to facilitate access for persons with SMI. The data system will maintain information and communications on community and hospital referrals and provides the information needed to monitor referrals and intervene to facilitate placement and linkages to services. The ability to manage behavioral health bed vacancies and ongoing referral communications in one system allows for timely response and efficiently managing diversionary efforts. The electronic registry will assist in diverting admissions from emergency rooms and inpatient settings including state hospitals. The electronic registry is necessary to enhance movement along the continuum. The data system will foster a continuum of community-based care that meets the needs of the individual where they live. The registry will eventually contain a public facing portal to identify vacant beds that can assist with next day appointments since the system captures service availability. Funding will be provided for annual costs and for one-time start-up costs beginning in 2023 through 9/30/2025.

Web-based Electronic Referral System - Crisis Management Module

The crisis management module expedites access to assessment and treatment for those in crisis, tracks their journey from call to treatment, and coordinates all stakeholders' information within a crisis management system. The module, combined with the vacancy treatment and referral system, supports collaboration between the state, law enforcement organizations, local community organizations, faith-based organizations, and other behavioral health stakeholders in their efforts to ensure the integrated delivery of culturally competent, evidence-based, and family-centered services. The system provides a real-time connection between crisis call center professionals, crisis response teams, and treatment providers. The Service Availability dashboard displays the availability and location of mobile crisis teams, along with the directory and availability of behavioral health providers at two distinct dashboard tabs. The Crisis Management professional at the call center can document their intake interview and perform a validated assessment, toggle between the Crisis Provider and Behavioral Health Provider dashboards, and select which pathway

is necessary for the client. The dual dashboard expands and collapses as needed, bringing into focus the necessary services to quickly serve the consumer. Crisis teams are dispatched using GPS-enabled technology and can view the caller's information, accept the dispatch, and document their assessment and plan at the scene. The crisis teams can, in turn, use the Service Availability dashboard to find available crisis beds or refer to outpatient assessment or treatment. The module's framework is based on SAMHSA's crisis management best practices and core elements of: 1) No "Wrong Door" Access; 2) Regional Crisis Call Centers; 3) Mobile Crisis Team Response; and 4) Crisis Receiving and Stabilization Facilities. The technology provides real-time situational awareness and connection to all crisis stakeholders so that crisis professionals can connect consumers to care more quickly. Funding is requested through the term of the grant of 9/30/25.

Crisis Diversion Homes Programs

In order to bridge the gap between homelessness and permanent housing, DMHAS will be developing four crisis diversion homes with 5 beds each which are staffed 24/7. At a minimum, staffing will include licensed clinical staff (LCSW and/or LPC), nursing coverage, behavioral health technicians, and prescriber services. Individuals experiencing a recent psychiatric hospitalization or relapse will receive the support they need from professionally trained and dedicated staff to continue their recovery in the community in a home like environment. The services and supports will be prioritized for individuals with complex behavioral health needs that require significant services and supports to return to the community and who have received crisis intervention services in a Crisis Receiving Stabilization Center or from Mobile Crisis Outreach Teams. The length of stay of this transitional program is dependent upon individual need and is anticipated to be up to 30 days. The Crisis Diversion programs will include linkages to peer supports, clinical services, and housing with a goal of community re-integration to permanent or long-term housing for the consumer. The goal of this additional level of care to the crisis service continuum is to decrease the number of individuals in emergency screening longer than 23 hours. DMHAS will not be using these funds for capital expenditures.

Community Mental Health Law Project - Legal Assistance Due to Covid/Housing Stability

These resources will also be used to support legal needs of SMI consumers that have arisen as a result of COVID, e.g., evictions. New Jersey and the federal government have eviction moratoriums in place related to COVID. Once the eviction moratorium is lifted, landlords will be able to commence eviction proceedings. Housing stability is an important component of recovery. The DMHAS will use funds to support housing stability to avert homelessness through eviction. DMHAS will use the MHBG COVID Supplement to enter into a contract with an agency that is staffed to provide landlord/tenant legal services to individuals facing eviction. Services will be provided statewide. DMHAS will use ARPA grant to continue to fund the Community Mental Health Law Project for 1.5 years. The funding will not be used for rent.

Outreach/Navigation of Underserved Populations/Crisis Response

DMHAS will continue to fund outreach, treatment, and services from the previous award cycle. This initiative is planned to provide opportunities for local or county stakeholder groups to suggest innovative solutions and promising practices to address health disparities of underserved SMI/SED

populations at the grassroots level. Some of the groups include individuals with SMI/SED from the following underserved populations: LGBTQIA+, Faith-based communities, Muslim, Haitian, Hispanics, African American, Indigenous populations, Low income, homeless or other people living in poverty, Co-occurring population, Veterans, Older adults, as well as colleges, high schools, and middle schools. Programs will assess the need for services to the SMI population and ensure that services are delivered in a culturally competent manner.

Peer Wellness Program

DMHAS is looking to expand its Peer Wellness Whole Health Initiative for individuals with SMI to include a tobacco cessation program in its Wellness Centers. DMHAS would like to adopt a train the trainer program for the community wellness center staff to conduct tobacco cessation activities.

Recovery-Oriented Cognitive Therapy (CT-R) training

DMHAS plans to fund a Wellness program which is intended to improve consumers' self-esteem and practicing positive self-care using empirically proven interventions. The peer-run centers that provide support and recovery services to a diverse population of consumers around the state will receive training and supervision on Recovery-Oriented Cognitive Therapy (CT-R) along with Peer Wellness Coaching.

DMHAS will use funds to offer Recovery-Oriented Cognitive Therapy (CT-R) training to providers. Guided by Dr. Aaron T. Beck's cognitive model, CT-R is an evidence-based practice that provides concrete, actionable steps to promote recovery and resiliency. Originally developed to empower individuals given a diagnosis of schizophrenia, CT-R applies broadly to individuals experiencing extensive behavioral, social, and physical health challenges. CT-R is highly collaborative, person-centered, and strength-based, and tailored to those who have a history of feeling disconnected from and distrustful of mental health professionals.

Acute Care Systems Review Committee (SRC) Technical Assistance

The contract for this initiative was effective as of August 22, 2022. The agency has begun to work to hire staff that will provide technical assistance to county-based mental health system review committees in examining wait times in emergency rooms for psychiatric services. This program focuses on assisting the SRCs in developing performance improvement projects to create a structure for the SRCs to review and revise processes that lead to more expeditious outcomes for individuals requiring hospitalization. The SRC TA service will: review current data and propose other data to be collected; conduct resource mapping to identify all resources available in county; conduct needs assessment for the identified counties; produce report outlining each county's challenges and needs; support each SRC in design of a performance improvement project to address identified needs using the Plan, Do, Study, Act (PDSA) model; and support each SRC in data collection, analysis, and in the implementation of the performance improvement project. This project is being implemented as of September 1, 2022 and will begin to focus on a small group of SRC committees initially.

Co-occurring SMI/DD initiative

The SMI/ID/DD Community Support Program will serve the target population of individuals who are dually diagnosed with a SMI (primary) and ID/DD, and who frequently seek help from the acute care system. The Program will offer services in the community to these individuals with the goal of providing a “stepdown” plan for individuals in EDs or on inpatient units (including state psychiatric hospitals, Trinitas 2D and Short-Term Care Facilities (STCFs)). Services will include: Assessment of SMI/ID/DD; medication and situational needs (in person as needed); Behavioral Plan; Prescriptions and medication management; Education regarding disabilities and symptom management; Psychological support; and Coordination of community-based services. The Community Support Program team will include: a prescriber, a therapist, a peer family member, a behavioral analyst and a consulting medical professional. The program will serve individuals statewide and include a mobile outreach component that can meet potential Program consumers at their ED or hospital location. The Program is expected to serve 100 unduplicated individuals per year.

Children's System of Care (CSOC) Acute Care Services Capacity Improvement Program

Psychiatric screenings centers and CCIS units may benefit from additional training with youth with co-occurring disorders including youth with mental health and intellectual or developmental disabilities or youth with mental health and substance use challenges. In addition, these agencies/programs do not always have a method for maintaining a resource directory and guidance for families regarding services available through the Children’s System of Care and/or understand the process for linking youth and families to the sub-acute providers. As a result, youth are sometimes discharged without being linked to an appropriate provider. The goal is to increase the capacity of psychiatric screening centers and CCIS units to utilize best practices in working with youth with mental health including youth with co-occurring disorders and to enhance their ability to link youth and families to appropriate community-based services that promote youth and family wellness and may reduce unnecessary use of the acute care system.

The proposed project is to create a statewide consultation and technical assistance center (Center) dedicated to psychiatric screening centers and CCIS units that will assume a systems and direct practice approach to improving the quality of care for youth with acute behavioral health needs. The Center will be charged with conducting a multi-systemic needs assessment of each agency to distill training and consultation needs from “door to discharge” that will serve in enhancing the work force and the delivery of quality care for youth with co-occurring disorders. Equally important, the needs assessment will identify system barriers that impede the delivery of services. Information gathered through the assessment will be used to develop an agency specific and statewide training and consultation curriculum. Similarly, information gathered related to system barriers will be utilized to inform the evolution of state-driven policies and contractual requirements. Following the review of the needs assessment data, the Center will design and offer agency specific and statewide training and technical assistance that will be complemented by subject matter experts in areas such as best practices in supporting and treating youth with IDD challenges with acute psychiatric needs and their family. In addition to providing training and consultation, the Center will concurrently develop structured forums for screening centers and CCIS units to consistently communicate with New Jersey Department of Health (DOH), DMHAS

and Department of Children and Family (DCF) with an agenda that elicits acute care service system strengths and challenges and nurtures collaboration. In addition, a best practice forum will be created amongst agency medical directors and led by the DCF Medical Director. Best practice forums will serve in unifying medical directors across the state and provide an opportunity to highlight and discuss optimal treatment strategies in acute care settings. Progress towards curriculum and forum goals will be monitored quarterly and will include gathering and reviewing data related to workforce confidence and consumer satisfaction. The work plan will be revised as needed through an iterative process. The work of the Center will serve in complementing an initiative funded through the Garret L Smith grant aimed at supporting emergency departments in linking youth who present as suicidal and their families to targeted services and supports. The project will be implemented over a three-year period.

Older Adults

DMHAS intends to draft an RFP to expand outpatient services in 3 Counties that will focus on serving the SMI older adult population. Older adults are defined as 55 years and older. DMHAS will utilize census data as well as a survey on outpatient access to determine need based on which Counties have a large older adult population, and have delayed access to outpatient services. DMHAS anticipates making one award per each region of the state (North, Central, South). This will improve access to services for this population and focus on the specific needs of the aging in population.

Law Enforcement Crisis Diversion Pilot Collaborative

A pilot program is to be implemented between a DMHAS crisis diversion funded program such as Early Intervention Supportive Services (EISS) program or Crisis Receiving and Stabilization program, and a local police department. Individuals in crisis will be able to communicate with a clinician on the EISS or Crisis Receiving and Stabilization team via an IPAD for assistance and potentially avoid an emergency room admission or an inpatient psychiatric admission through this intervention. The use of electronic platforms such as Doxy.me is free for the minimum service. The requested funding for this initiative is from 10/1/22-9/30/24.

Mobile Crisis Outreach Response Teams (MCORTS)

Mobile Crisis Outreach Response Teams (MCORTs) will be established as the "Someone to Come/Respond" for the NJ 988 system. The SFY23 budget includes $16 million for the establishment of statewide MCORTs. These teams are designed to respond 24 hours a day, every day of the year to non-life-threatening mental health, substance use or suicidal crises in the community. MCORTs will be comprised of a two-person unit in the field under remote supervision by a third professional from a centralized location. The professionals include: trained peer support specialists, bachelor's level staff with related educational and professional experience (in the field), and master's level supervisors providing clinical consultation. MCORTs will be dispatched by the NJ 988 Managing Entity after a 988 Lifeline Center determines a community-based response, without emergency responders, is necessary and appropriate. The goals of the Mobile Crisis Outreach Response system are:

1. Provide timely access to crisis intervention services;
2. Stabilize person receiving services in their community;
3. Prevent hospitalization, re-hospitalization, incarceration and intervention by law enforcement whenever it is safe to do so;
4. Deliver equitable behavioral healthcare to all New Jersey residents.

DMHAS will be procuring for MCORTs and anticipates making up to nine (9) regional awards with multiple counties served in each region.

b) Pregnant women with substance use disorders and
c) Women with substance use disorder who have dependent children

NJ DMHAS has developed special initiatives to improve access to care. DMHAS continues to contract with licensed women's treatment providers using women's set aside block grant funds. Providers are required to address the full continuum of treatment services. Services include family-centered treatment, evidence-based parenting programs, trauma-informed and trauma-responsive treatment using Seeking Safety, Strengthening Families, evidence-based parenting classes, recovery supports and housing assistance by linking women to transitional, permanent and/or supportive or sober living homes such as an Oxford House.

In 2019 the NJ DMHAS added Interim Services to ensure all substance use disorder Fee-for-Service (FFS) funded treatment agencies provide Interim Services as an engagement service at all levels of care. Pregnant and parenting women (PPW) consumers awaiting admission to their assessed level of care anywhere in the state can receive interim services within 48 hours at facilities closer to home. Interim services for PPW consumers are designed to reduce the adverse health effects of substance use, promote individual health, and reduce the risk of transmitting disease to sexual partners and their infants by providing individualized education, case management, referrals and MAT if needed, while awaiting admission.

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

The Maternal Wrap Around Program (MWRAP) is a statewide initiative that providers intensive case management and recovery supports to pregnant persons with a substance use disorder.

MWRAP is in seven regions in NJ, all 21 counties. Pregnant persons are eligible for services during pregnancy and up to one year after the birth event. The MWRAP alleviates barriers to services through comprehensive care coordination implemented within the five major timeframes when intervention in the life of the SEI can reduce potential harm of prenatal substance exposure: pre-pregnancy, prenatal, birth, neonatal and early childhood. MWRAP is intended to promote maternal health, improve birth outcomes, and reduce the risks and adverse consequences of prenatal substance exposure.

Improving maternal child health outcomes is a major agenda for NJ through the adoption of NurtureNJ, led by First Lady Tammy Murphy. NurtureNJ is a statewide, multi-agency campaign dedicated to this issue. Reach NJ, the central call-in line for NJ residents who are looking for help with a SUD, dedicated their public service announcement campaign to pregnant persons during late Fall 2022. MWRAP provided training to ReachNJ who will now offer MWRAP as a resource and provide warm hand-offs. MWRAP services provides the support needed to help pregnant and parenting women with SUD maintain a healthy recovery, resulting in less overdoses, and improved birth outcomes and maternal child health.

New Jersey continues its statewide advertising campaign centered around opioid use and bringing public awareness to call ReachNJ, the 24/7 Addiction Hotline, for treatment. New messaging, beginning in August 2022, has added pregnant women. This is a statewide campaign that utilizes television and radio advertisements, bus wraps, billboards and social media to encourage New Jerseyans to access treatment.

New Jersey contracts with Oxford House Inc. which has dedicated women's homes and women with children's homes. DMHAS expanded the Oxford House contract to develop additional homes for women with children. Women and Children Oxford Houses are required to provide lockboxes for medication storage. Residents in Oxford Houses is responsible for their individual medication lock boxes. Outreach staff conduct annual training (Overdose Specific) at each Chapter meeting at the annual state workshop. Currently, there are 14 Oxford House Chapters throughout the state. This is in response to the heroin overdose epidemic in the state of New Jersey and its effects. Each home is required to maintain Naloxone kits on site. The New Jersey Oxford House outreach team continues to educate members on Medication Assisted Recovery (MAR) and the importance of being an active member of their recovery community.

The Project ECHO Maternal Child Health. Pregnant and Parenting Women with Opioid Use Disorder (MCH PPW OUD) provides education and training to primary care practitioners, SUD treatment providers, behavioral health practitioners, and other stakeholders in clinic settings and at home, utilizing a web-based video collaboration between a multi-disciplinary team of specialists and primary care practitioners on best practices for the assessment, case management, intervention, treatment and recovery support services for PPW with an OUD. The goal of this ECHO is to increase access to care and the capacity and competency of providers, community support organizations and clinical teams to support prevention, treatment, and recovery of PPW with OUD. ECHO positions communities to reduce the NAS birth rates, improve use of medication assisted treatment, family formation and early infant development; improve access to physical and mental health care by educating more providers, midwives, doulas, and other health care professionals on best practices during prenatal and perinatal periods.

DMHAS renewed the MCH PPW-OUD ECHO series with 18 sessions through 2023. The curriculum covers the following areas: screening for SUD; new guidelines for prescribing buprenorphine; starting treatment: the patient contract, pharmacy partner and social services; managing buprenorphine treatment and follow-up; opioid dependency reporting guidelines; and hot topics. In an effort to reach out to practitioners and prescribers, the first of the ECHO 8 sessions was scheduled for a special evening time with a focus on the latest FDA approved techniques for MAT, integrated care, and wraparound services.

The Division of Medical Assistance and Health Services (DMAHS), in collaboration with DMHAS, continues a program to cover and support medications for opioid use disorder at Office Based Addiction Treatment (OBAT) providers. This program coordinates the delivery of multiple reimbursable services provided by primary care providers and community behavioral health specialists to NJ FamilyCare members with an addiction diagnosis. OBAT providers help to increase access to treatment for pregnant persons by linking to OTPs or other treatment services, when appropriate.

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

d) Persons who inject drugs

New Jersey historically has made persons who inject drugs one of its priority populations, specifically for their admission into statewide licensed substance use treatment programs. The current goal of the Division of Mental Health and Addiction Services (DMHAS) is to address substance use disorder, specifically the opioid epidemic confronting the State using a variety of strategies. The key objectives have been to increase access to medications for opioid use disorder (MOUD), reduce unmet treatment need and reduce opioid and other drug related deaths.

To address these objectives, DMHAS continues to fund traditional ambulatory and residential services (i.e., IWM, AWM, OP, IOP, PC, STR, LTR, HWH) through slot-based contracts and Fee-for-Service (FFS) funding that is made available through the DMHAS FFS Network. In addition, DMHAS has developed an infrastructure to support buprenorphine in standard residential and ambulatory (SUD) treatment throughout the State. In most recent years, specifically through State Opioid Response (SOR) funding, DMHAS supported strategies for low-threshold buprenorphine

induction programming, thus meeting individuals where they are at in the community and offering on-demand medication. A few of the innovative programs are listed below and target persons who actively inject drugs.

- In addition to five (5) mobile medication units operating in the State since 2008, DMHAS developed a new mobile van pilot program to facilitate outreach and low induction medication, case management and other ancillary services for individuals with an opioid use disorder (OUD) in communities with low access to MOUD or areas of the State where participate in a traditional SUD program may be a barrier.
- Implementation of a low threshold buprenorphine induction program at statewide Harm Reduction Centers (HRCs), where they are staffed with recovery specialists and patient navigators to ensure referral to comprehensive treatment programs, when clinically indicated.
- Development of an expanded-hour Opioid Treatment Program (OTP) initiative in efforts to provide increased (i.e., evening) hours that are not typically provided in efforts to assist individuals with easier access to services. Currently DMHAS contracts with six (6) OTPs that have expanded their operating hours six hours per day, six days per week.
- Initiative which provides access to buprenorphine and other ancillary services for individuals with a substance use disorder through current programming available at homeless shelters. Contracted providers are working to develop the capacity to provide low threshold medication (i.e., buprenorphine) as well as other support services for individuals who reside or drop in at the shelters, linking them to treatment and recovery services, when appropriate.

e) Persons with substance use disorders who have, or are at risk for, HIV or TB

As of September 30, 2019 the State of New Jersey was no longer classified as a designated HIV Block Grant State by SAMHSA. As a result, DMHAS was no longer permitted to utilize funds from its SAMHSA Substance Use Block Grant to support the continuance of HIV Early Intervention Services (EIS). Nevertheless, DMHAS continued to work closely with the NJ Department of Health, Division of HIV, STDs and TB Services (DHSTS) and its contracted providers encouraging the development of affiliation agreements with HIV testing and care agencies to ensure an integrated care approach for individuals with SUD who are at risk for HIV and other infectious diseases.

In CY 2021, 23,313 (24%) of 87,745 admissions used drugs intravenously. This particular group is at high risk for infectious diseases such as HIV and hepatitis, indicating the need for linkage to primary care. One attempt to address this need was applying for, and being awarded, a five-year Promoting Integration of Primary and Behavioral Health (PIPBHC) grant in March 2020. The two contractees provide models of integration to serve individuals with opioid use disorder (OUD) and other health co-morbidities. Sterile Syringe Programs, called Harm Reduction Programs in New Jersey, are an integral part of this program and provide an additional referral source.
Another activity to address this need was recent partnership with NJ Department of Health, the National Alliance of State and Territorial AIDS Directors (NASTAD) and the JSI Research & Training Institute, Inc. (JSI). One-time funds for a three-year grant were provided in 2019 to support activities related to the Strengthening Systems of Care for People with HIV and Opioid Use Disorder (SSC) project. The funds were designated to support concrete, time-based activities focused on enhancing systems of care for people with HIV and OUD and in alignment with state

technical assistance plans developed for the project. Goals were for strengthening systems of care to address HIV and OUD treatment, increase cross-sector collaboration, improve system-level coordination, enhance care and treatment services, and to ultimately improve health outcomes for people with HIV and OUD. One area that had been explored was data sharing among the two Departments to determine the number of individuals in substance use disorder (SUD) treatment who have HIV and the number of individuals who have HIV that are in SUD treatment. If a data sharing plan can be executed, information could be utilized by both Departments to help improve health outcomes for this population by better engaging individuals to either seek HIV services or SUD treatment (cross-referrals).

In addition, DMHAS currently has 248 supported housing slots for individuals with a substance use disorder: two programs in Camden (31 beds) and Atlantic (32 beds) counties, a 10-bed program for women in Somerset County, and 175 supportive housing subsidies for those with an OUD. Supportive housing has proven to be a successful, cost-effective, combination of affordable housing with services that help people live more stable, productive lives. It offers permanent housing with services that work for individuals and families who face complex challenges such as homelessness and/or have serious and persistent issues that may include substance use, mental illness, and HIV/AIDS.

In regard to TB, New Jersey requires that all substance use disorder treatment facilities who receive contracts from DMHAS conduct TB testing as part of the patients' routine admissions process. A provision of the guidelines requires that patients with TB, who were not admitted for treatment because the funded capacity at that facility had been exceeded, be referred to another treatment provider for services. Through DMHAS program monitoring visits, monitors continue to ensure agency compliance with this requirement. In addition, the DMHAS' Office of the Medical Director continues to have discussions with the NJ Department of Health, Division of HIV/AIDS, STDs and Tuberculosis Services (DHSTS) to consider and operationalize any new practice guidelines in this regard.

f) Persons with substance use disorders in the justice system

The New Jersey Department of Human Services' Division of Mental Health and Addiction Services (DMHAS), in collaboration with the Department of Corrections (DOC), Department of Health (DOH) and our community partners, coordinates and delivers medication-assisted treatment (MAT) for opioid addiction to individuals serving within county based correctional facilities. Known as the JIS Jail Medication Assisted Treatment (MAT) Initiative, this partnership will help facilitate the connections individuals will need in order to sustain treatment services upon release.

This funding is being made available as part of Governor Murphy's initiative to combat the opioid epidemic in New Jersey and designed to encourage the use of, or increase use of MAT, in county correctional facilities for individuals with an opioid use disorder (OUD). Nationally, 75 percent of inmates with opioid use disorder are reported to have relapsed within three months of release, and only 8 percent enter treatment after incarceration (Fox et al., 20151). Few inmates receive MAT during incarceration despite MAT being the clinical standard for OUD treatment.

In New Jersey, a recent survey conducted by the DMHAS, in collaboration with the County Jail Wardens' Association, indicates that an average of 17 percent of jail detainees screen positive for a substance use disorder with a range of 10 percent - 69 percent among the jails reporting (DMHAS/CJWA, 2018). Of particular concern are the rates of opioid overdose immediately following release from incarceration. In response to overdose deaths among its prison/jail population, the Rhode Island Department of Corrections initiated a model to screen and treat with MAT and sustain MAT post release through a community provider network. Results published in JAMA Psychiatry, researchers compared the pre- and post-intervention periods and found that "In the 2016 period, 26 of 179 individuals (14.5%) who died of an overdose were recently incarcerated compared with 9 of 157 individuals (5.7%) in the 2017 period, representing a 60.5% reduction in mortality"(Green et al, JAMA Psychiatry, April 2018).

With the arrival of criminal justice reform in New Jersey, jail/prison wardens are seeing more rapid return of individuals to their communities, often within 24 - 48 hours. Therefore, individuals are more likely to be released prior to or while experiencing the onset of opioid withdrawal symptoms. This can put individuals at an increased risk for overdose. Nevertheless, MAT being introduced pre-release has been shown to improve the likelihood of recovery sustainability post-release and can mitigate the risk associated with shorter jail stays. This initiative seeks to support wardens in building the capacity to deliver and sustain MAT for the impacted population.

g) Persons using substances who are at risk for overdose or suicide

DMHAS provides numerous programs for persons using substances who may be at risk of overdose. They are described as follows.

The Intensive Recovery Treatment Support (IRTS) program is a collaboration with the NJ Department of Corrections (DOC) providing peer services that expands pre- and post- release recovery support services to individuals within DOC with an opioid use disorder and facilitates continuity of care and treatment that includes comprehensive medical, substance use treatment and social services. Eligible Offenders being released from DOC custody who are receiving FDA approved medication assisted treatment for an OUD and who will continue to receive medication assisted treatment after their release from prison, and those Eligible Offenders, with an OUD, being released from custody who choose not to receive medication assisted treatment while incarcerated are participants in the IRTS program. This program was developed through Memoranda of Agreement (MOA) with Rutgers University Behavioral Health Care and DOC. A key feature of this program is that the provider begins working with offenders six months prior to release.

Data below (from December 2021) provide information about several important outcomes among persons participating in the program. Of particular interest are rates for those who experienced an overdose (fatal or non-fatal – 0.8%) and those using medication for opioid use disorder (65.4%).

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

In 2017, with Prescription Drug Overdose (PDO) funding from SAMHSA, DMHAS, in collaboration with the Robert Wood Johnson Medical School, established the Opioid Overdose Prevention Network (OOPN). The program has continued with SOR funding as well as a new (2023) PDO grant from SAMHSA. OOPN conducts community-based trainings on recognizing and responding to an overdose and provides naloxone kits to training attendees. Training is offered statewide, however, DMHAS focuses training on certain counties in which there is an urgent need for naloxone training and distribution – due to overdose rates and other factors. At any time after the training, attendees can receive additional naloxone upon request.

The intent of the Opioid Overdose Recovery Program (OORP) is to respond to individuals who have been reversed from opioid overdoses (by police, emergency responders, or friends/family) and are subsequently treated at hospital emergency departments as a result of the reversal. OORP utilizes Recovery Specialists and Patient Navigators to engage the individuals reversed from an opioid overdose to provide non- clinical assistance, recovery supports and appropriate referrals for assessment and substance use disorder treatment. The Recovery Specialists and Patient Navigators also maintain follow-up with these individuals for a minimum of 8 weeks after the initial contact. Recovery services provided for these individuals are fundamentally strengths-based. Additionally, Recovery Coaches and Patient Navigators deliver or assertively link individuals to appropriate and culturally-specific services and provide support and resources throughout the process. Recovery Specialists provide take-home naloxone kits to the persons with whom they've worked. OORP services are available 24/7 in 20 of New Jersey's 21 counties.

Support Teams for Addiction Recovery (STAR) provide case management and recovery support services for individuals in recovery from opioid use disorder (OUD). STAR recovery specialists provide non-clinical assistance and recovery support services. Each STAR program team consists of a program supervisor, case manager and recovery specialist who work with individuals to assist with issues that can occur when a person is suffering from an OUD, such as: homelessness, incarceration, legal issues, employment, education, transportation, need for social services, health care and insurance, child welfare involvement, etc. The overall goal of STAR is to help individuals with an OUD maintain their recovery, help reduce the risk of recurring opioid-related problems and prevent overdose.

The STAR team encourages self-determination and promotes knowledge and hope that the individual can recover from an OUD and regain meaningful roles and relationships in the community. The STAR team supports recovery by linking individuals to resources and services in the community, identifying factors that impact wellness and recovery, providing assistance in managing crisis situations, and modeling strategies on how to achieve and maintain recovery.

Telephone Recovery Support (TRS) is a statewide telephone recovery support system for individuals discharged from SUD treatment and those trying to maintain recovery from an OUD. TRS trained staff and volunteers provide weekly phone calls to “check in” on how people are managing their recovery and provide support, encouragement and information about recovery resources.

The 988 Suicide and Crisis Lifeline, the new three-digit dialing code for individuals experiencing suicidal, mental health, and/or substance use crisis, was established nationwide in July, 2022. It is part of a larger crisis care continuum being developed in New Jersey known as the 988 system. This system is being set up with the guiding principle that there will always be someone to call, chat, or text; someone to respond; and somewhere to go.

Individuals with SUD are at risk for suicide, which is a finding well documented in research studies. Substance use is a risk factor for both fatal and nonfatal overdoses, suicide attempts, and death by suicide. Compared with the general population, individuals with alcohol dependence and persons who use drugs have a 10–14 times greater risk of death by suicide, respectively, and approximately 22% of deaths by suicide have involved alcohol intoxication. One study found that opiates were present in 20% of suicide deaths, marijuana in 10.2%, cocaine in 4.6%, and amphetamines in 3.4%. Among the reported substances, alcohol and opioids are associated with the greatest risks of suicidal behavior. SABG Supplemental funds are being utilized to support this need.

New Jersey has five (5) crisis call centers that respond to calls, texts and chats for the 988 Suicide and Crisis Lifeline. They are certified by Vibrant Emotional Health (Vibrant) for meeting the minimum clinical, operations and performance standards and together they provide statewide coverage 24 hours a day, every day of the year.

In preparation for the transition to 988, NJ DMHAS was awarded approximately $2.5 million from the SAMHSA 988 Capacity Building Grant. These funds were designed to support Lifeline centers as they prepared for the anticipated increase in call, chat and text volume. Funding from a combination of federal grants totaling $3.7 million was awarded to the five (5) NJ Lifeline centers.

In December 2022, NJ DMHAS was awarded an additional $1 million through the SAMHSA 988 Capacity Building Supplemental Grant. Of this award, approximately $340,000 has been awarded to four of the five 988 Lifeline centers in New Jersey (one center declined additional funding). These awards continue to support centers as they onboard additional staff.

An additional $12.8 million was allocated in the State Fiscal Year 2023 (SFY23) budget toward the expansion of the 988 Lifeline network to handle the increased volume of 988 calls, chats and texts. From these funds Carelon Behavioral Health was awarded a contract to act as the Managing

Entity (ME) for the New Jersey 988 Suicide and Crisis Lifeline system. Among the ME's responsibilities will be to collect and report 988 Lifeline center data, establish and maintain a comprehensive resource and referral database, and to dispatch Mobile Crisis Outreach Teams (MCORTs) once they are operational.

The remaining $10 million will go toward the expansion of 988 Lifeline center operations (for current and/or additional centers). This expansion will add capacity to the NJ 988 Lifeline system and allow a higher rate of response to calls, chats and texts originating in New Jersey. Funding was allocated from the SUPTRS Block Grant for implementation of the 988 Lifeline. Individuals with an SUD are susceptible to suicide and suicide attempts. Suicide is a leading cause of death among those that misuse substances (SAMHSA 2008). Deaths due to alcohol, drugs, and suicide have been on the rise for over the last two decades, doubling from 104,379 deaths in 2011 to 209,225 deaths in 2021 (Trust for America's Health 2023).

The goal is to reach a 90% in-state answer rate with a maximum of 10% of calls being routed to the national backup system. Data provided by Vibrant for the month of March 2023 shows that NJ had an in-state answer rate of 79%. NJ 988 Lifeline centers continue to recruit and onboard staff to expand the capacity for responding to calls, chats and texts. However, future funding opportunities and ongoing funding streams are vital to reaching and maintaining this goal.

The next step for the 988 system will be to develop a Mobile Crisis Outreach Response system with teams of trained professionals who will meet with people in crisis in the community. Mobile Crisis Outreach Response Teams (MCORTs) will be established as the "Someone to Respond" for the NJ 988 system. The SFY23 budget includes $16 million for the establishment of statewide MCORTs. These teams are designed to respond 24 hours a day, every day of the year, to non-life-threatening mental health, substance use or suicidal crises in the community. Ongoing funding for this program will be critical to maintaining this community-based, lifesaving service.

h) Other adults with substance use disorders

Substance Use Disorder Prevention

DMHAS has developed the following initiatives targeting student athletes, older adults, tribal communities, and Gay, Lesbian, Bisexual, Transgendered, and Questioning youth to prevent substance use disorders.

A major component of New Jersey's SPF Rx project focuses on young athletes. A toolkit called "Tackling Opioids through Prevention for Athletes" (TOP) was developed by the New Jersey Prevention Network for use by providers. Literature suggests that when young athletes are prescribed opioid pain relievers for sports-related injuries, there is a risk of addiction and medication misuse. The 19 county coalitions that were established by DMHAS use the TOP to provide education regarding this issue to coaches, parents, prescribers, and young athletes. In SFY 2022, 4,384 individuals were served.

The Alternative Approaches to Pain Management for Older Adults (AAPMOA) program funded with State Opioid Response (SOR) funds, includes 20 of 21 NJ counties, since one county did not apply for this funding. Program providers have implemented a comprehensive educational program specifically focused on providing older adults with practical information regarding (1) the appropriate use of non-opioid analgesic pain medication and (2) non-pharmacological approaches to dealing with acute and chronic pain. The goal of the project is to reduce the overuse, misuse and abuse of prescription opioid medications within this population. Programs utilize current evidence-based treatment guidelines for non-pharmacological treatment modalities. The "efficacy" of the educational program on participants' knowledge about and understanding of alternative approaches to pain management is assessed by means of a pre and post-test. Most of the providers who are delivering the AAPMOA program use the evidence-based Wellness Initiative for Senior Education (WISE) program. WISE is a wellness and prevention program targeting older adults, which is designed to help them celebrate healthy aging, make healthy lifestyle choices and avoid substance abuse. It provides educational services to older adults on topics including medication management, stress management, depression, and substance misuse. Created by the New Jersey Prevention Network and implemented locally by prevention agencies across the country, WISE promotes health through education concerning high-risk behaviors in older adults. Since the program was launched in 1996, prevention programs presented by WISE facilitators have reached over 40,000 individuals.

Providing information about the risks associated with prescription pain medications is a component of these trainings. However, the primary focus is on providing information and answering questions about proven, non-pharmacological means of addressing pain. Providers do not deliver actual services, but offer information about alternative approaches and information regarding how and where to access such services as: physical therapy, chiropractic care, yoga, massage therapy, etc.

In 2023 DMHAS developed a Memorandum of Agreement (MOA) with the New Jersey Commission on American Indian Affairs, within the New Jersey Department of State. New Jersey is home to three state (not federally) recognized tribes: Nanticoke Lenni-Lenape Indians, Powhatan Renape Indians, and the Ramapough Lenape Indian Nation. To date, DMHAS has not collaborated with the Commission on Indian Affairs. But, under this MOA, DMHAS will provide funds (Block Grant Supplement and ARP) to enable the tribes to implement evidence-based primary prevention programs. Tribes will be instructed in the use of the Strategic Prevention Framework and will identify prevention programs or strategies that were developed by or for Native American communities. DMHAS will offer guidance and support to the tribes at their request,

The SSA provides prevention services to Gay, Lesbian, Bisexual, Transgendered, and Questioning (LGBTQ) youth. The SSA awarded funding to the North Jersey Community Research Initiative (NJCRI) to expand their existing programs for high-risk LGBT youth of color by using a "Street Smart" prevention model developed by the Centers for Disease Control and Prevention, as well as early intervention services, social marketing, and structured recreational activities. NJCRI provides services covering the northern NJ counties. In the spring of 2023, DMHAS (by means of a competitive RFP process) identified two additional organizations to provide services to LGBTQ persons in their communities: Prevention Resources in the central region of NJ and the

Robert Wood Johnson-Barnabas Health Institute for Prevention and Recovery, in the southern region.

Substance Use Disorder Treatment

An RFP was issued in August 2022 for providers to identify an underserved special population(s) to whom they would provide direct services. Ten SUD treatment providers were awarded a contract in November 2022. The underserved populations that will be served through this initiative include: veterans and their families, older adults, LGBTQIA+, homeless Black and Indigenous, and People of Color (BIPOC), Latinos, and Spanish speaking individuals. The services are intended to assist those who have experienced difficulties and challenges accessing SUD services. Providers were required to show the specific detail on how they identified their underserved population. These targeted services should be consumer-driven and planned with the specific needs of the individual and their special population in mind. This program is being funded with SUPTRS Block Grant COVID-19 Supplemental and will continue with ARPA funding.

DMHAS released an RFP for the development of Expanded Hours for Substance Use Disorder (SUD) Outpatient Programs. The funds for this initiative was funded through the Substance Abuse and Mental Health Services Administration's (SAMHSA) American Rescue Plan Act (ARPA). This funding was intended for a one year of program with providers having the program continue as part of their sustainability plan. These expanded services were developed to enhance access to treatment by removing barriers such as traditional service hours. These expanded hours will provide increased access to outpatient treatment for individuals with an SUD. The purpose of this expansion for outpatient services is to support, enhance and encourage the emotional development and the development of consumer's life skills in order to maximize their individual functioning during alternate times from standard business hours (after hours and weekends).

These services are designed to preserve or improve current functioning, strengths and resources. In outpatient services, consumers and staff work together to plan and implement effective treatment and offer individual, group and/or family sessions during these expanded hours. The expanded hours will also allow for an increase in medication monitoring, education and administration time that have all proven a reduction to barriers for engagement and ongoing treatment. By increasing the access to treatment for consumers, they are more readily willing to seek treatment because services are available at times that accommodate their work, school and family obligations.

The expanded hours initiative is designed to increase treatment options through expanded operating hours to ensure all consumers are able to attend treatment uninterrupted and maintain personal as well as business obligations. This will assist consumers in fulfilling personal needs, employment, etc. Providers are required to expand their hours at a minimum of six (6) days per week with the goal of extending hours into the evening and admitting new consumers for these services during these times. The additional operating hours from providers can either be continuous or separated by times when their programs/facilities close and reopen for their doors for business.

i) Children and youth with serious emotional disturbances or substance use disorders

In New Jersey, all youth under the age of 21 who meet clinical criteria have access to the service array offered by the Children's System of Care. All services are available to youth who meet clinical criteria regardless of the youth or family's income. Youth who do not meet clinical criteria or whose need has been determined to not be of a moderate or high acuity are provided with connections to services and supports outside of the service array. For example, if a family calls the contracted system administrator and the youth's biopsychosocial indicates need, but not to the extent that additional CSOC services are indicated, the CSA may provide the family with information about outpatient providers in their geographical area, even though outpatient services are not a part of the CSOC service array. In this way, all New Jersey youth under 21 with mental health, substance use disorders or co-occurring disorders have equitable access to services, based solely on the youth's need.

j) Individuals with co-occurring mental and substance use disorders

Beginning in SFY 2010, the SSA established a Co-Occurring Services Network (COSN) comprised of 53 treatment providers to provide treatment to clients with co-occurring disorders on a Fee for Service (FFS) basis. Now, agencies eligible to join the SUD FFS Initiatives Network as a Co-Occurring Provider must meet New Jersey Department of Health (DOH) Office of Certificate of Need Licensing (CN&L) requirements for co-occurring licensing approval. As of SFY 2024, there are approximately 140 agencies in the COSN that represent approximately 252 individually licensed sites with co-occurring approval. Authorization to provide co-occurring services is predicated on agency's co-occurring licensing approval.

Those agencies contracted in the Substance Use Disorder (SUD) Fee for Service (FFS) Initiative Network for the South Jersey Initiative (SJI), Driving Under the Influence Initiative (DUII), New Jersey Statewide Initiative (NJSI), Medication Assisted Treatment Initiative (MATI), Substance Abuse Prevention & Treatment Initiatives (SAPTI), and State Hospital Access to Rehabilitation and Education (SHARE) must also participate in the Co-occurring Services Network and have demonstrated readiness to provide integrated care for dually diagnosed clients. The contracted agency shall be co-occurring capable and provide at a minimum, assessments and treatment, or must be able to screen, refer and provide linkages to a co-occurring capable agency. The contracted agency shall ensure that clients screened as "at risk" for co-occurring disorders (COD) shall receive a complete mental health assessment. If the screening contractee is not qualified to provide COD services, it is the contracted agency's responsibility to facilitate a referral for this service and coordinate ongoing care.

The SUD FFS Initiatives Network reimburses the following Co-occurring services: Case Management, Clinical Consultation, Comprehensive Intake Evaluation, Crisis Intervention, Family Therapy, Group Therapy, Individual Therapy, Medication Monitoring, and Psychiatric Evaluation. The COSN has helped community SUD agencies, advocates, as well as individuals who have a substance use disorder and co-occurring mental illness, realize "one-stop", "treatment on demand", or "no wrong door" access to care.

2. Describe your efforts, alone or in partnership with your state's department of insurance and/or Medicaid system, to advance parity enforcement and increase awareness of parity protections among the public and across the behavioral and general health care fields.

Mental Health Condition and Substance Use Disorder Parity Laws – P.L. 2019, c. 58 was signed into law on April 11, 2019. The law requires health insurers to provide coverage for mental health conditions and substance use disorders under the same terms and conditions as provided for any other sickness and to meet the requirements of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act. Additionally, the law includes reporting requirements for insurance carriers and the New Jersey Department of Banking and Insurance. The following health insurers fall under the law: health service corporations, commercial insurers, health maintenance organizations, health benefits plans issued pursuant to the New Jersey Individual Health Coverage and Small Employer Health Benefits Programs, the State Health Benefits Program, and the School Employees' Health Benefits Program.

3. Describe how the state supports integrated behavioral health and primary health care, including services for individuals with mental disorders, substance use disorders, and co-occurring mental and substance use disorders. Include detail about:

a) Access to behavioral health care facilitated through primary care providers

NJ DMHAS has a cooperative and working relationship with the Department of Health that is integral in our integration efforts. The Office of Primary Care and Rural Health (Office of Primary Care) has assisted with efforts to expand behavioral services in FQHCs. DMHAS worked with the Office of Primary care to assist them in adding state reimbursement to FQHCs for the provision of behavioral health services for the uninsured. Together DMHAS and the Office of Primary Care surveyed all FQHC providers to understand the services that they provide for addictive disorders and worked to publicize the results so that the public understood which of these primary care offices were available for those treatments.

DMHAS works collaboratively with our sister division, the NJ Division of Medical Assistance and Health Services (NJ Medicaid) to expand access to medication services for addictive disorders in primary care services. Together DMHAS and NJ Medicaid developed the Office Based Addiction Treatment (OBAT) services and network. These OBATs are primary care offices which, with the support of enhanced funding as well as free technical assistance, are available to the public for medication, treatment and referral. Those providers are included in our statewide Substance Use Disorder Treatment Directory.

New Jersey is building an integrated regulatory rule that, when completed, will streamline the process whereby a behavioral health clinic can become a primary care clinic and vice versa. We expect that this will create access and a no wrong door network for individuals needing both primary and behavioral healthcare.

New Jersey is in the 4th year of a 5-year PIPBHC grant. As part of that grant an FQHC in Atlantic City, Atlantic County has implemented SUD treatment and Harm Reduction services into their

service array. Currently, the FQHC is working with DMHAS to sustain the services after the grant ends.

NJ is a CCBHC Demonstration State. The CCBHC providers are required to screen and coordinate referrals for appropriate medical services. Many of the CCBHC Demonstration providers have affiliated with local FQHCs and some have obtained their own primary care license. The CCBHC service has increased coordination of primary care and behavioral health care for the approximated 20,000 people that are serve each year.

b) Efforts to improve behavioral health care provided by primary care providers

New Jersey has developed two Centers for Excellence for Medication Assisted Treatment (COE) in Opioid Treatment. These centers maintain a provider hotline with is available to all primary care providers and other medical professionals. Through the contract with the Department of Health the COEs are required to advertise the hotline to physicians throughout the state.

The Southern COE at Rowan Cooper Medical Center has implemented training and consultation services for Emergency Medicine and Primary Care providers throughout the state who have an interest in treating opioid use disorder (OUD). Leveraging expertise and lessons learned from previous trainings, the Southern COE provides educational sessions and consultation services both on-site ("Elbow to Elbow") and via office hours for physicians, nurses, and front-line staff to address practice based and logistical issues. The Southern COE has learned that a training presentation is only the first step, and that healthcare providers new to this work often need additional support and guidance to implement medications services to support individuals with Opioid Use Disorder (OUD) and other substance use disorders successfully. Pairing in-person, virtual and recorded trainings with consultation services and open office hours is hopeful to build greater capacity to address the opioid overdose epidemic throughout New Jersey.

Project ECHO ("Extension for Community Healthcare Outcomes") is a collaborative model of medical education, training and care management that empowers front-line providers to provide better care to more people, right where they live, through access to specialty knowledge, mentoring and community resources that support patient care. The ECHO program focuses on building provider capacity across a region by connecting a multi-disciplinary team of subject matter experts with local providers. In this way, the medical providers and addiction specialists along with their community partners expand their ability to provide access to care to patients in their own communities.

The Project ECHO program in New Jersey, funded through the federal Substance Abuse Prevention and Treatment Block Grant, has been training and educating Primary Care Providers (PCPs) on substance use disorders since January, 2020. Topics focus on three critical areas of substance use disorders: specific substances, medications for opioid use disorder ("MOUD") and implementation of best practices for screening, managing and treating patients in the primary care setting. In March of 2020, New Jersey's Project ECHO redirected its resources to providing ECHO sessions focused on COVID-19, Mental Health and SUD to meet the needs of those with a substance use disorder in this current environment. Although the SUD ECHO Hub team has transitioned back to its original focus, virtual clinics continue to include discussions of the COVID-

19 impact on patients with a substance use disorder in its curriculum. In 2021, 33 sessions were conducted training 406 participants and in 2022, 33 sessions were again conducted training 340 participants. As a result of the trainings, participants indicated improvement with competence using evidence-based guidelines for treating patients with substance use disorders in primary care settings.

In the fall of 2022, with funding from DMHAS, the Department of Family Medicine at Rowan University School of Medicine (RSoM) initiated on-site, comprehensive, universal substance use Screening, Brief Intervention and Referral to Treatment (SBIRT) services in eight project sites (OB/GYN and internal medicine clinics, and the Rowan University Student Health Service). RSoM will screen a combined minimum 30,000 unduplicated adult patients and adult college students with a combined estimated minimum 2,550 of these patients/students in need of a substance use risk intervention. Additionally, the Department of Family Medicine at RSoM will assure that their SBIRT service delivery model is fully sustainable once DMHAS funding ends.

In the fall of 2023, DMHAS will issue a Request for Proposals to implement universal SBIRT services in hospital emergency departments. Three awards will be made: for regional services in north, central, and southern New Jersey.

c) Efforts to integrate primary care into behavioral health settings

New Jersey works directly with the NJ DOH Infectious and Zoonotic Disease Program-Communicable Disease Service. They provide advice and assistance to the DMHAS to include primary health screening, assessment, referral and treatment into the Behavioral Health treatment network. This includes review and assistance with relevant funding opportunities offered to behavioral health providers to assure that they include necessary health services, working on joint public relations efforts, sharing data and provider educational activities.

Our work with primary care providers and the DOH has offered us insights and opportunities for improvement of integrated services from both the primary care and the behavioral healthcare system. One such example that came to our attention through meetings with primary care providers, was that Medicaid funding rules made it more cumbersome and difficult for patients who are receiving care at substance use disorder providers to receive anti-viral medications. Our Medical Director was able to work with the NJ Drug Utilization Review Board to ultimately have those rules relaxed which created access to needed medical care.

NJ is the recipient of a SAMHSA PIPBHC grant. We are currently in the fourth year of that five-year grant. That grant has focused on bringing integrated services to patients of both the FQHCs and the substance use disorder providers in the PIPBHC initiative. The program provides screening, assessment, treatment and referral to specialty care with a focus on Hepatitis C and HIV. Through this initiative we were able to provide training and technical assistance of two Infectious Disease Consultants which has enhanced and improved the services of the providers.

NJ is a CCBHC Demonstration State. Through the CCBHC providers have screened, referred and followed patients with medical needs. NJ is considering the requirement of a more robust medical component in the CCBHC model as we embark on a Medicaid SPA for the service.

NJ has utilized State Opioid Response funding to place Nurse Case Managers (NCM) in state Opioid Treatment Programs, and will be expanding that program to all ambulatory levels of SUD care through a competitive bidding process. Through the program, NCMs are placed at the provider to screen, assess, treat and refer patients for medical issues. This program is specifically focused on Hepatitis C and HIV.

NJ holds regular meetings with the Medical Directors of behavioral health treatment providers. These provider meetings have been an opportunity for Medical Directors to bring issues of concern and share practices that improve the care provided at behavioral health clinics.

As stated above, NJ is building an integrated regulatory rule that, when completed, will streamline the process whereby a behavioral health clinic can become a primary care clinic and vice versa. We expect that this will create access and a no wrong door network for individuals needing both primary and behavioral healthcare.

DMHAS has explored several models of integration, with the most prominent being the behavioral health home (BHH) initiative. Health Homes is a Medicaid State Plan option that provides an opportunity to build a person-centered system of care that achieves improved outcomes and better services and value for the NJ Medicaid program. DMHAS has partnered with N.J. Medicaid to expand upon the existing behavioral health case management infrastructure to provide coordinated primary and behavioral health integration.

In a partnership with the Division of Medical Assistance and Health Services (Medicaid) and the Department of Children and Families, DMHAS launched health homes in select counties in July of 2014. Currently, there are nine BHHs in New Jersey: two each in Atlantic, Bergen and Mercer Counties and three in Monmouth County. The BHH is a high intensity service targeting those with the most need. It is continuing standard of care that allows individuals to have all of their health care needs identified, addressed, and treated in a coordinated way. The same team of clinicians and practitioners either deliver, or coordinate the delivery of, all the necessary medical, behavioral, and social supports required for the individual, acknowledging the impact each area has on the others. It is not a residential program. It is a whole-person care delivery model.

In accordance with guidance from the Centers for Medicare and Medicaid Services (CMS), a Health Home must have the capability to provide all of the following services, as warranted based on members' needs:

- Comprehensive care management;
- Care coordination;
- Health promotion;
- Comprehensive transitional care (including appropriate follow-up from inpatient to other settings)'
- Individual and family support;
- Referral to community and social support services;
- Use of health information to link services as feasible and appropriate.

It is expected that the use of a behavioral health home model will result in improved health outcomes for the consumer base, better quality of treatment, and improved cost effectiveness; improved consumer experience with care; and declines in the use of hospitals, emergency departments, and other costly inpatient care.

Children's System of Care

CSOC - Behavioral Health Homes.

In five counties, CMOs serve as the designated Behavioral Health Home (BHH) entities for youth in New Jersey, serving as a "bridge" that connects prevention, primary care, and specialty care. Each Behavioral Health Home (BHH) is a designated Care Management Organization (CMO) with enhanced care management teams that include medical expertise and health/wellness education for purposes of providing fully integrated and coordinated care for youth remaining in their home and who have chronic medical conditions. Medical and wellness staff are integrated into the existing CMO CFT structure responsible for care coordination and comprehensive treatment planning for youth and their families, which includes planning for the holistic needs of the youth.

CSOC Pediatric Psychiatry Collaborative

Over the past six years, with support from the NJ Governor's Office and funding from the NJ Department of Children and Families, Hackensack Meridian Health, along with Cooper University Health Care and Atlantic Health System, has successfully established the New Jersey Pediatric Psychiatry Collaborative (NJPPC) across 20 counties in New Jersey, comprising 8 regional Hubs throughout the state. The ninth Hub, in Essex County, is managed by Rutgers University Behavioral Health Care, ensuring that every county in the state has improved access to pediatric mental/behavioral health care.

As a mental/behavioral health and substance use consultative and referral support program, the NJPPC has aimed to improve the comfort and competence of pediatric primary care clinicians to screen, identify and care manage their patients with mental/behavioral health concerns. Participating pediatric primary care and specialty care providers now have quick access to mental/behavioral health consultative and referral services for the children and families in their care.

The program is available for children and adolescents up to age 18 (or up to 21, if patient is still being seen by the pediatric practices) and requires participating primary care providers (PCP) to universally provide standardized mental/behavioral health and substance use screenings at each well visit. Participating pediatricians and pediatric clinicians can consult with the NJPPC Hub Child & Adolescent Psychiatrists (CAPs) and behavioral health staff. They can also refer patients with identified concerns to the Hub behavioral health staff for intake and referral to services in their community. As of 2020, patients who are referred to the Hub can also access psychiatry evaluation services via tele-psychiatry.

4. Describe how the state provides care coordination, including detail about how care coordination is funded and how care coordination models provided by the state vary based on the seriousness and complexity of individual behavioral health needs. Describe care coordination available to:

a) Adults with serious mental illness

Care coordination is not generally a billable service in NJ Medicaid for individuals with a serious mental illness (SMI) or any other individuals, with certain exceptions. There are two programs that do routinely provide care coordination as a service that is incorporated into their model of federal reimbursement. Many mental health agencies provide targeted case management through Medicaid reimbursed integrated case management services (ICMS) that incorporates care coordination and is provided to at risk clients with SMI, especially those who had been recently discharged from a psychiatric hospital.

The state was an original awardee of the Section 223 CCBHC Medicaid Demonstration Grants, has seven certified community behavioral health clinics (CCBHCs) that provide access to a comprehensive array behavioral health care. CCBHCs are required to serve anyone who requests care for mental health or substance use, regardless of their ability to pay, and this is provided to adults, as well as children and youth. In addition to a comprehensive array of behavioral health service, CCBHCs must provide care coordination to help people navigate behavioral health care, physical health care, social services, and the other systems they are involved in.

Behavioral Health Homes (BHHs) address overall health with a whole-person approach to care for individuals with SMI that is provided though care coordination. The services are directed to individuals with SMI who also have chronic medical illness. The BHHs are Medicaid and the original funding was through a Medicaid State Plan option with an enhanced federal match that was originally provided for eight quarters.

The state's nine BHH programs in N.J. exist in eight counties and offer a wide variety of health promotion and wellness activities in addition to connecting individuals to the care they need. BHH staff provide care coordination for clients' medical needs and will them to make and keep appointments, take prescribed medication plans, find transportation, plan healthy meals, and set exercise routines, among other services.

Individuals with a mental health issue can receive case management services through a myriad of services. The DMHAS, in collaboration with the Division of Medical Assistance and Health Services (DMAHS), submitted a State Plan Amendment to CMS requesting permission to provide a new Medicaid billable rehabilitation service. Community Support Services (CSS) is a rehabilitation service that provides consumers with the supports and services necessary to achieve their life goals. Included in the rehabilitative services that are part of the Individualized Rehabilitative Plan (IRP) is case management that is done by a bachelor level staff or a certified peer. This service works to connect the consumer with medical, dental, behavioral health, housing resourced and entitlements.

Care coordination is structured so the consumer seeking assistance, is provided care coordination's through the staff such as PATH worker, Intensive Case Management Services (ICMS), PACT workers, etc. services are done with and on behalf of a consumer and is a Medicaid billable service.

Programs in Assertive Community Treatment (PACT) is an evidence-based model of service delivery in which a multi-disciplinary, mobile, treatment team provides a comprehensive array of mental health and rehabilitative services to a targeted group of individuals with SMI. The program is designed to meet the needs of person receiving services, who are at high risk for hospitalization, are high service users and who have not been able to benefit from traditional mental health programs. In order to meet the unique needs of this targeted population, PACT teams offer highly individualized services, employ a low staff-to-person receiving services ratio, conduct the majority of their contacts in natural community settings (e.g., person receiving services residence) and are available to help individuals address psychiatric crises 24 hours a day. Service intensity is flexible and regularly adjusted to person receiving services needs. Per the evidence-based model, person receiving services are eligible for PACT for an indeterminate period as clinically needed.

As a long-term program, in which the course of treatment has no pre-determined end point, most New Jersey PACT teams are staffed with eight to ten full-time equivalent direct care staff and can serve between 70-75 person receiving services at any point in time. There are 31 PACT teams in New Jersey, serving all of the 21 counties. The SMHA contracts with 10 different non-profit agencies that operate these teams. Since state fiscal year (SFY) 2010, the SMHA has expanded 20 of the 31 teams with additional staffing. As an Evidence-Based Practice (EBP), ACT is endorsed by SAMHSA. PACT will continue to be integral to enhancing the network of community mental health services. Teams have responded to COVID-19 with strategies to maintain face-to-face services by utilizing personal protective equipment, telehealth interventions, and vehicle protective equipment. According to quarterly contract monitoring report (QCMR) data reported by providers, there were 2,415 persons receiving PACT services SFY 2022.

b) Adults with substance use disorders

ReachNJ is a 24-hour helpline for people seeking help with substance use disorders. A caller to ReachNJ receives a screening and, when appropriate, is given a referral to treatment. The ReachNJ staff then track that referral. If the caller has not been contacted by the provider within 72 hours, the ReachNJ Care Coordination staff reach out to the caller and to the provider to explore the lack of connection and offer assistance. Care Coordination was offered to 49% of the callers who were given a referral to treatment by the ReachNJ call center.

NJ has several treatment initiatives that focus on coordinating services. As mentioned previously NJ is a CCBHC Demonstration State. CCBHC's offer significant care coordination to the clients enrolled in that service and NJ tracks the numbers of client who receive that service and in the most recent data analysis 77% of CCBHC enrolled clients were receiving the case management/care coordination.

NJ recognizes the value of care coordination for integrating physical health and behavioral health. As mentioned above, the Nurse Case Manager program and NJ's PIPBHC teams include a care coordinator to assist in coordinating care and providing case management.

Support Team for Addiction Recovery

Support Teams for Addiction Recovery (STAR) provide case management and recovery support services for individuals with opioid use disorders (OUD). The STAR initiative is comprised teams, with each team consisting of a program supervisor, two case managers and two recovery specialists. The team maintains a caseload of 40 individuals. STAR case managers work with individuals to assist with issues that often occur concurrently with an OUD, such as homelessness, incarceration, legal issues, employment, education, transportation, need for social services, health care, child welfare involvement, child care, health insurance, documentation, etc. The STAR recovery specialists provide non-clinical assistance and recovery support services. The overall goal of STAR is to help individuals with an OUD achieve and maintain recovery, help reduce the risk of recurring episodes of opioid related problems, and prevent future overdose. STAR programs in all 21 NJ counties are funded by the SOR grant. In early 2020, services were expanded in 10 counties to enable STAR to serve individuals newly-released from county correctional facilities.

Opioid Overdose Recovery Program

The Opioid Overdose Recovery Program (OORP) responds to individuals reversed from opioid overdoses and treated at hospital emergency departments as a result of the reversal. OORP utilizes Recovery Specialists and Patient Navigators to engage individuals reversed from an opioid overdose to provide non-clinical assistance, recovery supports and appropriate referrals for assessment and substance use disorder treatment. The Recovery Specialists and Patient Navigators maintain follow-up with these individuals for a minimum of 8 weeks after the initial contact. OORP includes linking individuals to appropriate and culturally-specific services and provides support and resources throughout the process. OORP providers are required to have protocols and procedures in place for priority populations that include pregnant women and parents who have custody of their children and are at risk of child welfare involvement. For pregnant women, OORP provider policies must indicate how they will collaborate with the hospital social worker and/or hospital staff to ensure coordination and access of MAT services. This program was initially implemented in five counties as of January 2015 and is now currently operational in all 21 counties in New Jersey, utilizing state, SABG, and SOR funds. A key goal of OORP is to prevent relapse and future overdose.

DMHAS was able to provide Governor's Initiative funding to 17 OORPs to expand services. The funds enable them to serve individuals who did not experience an overdose, but who present in the emergency department with issues attributable to opioid use disorder. These individuals are also able to receive OORP services as described above. Effective July 2021, expansion services are funded by the SABG.

Recovery Support Care Management (RSCM).

Recovery Support Care Management (RSCM) was established and effective on March 7, 2023 and is a behavioral health service intended to support consumers who have a SUD with complex physical and/or psychosocial needs. It is now available in the SUD Fee-for Service initiative. RSCM provides direct and comprehensive assistance to consumers to ensure access to the

necessary treatment, rehabilitative and recovery services with the intent of reducing psychiatric and addiction symptoms, connect consumers with services, improve transitions between levels of care, implement strategies to address their unique needs, reduce opioid related deaths and sustain recovery in the community while supporting the consumers' continued stability and recovery throughout the continuum of care. This service is available as an enhancement in all levels of care. This service may be provided face-to-face or via a telehealth platform. Since Medicaid offers Care Management in outpatient, RSCM is excluded from reimbursement for consumers admitted into Ambulatory LOCs in Recovery Care Efficiency (RCE). RSCM is being funded with SUPTRS Block Grant COVID-19 Supplemental and will continue with ARPA funding. As of July 18, 2023, there were 1,186 unduplicated clients who received this service.

c) Children and youth with serious emotional disturbances or substance use disorders

The DCF-CSOC provides behavioral health care to youth and families every day in a broad continuum of services with total budget authority of state and federal resources consisting of Grants in Aid, Medicaid (Title XIX), the State Children's Health Insurance Plan (S-CHIP) (Title XXI), and, for some youth (18-20 yr. old), through an Alternative Benefit Plan (ABP).

The primary goals of CSOC are to ensure youth receive quality care in the most appropriate, community-based setting whenever possible to maintain connections to family and communities for sustainable relationships and planning. CSOC also has a continuum of out-of-home treatment settings of varying degrees of intensity of service accessible based on youths' individual needs.

1. CSOC employs the use of the system of care approach and collaborates with many system partners throughout the State to leverage expertise of the local communities. There are state administrative and management staff, and services are provided by private agencies – primarily not-for-profit agencies.

2. CSOC staff members are assigned to manage the key services available through CSOC (i.e. CMO, MRSS, IIC/BA, FSO) in a collaborative, regional model.

3. Services are primarily funded through Medicaid state plan amendments (Title XIX and Title XXI).

4. CSOC also receives funding through the NJ FamilyCare Comprehensive Demonstration (1115 Waiver). The most recent Waiver renewal was approved by the Centers for Medicare and Medicaid Services (CMS) on April 1, 2023. More information about the Children's Support Services Program is available at Department of Human Services | 1115 NJ FamilyCare Demonstration Renewal Request.

5. Services are provided based on medical necessity.

6. Medical necessity is authorized by PerformCare, the Contracted System Administrator (CSA)/Administrative Services Organization (ASO), which provides the administrative services to the system of care.

Care Management Organization (CMO). CMOs are nonprofit organizations responsible for care management, assessment, and comprehensive service planning for youth and their families with intense and/or complex needs related to behavioral health, substance use, and/or intellectual or developmental disability. Youth are enrolled with a CMO when independent CSOC CSA review of clinical and need-based information about the youth meets the threshold of clinical criteria, and the youth and family can benefit from services. CMOs engage families and youth, coordinate Child/Family Team (CFT) meetings, and implement Individual Service Plans (ISP) for each youth and their family. The CMO provides a single point of accountability for the organization, coordination, and delivery of services and supports needed to maintain stability for each youth.

Child Family Team (CFT)-Wraparound Approach. The Wraparound approach depends on collaboration among a team of family members, professionals, and significant community residents identified by the family and organized by the care manager to design and oversee implementation of the Individual Service Plan (ISP). The ISP connects the assessed strengths and needs of the youth with plan elements including family vision, goals, strategies, supports, and services. The CFT is an ongoing coordinated process that includes participation from the youth, the youth's family, the CMO care manager, and any other individual identified by the youth and family to help support the family towards a sustainable plan of care. The CFT meets, at minimum, every 90 days or as needed. Through the CFT process strengths and needs, progress and barriers to care, and services to be implemented are identified. Once identified, a request is added to the youth's treatment (care) plan, which is reviewed by CSA's licensed clinical staff (Care Coordinators) against established clinical criteria and in the context of the youth's assessment and comprehensive plan. Clinical criteria for services are located at: http://www.performcarenj.org/provider/clinical-criteria.aspx. The Care Coordination staff requests additional information from the CMO when there is a question about the youth meeting the clinical criteria. Clinically appropriate services are authorized by the CSA.

5. Describe how the state supports the provision of integrated services and supports for individuals with co-occurring mental and substance use disorders, including screening and assessment for co-occurring disorders and integrated treatment that addresses substance use disorders as well as mental disorders. Please describe how this system differs for youth and adults.

The CY 2022 Substance Abuse Overview indicate that for individuals who were discharged from treatment, 49,635, or 59% had a co-occurring disorder. It is important for DMHAS to address SUD clients who also have a co-occurring mental health disorder.

One initiative that has increased care for individuals with COD is the CCBHC. New Jersey is a CCBHC Demonstration State. NJ serves a significant number of individuals in the CCBHC program. In Year 5 of the Demonstration (July 2021-June 2022), the most recent year for which we have data, 20,279 individuals were treated in the CCBHC. All individuals treated in the CCBHC receive an array of screenings including screening for SUD. Increasing numbers of individuals that when screened, can be identified and treated for a COD. In Year 3 of the CCBHC

21% of individuals who presented for care for SMI were identified as having unhealthy drug use. In Year 4 that number rose to 29% and in Year 5 it rose to 52%.

Beginning in SFY 2010, the SSA established a Co-Occurring Services Network (COSN) comprised of 53 treatment providers to provide treatment to clients with co-occurring disorders on a Fee for Service (FFS) basis. Now, agencies eligible to join the SUD FFS Initiatives Network as a Co-Occurring Provider must meet New Jersey Department of Health (DOH) Office of Certificate of Need Licensing (CN&L) requirements for co-occurring licensing approval. As of SFY 2024, there are approximately 140 agencies in the COSN that represent approximately 252 individually licensed sites with co-occurring approval. Authorization to provide co-occurring services is predicated on agency's co-occurring licensing approval.

Those agencies contracted in the Substance Use Disorder (SUD) Fee for Service (FFS) Initiative Network for the South Jersey Initiative (SJI), Driving Under the Influence Initiative (DUII), New Jersey Statewide Initiative (NJSI), Medication Assisted Treatment Initiative (MATI), Substance Abuse Prevention & Treatment Initiatives (SAPTI), and State Hospital Access to Rehabilitation and Education (SHARE) must also participate in the Co-occurring Services Network and have demonstrated readiness to provide integrated care for dually diagnosed clients. The contracted agency shall be co-occurring capable and provide at a minimum, assessments and treatment, or must be able to screen, refer and provide linkages to a co-occurring capable agency. The contracted agency shall ensure that clients screened as "at risk" for co-occurring disorders (COD) shall receive a complete mental health assessment. If the screening contractee is not qualified to provide COD services, it is the contracted agency's responsibility to facilitate a referral for this service and coordinate ongoing care.

The SUD FFS Initiatives Network reimburses the following Co-occurring services: Case Management, Clinical Consultation, Comprehensive Intake Evaluation, Crisis Intervention, Family Therapy, Group Therapy, Individual Therapy, Medication Monitoring, and Psychiatric Evaluation.

The COSN has helped community SUD agencies, advocates, as well as individuals who have a substance use disorder and co-occurring mental illness, realize "one-stop", "treatment on demand", or "no wrong door" access to care.

Additionally, in March 2023, a Recovery Support Care Management (RSCM) service was introduced as a behavioral health service available to consumers with a SUD and complex physical and/or psychosocial needs. RSCM provides direct and comprehensive assistance to consumers to facilitate access to the necessary treatment, rehabilitative and recovery services. RSCM is designed to reduce psychiatric and addiction symptoms, connect consumers with services, improve transitions between levels of care, implement strategies to address their unique needs, reduce opioid related deaths, sustain recovery in the community and support the consumers' stability and recovery throughout the continuum of care.

Children's System of Care

The Children's System of Care offers an array of substance use treatment services for youth and young adults, including four withdrawal management beds, contracted outpatient/intensive outpatient services through 9 providers statewide, partial care services through one provider, and short term out-of-home treatment through one provider with 19 beds. In addition, residential treatment services for youth with co-occurring substance use needs and significant behavioral health needs can be accessed through the CMO from five providers with a total of 54 beds.

The South Jersey Initiative provides fee for service funding to 10 providers for outpatient and intensive outpatient substance use services for the eight southern counties. One agency, with a capacity of three beds, provides short term out-of-home treatment.

Outpatient and Intensive Outpatient services are authorized based on individual clinical need and are not monitored on a slot-based method. This allows the providers to serve more youth and avoid waiting lists. The contracted providers manage their annual funding for these services.

A parent/legal guardian may contact the CSA to access CSOC contracted services. If the parent/legal guardian is requesting substance use treatment services, the CSA licensed clinicians complete the CSOC standardized substance use assessment via phone, determine appropriate levels of care, provide referrals, and authorize services. If a youth meets clinical criteria for out of home co-occurring services, he/she will be opened with a CMO from their service area. The CMO Care Manager will assist in coordinating treatment services for youth and families, including meet and greets with treatment providers, educating families about services for their youth during and after treatment process, as well as providing support and encouraging family involvement throughout this process.

Families may also access services directly through one of the CSOC contracted substance use treatment providers. The provider will complete a substance use assessment and submit it to the CSA for review by licensed clinicians for intensity of service determination and authorization for treatment.

The ASAM Criteria (developed by the American Society of Addiction Medicine (ASAM)) are used to determine admission to level of care and readiness for discharge/transfer to another level of care. These decisions are made by Licensed Clinical Alcohol and Drug Counselors (LCADCs) with appropriate specialized training employed by the CSA.

Substance use treatment services are authorized without regard to income, private health insurance, or eligibility for FamilyCare. The types of substance use treatment services offered through CSOC include:

- Outpatient (Level I) – consists of less than 6 hours of service per week for adolescents including individual, family, and group therapy/counseling, including co-occurring services.
- Intensive Outpatient (Level 2.1) – consists of more than 6 hours per week of day treatment for adolescents including individual, family, and group therapy/counseling, including co-occurring services.

- Partial Care (Level 2.5) – consists of 20 hours per week for adolescents including educational programming, individual, family, and group therapy/counseling, including co-occurring services.
- Co-Occurring OOH Treatment (Level 3.5 and Level 3.7) – consists of residential services for adolescents/young adults providing 24-hour care with dually licensed clinicians including individual, family, and group therapy/counseling, including co-occurring services. Level 3.7 also provides 24-hour nursing care and a more intense clinical program, offering more hours of clinical services including individual, family, and group therapies by a dually licensed clinician, as well as an increased ratio of direct care staff to youth.
- Medically Monitored High Intensity Inpatient-Withdrawal Management (Level 3.7 WM) - Medically monitored withdrawal management, providing medical and nursing 24-hour care, evaluation, and withdrawal management in an agency with inpatient beds.
- Co-Occurring Behavioral Health/Substance Use Treatment Program – provides 24 hours supervised, all inclusive, co-occurring clinical services in a community-based setting for adolescents ages 13-18 who present with challenges in social, emotional, behavioral and/or psychiatric functioning as well as co-occurring substance use treatment needs.
- South Jersey Initiative (SJI) **-** The South Jersey Initiative is a historical funding stream that was designated as a result of advocacy to increase substance use treatment resources for youth and young adults in Southern NJ. To receive SJI funding, the youth must meet ASAM criteria for services and must be from one of the following eight counties: Atlantic, Burlington, Camden, Cumberland, Gloucester, Cape May, Ocean, and Salem. SJI funding is the payer of last resort. Authorization for outpatient/intensive outpatient substance use treatment services, under the SJI funding, is the same process for accessing contracted funding. Intensity of service determination is based on ASAM criteria.

Environmental Factors and Plan

2. Health Disparities - Required

Narrative Question

In accordance with Advancing Racial Equity and Support for Underserved Communities Through the Federal Government (Executive Order 13985), Advancing Equality for Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex Individuals (Executive Order 14075), the **HHS Action Plan to Reduce Racial and Ethnic Health Disparities**[1], **Healthy People, 2030**[2], **National Stakeholder Strategy for Achieving Health Equity**[3], and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and M/SUD outcomes among individuals of all cultures, sexual orientations, gender identities, races, and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (e.g., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the **Behavioral Health Implementation Guide for the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care** (CLAS)[4].

Collecting appropriate data are a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status[5]. This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations[6]. In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBTQI+ populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide M/SUD services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

In the block grant application, states define the populations they intend to serve. Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, lack of Spanish primary care services may contribute to a heightened risk for metabolic disorders among Latino adults with SMI; and American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community. In addition, LGBTQI+ individuals are at higher risk for suicidality due to discrimination, mistreatment, and stigmatization in society. While these factors might not be pervasive among the general population served by the block grant, they may be predominant among subpopulations or groups vulnerable to disparities.

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is and is not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations.

---

[1] **https://www.minorityhealth.hhs.gov/assets/pdf/hhs/HHS_Plan_complete.pdf**

[2] **https://health.gov/healthypeople**

[3] **https://www.mih.ohio.gov/Portals/0/Documents/CompleteNSS.pdf**

[4] **https://thinkculturalhealth.hhs.gov/**

[5] **https://aspe.hhs.gov/basic-report/hhs-implementation-guidance-data-collection-standards-race-ethnicity-sex-primary-language-and-disability-status**

[6] **https://www.whitehouse.gov/wp-content/uploads/2017/11/Revisions-to-the-Standards-for-the-Classification-of-Federal-Data-on-Race-and-Ethnicity-October30-1997.pdf**

Please respond to the following items:

1. Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, sexual orientation, gender identity, and age?

a) Race ◉ Yes ○ No

b) Ethnicity ◉ Yes ○ No

c) Gender ◉ Yes ○ No

d) Sexual orientation ○ Yes ◉ No

e) Gender identity ◉ Yes ○ No

f) Age ◉ Yes ○ No

2. Does the state have a data-driven plan to address and reduce disparities in access, service use and outcomes for the above sub-population? ○ Yes ◉ No

3. Does the state have a plan to identify, address and monitor linguistic disparities/language barriers? ◉ Yes ○ No

4. Does the state have a workforce-training plan to build the capacity of M/SUD providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations? ◉ Yes ○ No

5. If yes, does this plan include the Culturally and Linguistically Appropriate Services (CLAS) Standards? ◉ Yes ○ No

6. Does the state have a budget item allocated to identifying and remediating disparities in M/SUD care? ◉ Yes ○ No

7. Does the state have any activities related to this section that you would like to highlight?

Please see attached.

Please indicate areas of technical assistance needed related to this section

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Health Disparities - Required

7. Does the state have any activities related to this section that you would like to highlight?

Division of Mental Health and Addiction Services (DMHAS)

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

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

To assist agencies with preparing and maintaining a culturally and linguistically responsive delivery plan, the DMHAS contracts with two Multicultural Training and Technical Assistance Centers. The Centers provide technical assistance in the form of workshops, groups, and customized individualized support to assist agencies in the development of Cultural Competency Plans. Additionally, a statewide diversity consultant assists the two Centers with collecting, reviewing, and analyzing the plans. As a result of DMHAS commitment to cultural competency and the efforts of the Centers, there has been in increase in the number of agencies in the state developing and implementing cultural competency operations and practices. Agencies who meet cultural competency benchmarks will receive a certificate from the Centers that indicates their achievement in meeting this goal.

In an effort to ensure that the services funded by DMHAS ensure diversity, inclusion, equity, and cultural and linguistic competence to the target population, DMHAS includes cultural competency

requirements in its RFPs. In their proposals, bidders must describe their ability and commitment to provide culturally competent services (CLAS Standards) and diversity (Law against Discrimination, N.J.S.A. 10.5-1et seq.) and submit their agency's cultural competency plan as an attachment. In addition, bidders must describe program efforts to recruit, hire and train staff who are from or have experience working with target population and their strategy to address topics related to diversity, inclusion, cultural competence, and the reduction of discrepancies in the access, quality, and program outcomes, which includes information on implicit bias, diversity, recruitment, creating inclusive working environments, and providing languages access services.

The SSA funds the North Jersey Community Research Initiative to continue and expand their existing programs for high-risk LGBT youth of color by adapting a prevention model developed by the Centers for Disease Control and Prevention, early intervention services, social marketing, and structured recreational activities. A CSAP-sponsored evaluation of the program determined that the program was effective in reducing rates of substance use among participants and that participants were highly satisfied with the services that were provided. During 2022, the SSA will issue an RFP to identify and fund two additional programs for LGBT youth

The SSA recently released an RFP in August 2022 to provide treatment services to underserved populations. Ten SUD treatment providers were awarded a contract in November 2022. The services are intended to assist those who have experienced difficulties and challenges accessing SUD services. Providers were required to show the specific detail on how they identified their underserved population. These targeted services should be consumer-driven and planned with the specific needs of the individual and their special population in mind. Groups being addressed are Veterans, Older Adults, LGBTQ, homeless Black and Indigenous, and People of Color (BIPOC), Latinos and Spanish Speaking individuals.

The SSA also tracks the information noted in Question 1 through its administrative data collection system (NJSAMS). In addition, *Substance Use Overviews* are prepared annually and posted on the DMHAS website at https://www.state.nj.us/humanservices/dmhas/publications/statistical/. These provide information on access to SUD licensed treatment by these categories: race/ ethnicity, gender and age. These reports are also produced for each of NJ's 21 counties and provides information for each county's municipality.

A new feature that will be implemented in CY 2023 is a data dashboard for SUD treatment admissions. Key variables will be level of care and primary drug over time. Filters will be included to allow the public to view this information by age group, gender, and race/ethnicity.

Children's System of Care (CSOC)

New Jersey's Children's System of Care tracks data on a variety of topic areas through its Contracted System Administrator (CSA), PerformCare. Data tracked includes access and/or enrollment in services, types of services received, outcomes by demographics (race, ethnicity, gender, and age), language needs, and vulnerable subpopulations. System partners, including the Children's InterAgency Coordinating Councils, participate in the biennial Human Services Advisory Council Needs Assessment, which collects information needed to make sure the right mix of services and activities are available in each county. Counties are charged with gathering information related to local service

needs, social connections, community networks, the impact of those needs on subpopulations, trends in needs over time, key barriers to service delivery, and considerations for action.

More about the HSAC Needs Assessment can be found here:
https://www.nj.gov/dcf/about/divisions/opma/hsac_needs_assessment.html

The Department of Children and Families intends to develop strategic plans to advance race equity for each division, including the Children's System of Care (CSOC). CSOC will work with the Department of Children and Families Office of Analytics and Systems Improvement to identify and understand existing disparities within our system and develop a data-driven strategy to address disparities in service access, utilization, and outcomes. CSOC's current efforts to reduce disparities include:

- A utilization management program implemented by the CSOC CSA
- Ensuring that the CSA employs licensed clinical staff available 24 hours/day, 7 days/week with linguistic and cultural competency using the CSA's management information system to capture accurate, real-time data for analysis and identification of opportunities for improvement and right-sizing of the Children's System of Care.
- Promoting family-centered, strengths-based, culturally competent planning, and community-based services, natural supports, and active care coordination.

Data about the Children's System of Care is also available to the public by accessing the New Jersey Child Welfare Data Hub / CSOC portal. Link: https://www.nj.gov/dcf/childdata/protection/hub/

DCF is committed to promoting and realizing race equity in the State of New Jersey. To that end, DCF created the Office of Diversity, Equity and Belonging. More about DCF's efforts towards race equity can be found here: https://www.nj.gov/dcf/equity.html

CSOC does not utilize Block Grant funds to measure, track, or address these disparities.

Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question

While there are different ways to define value-based purchasing, its purpose is to identify services, payment arrangements, incentives, and players that can be included in directed strategies using purchasing practices that are aimed at improving the value of health care services. In short, health care value is a function of both cost and quality:

Health Care Value = Quality ÷ Cost, (**V = Q ÷ C**)

SAMHSA anticipates that the movement toward value-based purchasing will continue as delivery system reforms continue to shape states systems. The identification and replication of such value-based strategies and structures will be important to the development of M/SUD systems and services. The **National Center of Excellence for Integrated Health Solutions**[1] offers technical assistance and resources on value-based purchasing models including capitation, shared-savings, bundled payments, pay for performance, and incentivizing outcomes.

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including M/SUD services. Over the past several years, SAMHSA has collaborated with CMS, HRSA, SMAs, state M/SUD authorities, legislators, and others regarding the evidence for the efficacy and value of various mental and substance use prevention, SUD treatment, and recovery support services. States and other purchasers are requesting information on evidence-based practices or other procedures that result in better health outcomes for individuals and the general population. While the emphasis on evidence-based practices will continue, there is a need to develop and create new interventions and technologies and in turn, to establish the evidence. SAMHSA supports states' use of the block grants for this purpose. The NQF and the IOM/NASEM recommend that evidence play a critical role in designing health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. SAMHSA's Evidence Based Practices Resource Center (EBPRC) assesses the research evaluating an intervention's impact on outcomes and provides information on available resources to facilitate the effective dissemination and implementation of the program. SAMHSA's EBPRC provides the information & tools needed to incorporate evidence-based practices into communities or clinical settings.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions used with individuals with mental illness and substance use disorders, including youth and adults with substance use disorders, adults with SMI, and children and youth with SED. The recommendations build on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General[2], The New Freedom Commission on Mental Health[3], the IOM, NQF, and the **Interdepartmental Serious Mental Illness Coordinating Committee** (ISMICC)[4].

One activity of the EBPRC[5] was a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."[6] SAMHSA and other HHS federal partners, including the Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the M/SUD field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

In addition to evidence-based practices, there are also many innovative and promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, evidence is collected to determine their efficacy and develop a more detailed understanding of for who and in what circumstances they are most effective.

SAMHSA's Treatment Improvement Protocol Series **(TIPS)**[7] are best practice guidelines for the SUD treatment. SAMHSA draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPS is expanding beyond public and private SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation **(KIT)**[8] was developed to help move the latest information available on effective M/SUD practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement M/SUD practices that work. Each KIT covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice

demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, for educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is interested with what additional information is needed by SMHAs and SSAs to support their and other purchasers' decisions regarding value-based purchase of M/SUD services.

---

[1] https://www.thenationalcouncil.org/program/center-of-excellence/

[2] United States Public Health Service Office of the Surgeon General (1999). *Mental Health: A Report of the Surgeon General*. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service

[3] The President's New Freedom Commission on Mental Health (July 2003). *Achieving the Promise: Transforming Mental Health Care in America*. Rockville, MD: Department of Health and Human Services, Substance use disorder and Mental Health Services Administration.

[4] National Quality Forum (2007). *National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices*. Washington, DC: National Quality Forum.

[5] https://www.samhsa.gov/ebp-resource-center/about

[6] http://psychiatryonline.org/

[7] http://store.samhsa.gov

[8] https://store.samhsa.gov/?f%5B0%5D=series%3A5558

Please respond to the following items:

1. Is information used regarding evidence-based or promising practices in your purchasing or policy decisions? (●) Yes ( ) No

2. Which value based purchasing strategies do you use in your state (check all that apply):
   - a) [ ] Leadership support, including investment of human and financial resources.
   - b) [ ] Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
   - c) [x] Use of financial and non-financial incentives for providers or consumers.
   - d) [ ] Provider involvement in planning value-based purchasing.
   - e) [x] Use of accurate and reliable measures of quality in payment arrangements.
   - f) [x] Quality measures focused on consumer outcomes rather than care processes.
   - g) [ ] Involvement in CMS or commercial insurance value-based purchasing programs (health homes, ACO, all payer/global payments, pay for performance (P4P)).
   - h) [ ] The state has an evaluation plan to assess the impact of its purchasing decisions.

3. Does the state have any activities related to this section that you would like to highlight?

   Please see attached.

   Please indicate areas of technical assistance needed related to this section.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Innovation in Purchasing Decisions – Requested

3. Does the state have any activities related to this section that you would like to highlight.

Division of Mental Health and Addiction Services (DMHAS)

During spring of 2016, the Single State Authority on Substance Abuse (SSA) developed piloted a summary rating scale (1 = far below average to 4 = far above average) for each provider of treatment services. The scale used the State Outcomes Measures plus some additional outcomes. The purpose of the scale was to promote value-based purchasing by county governments when spending state dollars to purchase treatment services for their residents. Counties used these ratings to challenge potential or existing vendors to accept quality improvement strategies that are incorporated into their service contracts. This process continues for FY 2024.

As part of its Certified Community Behavioral Health Clinics (CCBHC) project, the Division of Mental Health and Addiction Services (DMHAS) uses the Prospective Payment System 2 (PPS 2) and as provided Quality Bonus Payments (QBPs). Performance measures required for QBPs were determined by NJ Medicaid Office and DMHAS, most factors are based on HEDIS measures.

New Jersey's Coordinated Specialty Care (CSC) program is based upon the Recovery After an Initial Schizophrenia Episode (RAISE) model in the treatment of First Episode Psychosis and the principles of Coordinated Specialty Care. CSC is a recovery model promoting shared decision making and personalized treatment planning. Services offered under CSC include psychotherapy, medication management, case management, supported employment and education, family education and support, cognitive behavioral therapy, motivational interviewing, and peer recovery supports. DMHAS collects data quarterly from the CSC programs to monitor client outcomes, benchmark progress of the programs with other CSC programs, contract requirements, and to monitor needs of the individuals served. It is through this monitoring that DMHAS saw a need for additional services, including enhancing CSC access and the addition of a stepdown program.

"Opioid Use Disorder Commitment to Change" is an immersive simulation training experience, called "SimMersion." SimMersion is an online flexible approach based on simulated conversations and role-plays that allow peer recovery specialists and others working in the addiction field to build skills and core competencies at their own pace while receiving on-demand feedback. By integrating an online platform which allows participants to engage in actual conversations and interventions with real individuals, the communication exchanges provide instant evaluation and coaching on Motivational Interviewing. These unique client interactive training modules focus on topic areas fundamental to peer interactions, including treatment engagement and initiation, MOUD, recovery capital, boundaries, ethics, etc. Topics were developed with input from NJ subject matter experts, including peer specialists, to enhance best practices and evidence-based practice.

DMHAS recognized how the impact of primary and secondary stressors placed on the helping profession can impact their personal and professional wellness. As a response, DMHAS and the New Jersey Prevention Network (NJPN) created safe spaces to discuss issues and strategies that can assist in the overall health and well-being of individuals working in the helping profession.

Supportive and professional counseling sessions were offered to 110,500 peers and clinical staff as a proactive response to the Coronavirus (COVID-19). In addition, realizing most peer recovery specialists are maintaining recovery themselves, NJPN created what they call the Confab platform to provide a safe, virtual supportive environment for peers to engage in an informal conversation regarding self-care. This platform was designed with a hope to create an inclusive space that embraces and honors recovery allies and peers from all multiple pathways of recovery. Approximately, 73 more peers participated in the Confab sessions from the ordinal 130 reported during the previous year.

Environmental Factors and Plan

4. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) - 10 percent set aside - Required MHBG

Narrative Question

Much of the mental health treatment and recovery service efforts are focused on the later stages of illness, intervening only when things have reached the level of a crisis. While this kind of treatment is critical, it is also costly in terms of increased financial burdens for public mental health systems, lost economic productivity, and the toll taken on individuals and families. There are growing concerns among consumers and family members that the mental health system needs to do more when people first experience these conditions to prevent long-term adverse consequences. Early intervention* is critical to treating mental illness before it can cause tragic results like serious impairment, unemployment, homelessness, poverty, and suicide. The duration of untreated mental illness, defined as the time interval between the onset of a mental disorder and when an individual gets into treatment, has been a predictor of outcomes across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be viewed as a negative prognostic factor for those who are diagnosed with mental illness. Earlier treatment and interventions not only reduce acute symptoms, but may also improve long-term prognosis.

SAMHSA's working definition of an Early Serious Mental Illness is "An early serious mental illness or ESMI is a condition that affects an individual regardless of their age and that is a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-5 (APA, 2013). For a significant portion of the time since the onset of the disturbance, the individual has not achieved or is at risk for not achieving the expected level of interpersonal, academic or occupational functioning. This definition is not intended to include conditions that are attributable to the physiologic effects of a substance use disorder, are attributable to an intellectual/developmental disorder or are attributable to another medical condition. The term ESMI is intended for the initial period of onset."

States may implement models that have demonstrated efficacy, including the range of services and principles identified by National Institute of Mental Health (NIMH) via its Recovery After an Initial Schizophrenia Episode **(RAISE)** initiative. Utilizing these principles, regardless of the amount of investment, and by leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, states should move their system to address the needs of individuals with a first episode of psychosis (FEP). RAISE was a set of NIMH sponsored studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP. The NIMH RAISE studies, as well as similar early intervention programs tested worldwide, consist of multiple evidence-based treatment components used in tandem as part of a Coordinated Specialty Care (CSC) model, and have been shown to improve symptoms, reduce relapse, and lead to better outcomes.

State shall expend not less than 10 percent of the MHBG amount the State receives for carrying out this section for each fiscal year to support evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset. In lieu of expending 10 percent of the amount the State receives under this section for a fiscal year as required a state may elect to expend not less than 20 percent of such amount by the end of such succeeding fiscal year.

* MHBG funds cannot be used for primary prevention activities. States cannot use MHBG funds for prodromal symptoms (specific group of symptoms that may precede the onset and diagnosis of a mental illness) and/or those who are not diagnosed with a SMI.

Please respond to the following items:

1. Please name the model(s) that the state implemented including the number of programs for each model for those with ESMI using MHBG funds.

Model(s)/EBP(s) for ESMI/FEP	Number of programs
RAISE CSC	6

2. Please provide the total budget/planned expenditure for ESMI/FEP for FY 24 and FY 25 (only include MHBG funds).

FY2024	FY2025
7853128	12245266

3. Please describe the status of billing Medicaid or other insurances for ESMI/FEP services? How are components of the model currently being billed? Please explain.

Providers bill Medicaid and private insurance for CSC services.

4. Please provide a description of the programs that the state funds to implement evidence-based practices for those with ESMI/FEP.

The Division of Mental Health and Addiction Services (DMHAS) first implemented Coordinated Specialty Care (CSC) for First Episode Psychosis (FEP) in 2016. There are three community providers that provide services across the state. CSC services are provided to individuals between the ages of 15-35 years of age with psychotic symptoms for less than 2 years with or without treatment. Coordinated Specialty Care is a collaborative, recovery-oriented approach, involving the individual, treatment members, and, when appropriate, family/relatives as active participants. All services are highly coordinated with primary medical care and focus on optimizing the individual's overall mental and physical health. The New Jersey's CSC programs emphasize a team approach. Services are provided in home, community, and clinic settings that include evidence-based pharmacological treatment, outreach, supported employment and education services, individual and group psychotherapy, care management, family therapy, cognitive behavioral therapy, peer wellness coaching, and recovery support with 24-hour accessibility. The CSC team members include: a Team Leader, masters level clinicians, Supported Employment and Education Specialist, a Pharmacotherapist/Prescriber, an Outreach and Referral Specialist, and a Peer Support Specialist.

Since inception in 2017, CSC programs have effectively improved the quality of care for the FEP population in New Jersey. By the end of the fiscal year 2022, the CSC program has received approximately 1635 referrals and treated 719 clients. The psychotropic medication adherence rate was 91% in FY 2022, compared to the national average for medication adherence in FEP populations that can vary from 40 to 60%???. CSC has also provided a stable system for FEP individuals to interact in the community through gainful employment, continuing education and return to school, and improved level of functioning for those who remain in care for a consistent period.

New Jersey plans to continue utilizing the 10% set-aside funding in the FY 2024-25 and leverage that funding with Covid Supplemental and ARPA funding for a total of six (6) statewide CSC teams that are also funded to do step down for individuals with early psychosis.

By the end of the fiscal year 2020, the CSC program had received approximately 974 referrals and treated over 477 clients. New Jersey utilized the 10% set-aside funding in the FY 2020-21 to support these three CSC teams by providing funding to increase their staffing to double their caseload due to the demand in services. The CSC programs expanded from serving a caseload of 35 clients in FY 2017 to 70 clients per agency in FY 2022 and increased clinical staff from 5.2 FTE to 6.6 FTE levels. The demand for CSC for FEP services continues to exceed existing capacity. Additionally, the CSC teams receive calls from individuals with affective psychosis for services that they are trying to link with services. Also, our existing CSC individuals have found it difficult to adjust to generic outpatient programs and we have identified a need for CSC step down programs. Therefore, DMHAS will be expanding CSC services to create a total of 6 CSC programs and 6 step down programs and expand the access to these programs to include both FEP and affective psychosis.

5. Does the state monitor fidelity of the chosen EBP(s)?

(●) Yes ( ) No

6. Does the state provide trainings to increase capacity of providers to deliver interventions related to ESMI/FEP?

(●) Yes ( ) No

7. Explain how programs increase access to essential services and improve client outcomes for those with an ESMI/FEP?

Providers link individuals to primary care physicians and maintain a referral resource list to increase access to essential services. They will also refer to case management services as needed.

8. Please describe the planned activities for FY 2024 and FY 2025 for your state's ESMI/FEP programs.

DMHAS is in the process of expanding CSC services by supporting a total of up to six Coordinated Specialty Care programs. These programs will serve individuals with FEP as well as individuals with affective psychosis. Additionally, DMHAS will establish up to six CSC Community Integration (CSC CI) programs to serve as step down programs providing treatment and supports to individuals who either complete the CSC program or do not need the intensive supports of a CSC program, but rather a less intensive ESMI Community Integration or step-down program. The CSC CI programs will serve as transitional programs that provide clinical stability through reducing external triggers after care as well as a continuation of client medication motoring and referral networks that provide external community supports for early psychosis clients. Clients will be able to transition to step down or up to CSC seamlessly based upon clinical need without changing providers or their clinical team.

9. Please list the diagnostic categories identified for your state's ESMI/FEP programs.

The current client diagnostic criteria for Coordinated Specialty Care for First Episode Psychosis in New Jersey are:
• Diagnosis: schizophrenia, schizoaffective and schizophreniform disorders, delusional disorder, psychosis not otherwise specified (NOS)

• Duration of psychotic symptoms greater than 1 week and less than 2 years

10. What is the estimated incidence of individuals with a first episode psychosis in the state?

It is estimated that the FEP incidence rate in New Jersey per year is .0003 (3 per 10,000)

11. What is the state's plan to outreach and engage those with a first episode psychosis who need support from the public mental health system?

Each agency providing CSC services has a masters level clinician that serves as an outreach coordinator whose sole responsibility is to disseminate information on CSC programs to potential referral sources such as Emergency Departments, schools, colleges, police departments, and other mental health agencies.

Please indicate areas of technical assistance needed related to this section.

As of May 9, 2023 the SMHA finished the requested TA to SAMHSA. The details of the TA request are: Coordinated Specialty Care (CSC) and CSC Community Integration (CI)

With the support of MHBG 10% set aside, COVID-19 Supplemental Funding and ARP funds, the New Jersey CSC program was able to plan a major expansion and serve a broader population in need. The SMHA has spent resources to research and plan the details of the expansion to ensure that the expansion of the program and the addition of a community integration or seamless step-down program did not change any of the fundamental elements of the CSC model. The New Jersey CSC program will be expanding its scope of services to include Affective Psychosis and other ESMI diagnoses that our current CSC programs are receiving referrals for, but cannot serve under the admission criteria for CSC FEP. The SMHA has also added a CSC community integration component so that individuals ready for discharge from the CSC program can transition into the CSC CI program to continue to receive seamless step-down services to address the needs of the individuals in CSC. NJ will be leveraging the current mental health block grant set aside funding with the Covid Supplemental and ARPA funding and funding a total of six CSC programs statewide. Each of the 6 providers will serve the ESMI population in New Jersey. Each provider will administer a CSC program and a CSC CI program that will serve individuals age 15 to 35 with early psychosis (FEP and affective psychosis).

Technical Assistance: New Jersey is requesting to receive technical assistance (TA) for Evidenced Based Practices for Early Serious Mental Illness (ESMI) including First Episode Psychosis (FEP) from OnTrack New York. The SMHA would like for its CSC Management team to receive a half day training to discuss the implementation of this new program as well as to train new staff in the CSC model. Once the six teams are awarded, DMHAS would like for OnTrackNY to provide training on the RAISE/CSC model and the EBPs within the model to the teams and DMHAS as was done previously in 2017 followed by the development of a learning collaborative. The teams will benefit from technical assistance related to early psychosis, particularly with regard to recruiting, retaining, hiring relevant staff, providing clinical training, role base training, and supervision necessary to make the CSC programs a success. The SMHA requests to obtain appropriate trainings for these teams from OnTrackNY group through SAMHSA's TA services.

Topics that we are requesting for our Coordinated Specialty Care programs to receive technical assistance include:
• A Learning Collaborative (previously in place with OnTrackNY) where specific case examples are discussed as to the best way to approach care with CSC Clients
• A continuation on TA for CSC Learning Collaborative for role development for CSC team members (previously in place with OnTrackNY) including; Team Lead, Prescriber, Clinician, Supported Employment Education Specialist and Peer Recovery Specialist.

Topics the DMHAS CSC Management team are requesting technical assistance in include the following:
• Working with Medicaid and third-party payers to set a bundled rate for CSC and speak with states that have been successful in working with third party payers in negotiating bundled rates and/or payment for CSC.
• Familiarizing and adopting effective Needs Assessment methods used in other CSC programs in the country.
• Developing a benchmark for CSC programs against other CSC programs in the country when reporting performance measures.
• Provide the state with TA to assist with expansion, development, and implementation of CSC programs and monitoring site visits including both onsite and offsite.
• Training for providers in developing strategies and incorporating methods utilized by providers on how to engage consumers in groups and family psychotherapy.
• Training for provider and state staff on the EBP’s including but not limited to CBT, CBT-Psychosis, CBT-TIC, Individual Placement and Support, Person-Centered Therapy, Motivational Interviewing, Cognitive remediation, Trauma treatment, Peer wellness coaching, Individual Resiliency Training (IRT), Psychoeducation, Supported Education and Employment.
• Technical assistance in the development of regulations and state plan amendment for CSC.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Environmental Factors and Plan

5. Person Centered Planning (PCP) - Required for MHBG

Narrative Question

States must engage adults with a serious mental illness or children with a serious emotional disturbance and their caregivers where appropriate in making health care decisions, including activities that enhance communication among individuals, families, caregivers, and treatment providers. Person-centered planning is a process through which individuals develop their plan of service. The PCP may include a representative who the person has freely chosen, and/or who is authorized to make personal or health decisions for the person. The PCP team may include family members, legal guardians, friends, caregivers and others that the person or his/her representative wishes to include. The PCP should involve the person receiving services and supports to the maximum extent possible, even if the person has a legal representative. The PCP approach identifies the person's strengths, goals, preferences, needs and desired outcome. The role of state and agency workers (for example, options counselors, support brokers, social workers, peer support workers, and others) in the PCP process is to enable and assist people to identify and access a unique mix of paid and unpaid services to meet their needs and provide support during planning. The person's goals and preferences in areas such as recreation, transportation, friendships, therapies, home, employment, education, family relationships, and treatments are part of a written plan that is consistent with the person's needs and desires.

In addition to adopting PCP at the service level, for PCP to be fully implemented it is important for states to develop systems which incorporate the concepts throughout all levels of the mental health network. Resources for assessing and developing PCP systems can be found at the National Center on Advancing Person-Centered Practices and Systems **https://ncapps.acl.gov/home.html** with a systems assessment at **https://ncapps.acl.gov/docs/NCAPPS_SelfAssessment_201030.pdf**

1. Does your state have policies related to person centered planning? (●) Yes ( ) No

2. If no, describe any action steps planned by the state in developing PCP initiatives in the future.

   n/a

3. Describe how the state engages consumers and their caregivers in making health care decisions, and enhance communication.

   DMHAS endorses person-centered planning for mental health consumers in its Vision Statement: At any point of entry the service system will provide access to appropriate and effective person-centered, culturally-competent services delivered by a welcoming and well trained workforce.

   Furthermore, person-centered planning is recognized in the DMHAS statement about its Values: Staff with the Division and its partner agencies value consumers' dignity and believe that services should be person-centered and person-directed.

   DMHAS has endorsed consumer empowerment and decision-making in the delivery of treatment and support services. It supports the hiring of peer specialists and ensures that they have a prominent role in assisting consumers. The Division currently supports 34 consumer-run Wellness/Self-Help Centers statewide, as well as many initiatives to train and support peer specialists (these are described elsewhere). DMHAS initiatives also encourage the engagement of caregivers. DMHAS empowers family members of those with a mental illness in its ongoing programs of Intensive Family Support Services (IFSS) that are situated statewide. Family members work with professionals to acquire the knowledge, skills and supports they need to improve functioning and gain a sense of control.

   In the last year, DMHAS used a TTI grant for training in Recovery-Oriented Cognitive Therapy (CT-R) at four Behavioral Health Homes; the initiative implemented a "Train the Trainer" approach through a collaboration between the Aaron T. Beck Center, the New Jersey Division of Mental Health and Addiction Services (DMHAS) and Rutgers-University Behavioral Health Care (R-UBCH). The trainees included team nurses (LPNs), nurse care managers, wellness coaches, care managers, program directors, Behavioral Health Home (BHH) outpatient clinicians and therapists, partial care coordinators, dual disorder specialists, population health managers, mental health specialists, as well as peer support specialists of the BHH Team. This project demonstrated that training peers in CT-R in Behavioral Health Home settings improves the effectiveness of peer support specialist and empowers then in assisting consumers in recovery. DMHAS also has a contract with NAMI New Jersey to support their activities and efforts with family members.

   After DMHAS saw the benefits of CT-R in this initiative, a TTI-funded initiative trained peer specialists to use CT-R in their work with individuals in outpatient programs who were adversely affected by COVID. From these initiatives, DMHAS recognized that CT-R had great potential in helping seriously mentally ill individuals meet their recovery goals. In 2023, DMHAS awarded funding from SAMSHA mental health block grant to the Beck Institute to develop a Center of Excellence for CT-R and began to provide training and technical assistance to outpatient providers statewide. Initially, Beck has initially CT-R focused training on Community Support Services and Group Home programs. A unique aspect of the program is the use of personalized incentives to help promote individuals' recovery-oriented goals. Beck is developing project components that will promote and sustain the COE

initiative, including a dedicated website, and it will also conduct a full evaluation of the project.

In cooperation with Rutgers Behavioral Healthcare, it has supported development of various tools to promote and facilitate consumer autonomy. These include a toolkit addresses use of tobacco called, Learning About Healthy Living, which has been used by several other states. A toolkit completed last year, Your Wellness Counts, which is a self-care/consumer-directed manual that teaches about healthy lifestyle choices and wellness goal setting. DMHAS also developed a 'Shared Decision Making around Medication' tool that guides consumers on how to prepare for medication appointments and create a record for future use. The tools are also posted on the DMHAS website for access and use.

DMHAS continues to support consumers' development of Psychiatric Advance Directives (PADs) to express their wishes about their mental health care and other assistance during a personal mental health crisis. DMHAS implemented an electronic registry of PADs by contracting with U.S. Living Will Registry, so that providers and consumers can retrieve PADs during episodes of crisis care. The database of PADs is held in a confidential and secure site, which is protected by the most up-to-date web and database security standards, and this can only be accessed by the consumer or by authorized individuals. Having PADS accessible through the electronic registry significantly increases the probability that an individual's PAD is available to providers when they are in crisis.

DMHAS also supports training to the provider community about how to engage consumers and promote their decision-making about their recovery. Illness Management and Recovery (IMR) training and follow up consultation and technical assistance is conducted by Rutgers-UBHC with the support of DMHAS. Before DMHAS transfer to DHS, it held a Statewide Wellness Committee with representatives of each of the four state hospitals to promote person centered planning, and assist with wellness initiatives and programs. Individuals with lived experience were active participants on the committee.

4. Describe the person-centered planning process in your state.

A person-centered planning process is integrated in a number of services offered to consumers in New Jersey. These include Illness Management and Recovery (IMR), Supported Employment (SE), Coordinated Specialty Care (CSC), Community Support Services (CSS), all licensed treatment services (Outpatient, PACT), ICMS and licensed residential Services. Each of these services engages the individual in soliciting their wants, needs and desires as well as the skills and supports available to them. The consumers' goals are typically tied to a role and environment that they would like to attain or successfully remain in. The SMHA has incorporated IMR into the foundation of principles and practices central to a recovery-oriented, person-centered system of community mental health services; decrease symptoms, reduce relapses and hospitalizations and make progress towards personal goals through recovery. IMR is incorporated into the partial care systems and it is supported by the regulations. It is incorporated into the supportive housing now CSS systems. SE begins with a discussion of consumers' preferences field of work, occupation and or job. The consumer's employment background is reviewed to determine transferable skills and then individualized job development initiated based upon the consumer's choice. While SE begins with paid support, natural supports provided by family, co-workers, friends or others are identified.

CSC uses person-centered planning in the engagement process to provide a vision of recovery and hope that communicates the program's person-centered focus, as opposed to an illness-focused approach. PCP is first introduced to CSC clients in the shared decision-making model that incorporates suggestive advice from CSC therapists based on Evidence Based Practice methods. All of the eleven core EBP treatment methods address PCP in client care though engaging the client in weekly sessions to improve their quality of life while reducing symptomology. All of the CSC service modalities use PCP that include: Supported Employment and Education, Peer Support, Medication Monitoring, and Client Therapy.

CSS is a mental health rehabilitation services and support process designed to assist the consumer in achieving rehabilitative and recovery goals as identified in an individualized rehabilitation plan; including achieving and maintaining valued life roles in the social, employment, educational, and housing domains; and assisting the consumer in restoring or developing his or her level of functioning to that which allows the consumer to achieve community integration, and to remain in an independent living setting of his or her choosing.

New Jersey PACT's consumer-centered services begins with comprehensive assessment and recovery planning. Team members meet with the consumer to gather historical information and assess current functioning. The consumer is encouraged to actively participate in this process, sharing expectations and desired outcomes of their involvement with PACT services. Consistent with PACT's evidence base, consumers are involved in a collaborative goal-setting process that flows from the information obtained from the initial assessments into development of mutually agreed-upon goals and objectives.

Staff interventions are designed to support these goals and to help the consumer maintain focus on recovery. Incorporating consumers' lived experience is key to developing collaborative recovery plans, and at each recovery plan update, the consumer is invited to discuss their perception of their progress toward their goals and about any new directions they would like to explore. In the event that the consumer and the staff differ in their perspectives, the staff defer to the consumer to the greatest extent possible, with the goal of supporting successive approximations of shared goals.

New Jersey focuses on person- centered planning as the foundation of providing services to individuals with mental health needs. Regulation N.J.A.C. 10:37-5.59 1 specifies that each individual shall be involved in determining their service goals, and documentation of their participation (see below for reference). The use of Psychiatric Advance Directives to ensure the services are

person-centered is also utilized in NJ for licensed services. For individuals enrolled in ICMS, PACT, Outpatient, residential and licensed and contracted services in NJ it is the expectation that the services are all person centered, with the individual having involvement in determining their treatment goals. Additionally, NJ is focused on a Wellness and Recovery model of service as evidence in our Mission statement (Below for reference). This is a person-centered approach that believes in the individuals ability recover and focus on their strengths and stated goals.

DMHAS Mission

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, and treatment and recovery services delivered by a culturally competent and well-trained workforce.

N.J.A.C. 10:37-5.59 1. Each client shall be involved in determining service goals, modalities of treatment and timetables, to the extent that his or her condition permits. Participation should be documented by having the client's signature on the plan. (See N.J.A.C. 10:37-6, Article VIII.) Client involvement shall include the development, modification, execution, and registration of an advance directive for mental health treatment if the consumer, after receiving complete information about such directives, wishes to designate either a mental health representative or to execute an instruction directive.

Person-centered planning by CSOC:

The goal of DCF's CSOC is to enable the youth to remain at home, in school, and within their community. Therefore, through an organized system of care approach, CSOC is committed to providing services that are:
A. Clinically appropriate and accessible;
B. Individualized, reflecting a continuum of services and/ or supports, both formal and informal, based on the unique strengths of each youth and his or her family/ caregivers;
C. Provided in the least restrictive, most natural setting appropriate to meet the needs of the youth and his or her family/ caregivers;
D. Family-guided, with families engaged as active participants at all levels of planning, organization, and service delivery;
E. Community-based, coordinated, and integrated with the focus of having services, decision-making responsibility, and management resting at the community level;
F. Culturally competent, with agencies, programs, services, and supports that are reflective of and responsive to the cultural, racial, and ethnic differences of the populations they serve;
G. Protective of the rights of youth and their family/caregivers; and
H. Collaborative across child-serving systems, involving; child protection, juvenile justice, and other system partners who are responsible for providing services and supports to the target populations.

The NJ Children's System of Care is founded on the following Core Values and Principles:

• Family Driven and Youth Guided– Families are engaged as active participants at all levels of planning, organization, and service delivery.
• Culturally and Linguistically Competent – learning and incorporating the youth and family's culture, values, preferences, and interests into the planning process, including the identified language of the family.
• Community Based – identifying and utilizing supports that are least restrictive, accessible, and sustainable to maintain and strengthen the family's existing community relationships.

Child Family Team (CFT)-Wraparound Approach

The Wraparound approach depends on collaboration among a team of family members, professionals, and significant community residents identified by the family and organized by the care manager to design and oversee implementation of the Individual Service Plan. The ISP connects the assessed strengths and needs of the youth with plan elements including family vision, goals, strategies, and supports and services. The CFT is an ongoing coordinated process that includes participation from the youth, the youth's family, the CMO care manager, and any other individual identified by the youth and family to help support the family towards a sustainable plan of care. The CFT meets, at minimum, every 90 days or as needed. Through the CFT process, strengths and needs, progress and barriers to care, and services to be implemented are identified. Once identified, a request is added to the youth's treatment (care) plan, which is reviewed by CSA's licensed clinical staff – Care Coordinators - against established clinical criteria and in the context of the youth's assessment and comprehensive plan. Clinical Criteria for services is located at: http://www.performcarenj.org/provider/clinical-criteria.aspx. The Care Coordination staff requests additional information from the CMO when there is question about the youth meeting clinical criteria. Clinically appropriate services are authorized.
CFT members include, but are not limited to, the following individuals:
• Child/Youth/Young Adult
• Family Support Partner
• Parent(s)/Legal Guardian
• Care Management Organization
• Natural supports as identified and selected by youth and family
• Treating Providers (in-home, out-of-home, etc.)

• Educational Professionals
• Physical Health Providers (pediatrician, specialist)
• Probation Officer (if applicable)
• Child Protection & Permanency (CP&P) (if applicable)

Family Support Organizations

Family Support Organizations are operated by 15 agencies under contract with CSOC to: ensure that service plans developed for families are child-centered and family-focused; provide support to families through peer counseling, family training and workshops; advocate for families at the local level with other system partners; and cultivate and empower youth development consistent with the wellness and recovery model. The FSOs offer support to families of youth with behavioral health needs, substance use needs, and intellectual and developmental challenges. Family Support Partners within the FSOs are assigned to each family of youth enrolled in CMOs to offer and provide individual family peer-to-peer support. Additionally, the FSOs offer community-based supports to all youth and families in their service area. They provide community outreach and education on peer support and CSOC, family and youth support groups, youth partnership structure and activities, and telephonic support for families. The FSO NJ Alliance is contracted to provide training and technical assistance to FSOs.

Contracted System Administrator (CSA)

The Contracted System Administrator (CSA) was designed to provide the State with overall healthcare system management to assure 24-hour access to appropriate and coordinated services and provide child-specific and systemic data analysis on all children under the jurisdiction of CSOC.

The CSA creates a common single point of entry for youth and families. The CSA registers all youth requesting services and authorizes services in a single electronic record. The CSA tracks and coordinates care for all New Jersey youth enrolled in CSOC.

CSOC retains all regulatory and policy-making authority. The CSA is not a pre-paid health plan; instead it functions as and is inclusive of the activities of a non-risk Administrative Services Organization (ASO). As such, there are key functions that remain the responsibility of CSOC, including, but not limited to, network development, provider contracting, and provider outcome standards. As a partner to CSOC, the CSA provides administrative support and is encouraged to offer recommendations for improvements to the delivery of services which may be implemented with the approval of CSOC.

The CSA performs a broad range of administrative service functions including, but not limited to, the following:

• Providing a Call Center with 24-hour/7-day intake and Customer Service capability;
• Providing a web-based application/interface with the CSA’s Management Information System (MIS);
• Managing care, which includes utilization management, outlier management (including authorization of services), and care coordination; if youth are involved with a Care Management Organization, PerformCare reviews service requests based on the youth’s comprehensive plan of care which is developed by the Child Family Team (CFT).
• Coordinating access to services for all youth, including facilitating access to specialized services for youth involved with the Division of Child Protection and Permanency (DCP&P);
• Coordinating Third Party Liability and medical coverages;
• Coordinating a transition to adult services for youth;
• Providing Quality and Outcomes Management, and System Measurement that supports CSOC’s goal to promote best practices, and providing assistance to the State to assure compliance with State and federal guidelines;
• Providing training and training materials;
• Providing support for Provider Network Development; and
• Completing annual audit reviews.

To support these administrative services, the CSA provides an MIS called CYBER (Child and Youth Behavioral Electronic Record) that is backed by strong, clinical guidance and fosters flexibility, system integration, comprehensive information management, and production of management reports that support business decisions. The contract for PerformCare was renewed for five years upon RFP award in November 2017.

5. What methods does the SMHA use to encourage people who use the public mental health system to develop Psychiatric Advance Directives (for example, through resources such as SAMHSA's **A Practical Guide to Psychiatric Advance Directives**)?"

DMHAS largely promotes PADs through a collaboration with peer and family organizations, such as the Mental Health Association of NJ (MHANJ) and NAMI, among others. DMHAS contract with MHANJ to serve as a hub for support and resources for individuals and family members regarding mental illness, and the organization promotes PADs and provides mental health consumers with information about how to develop a PAD and access the PAD registry.

Data from the U.S. Living will Registry on the numbers of PADs being registered in in the state in recent years suggests that relatively low. Consumers have voiced concerns about PADs being a legal document, and noted the difficulties of completing the required form and with submitting it online, and some mistrust providers around PAD implementation. DMHAS is forming a workgroup to develop strategies to support consumers with targeted education and assistance writing PADS, as well the

development of user-friendly PAD documents and resources.

Please indicate areas of technical assistance needed related to this section.

DMHAS can benefit from technical assistance on psychiatric advanced directives as it enters into a new phase of implementation – post pandemic. Additionally, DMHAS is interested in how best to implement advanced psychiatric directives in the community and interested in resources for the creation of PADs that are meaningful and accessible to the individuals, providers and their caregivers.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Environmental Factors and Plan

6. Program Integrity - Required

Narrative Question

SAMHSA has a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds.

While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for M/SUD services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 U.S.C. §§ 300x–5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 U.S.C. § 300x-55(g), SAMHSA periodically conducts site visits to MHBG and SUPTRS BG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SUPTRS BG funds can only be used for individuals with or at risk for SUD. SAMHSA guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: **http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf**. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SUPTRS BG resources are to be used to support, not supplant, services that will be covered through the private and public insurance. In addition, SAMHSA will work with CMS and states to identify strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SUPTRS BG funds are allocated to support evidence-based, culturally competent programs, substance use primary prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for M/SUD services funded by the MHBG and SUPTRS BG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered M/SUD benefits; (3) ensuring that consumers of M/SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of M/SUD benefits in light of utilization review, medical necessity, etc. Consequently, states may have to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please respond to the following:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers? (●) Yes ( ) No
2. Does the state provide technical assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards? (●) Yes ( ) No
3. Does the state have any activities related to this section that you would like to highlight?

   Please see attached.

   Please indicate areas of technical assistance needed related to this section

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Program Integrity - Required

3. Does the state have any activities related to this section that you would like to highlight?

Division of Mental Health and Addiction Services (DMHAS)

Technical assistance is provided through in-person trainings and webinars, specifically when implementing new initiatives/programming or discussing evidence-based or innovative practices throughout the State (i.e., Vivitrol Enhancement Network, Best Practices for Drug Screening, Integrating Hepatitis C Treatment and Prevention, etc.).

The grants monitoring program at the Division of Mental Health and Addiction Services (DMHAS) monitor Substance Use Prevention, Treatment, and Recovery Services (SUPTRS) Block Grant recipients. Onsite visits are made to each SUPTRS Block Grant recipient a minimum of one time per calendar year. More frequent reviews are conducted on an as needed basis for agencies recommended by the Contract Coordination meeting as needing additional technical assistance or monitoring because of violations, other deficiencies, or special grant requirements. The Contract Coordination meeting includes representatives from the Monitoring, Prevention, Fiscal and Treatment program units within DMHAS.

Site visits may be anywhere from 1 to 5 days in duration depending on the size and scope of the program. The reviewer conducts chart reviews for the selected sample and completes an Annual Site Monitoring Report. The Annual Site Monitoring Report addresses at a minimum five core areas of performance: Facility, Staff, Treatment Records, Quality Assurance, Specialized Services, and Other contract requirements. A site visit report is submitted to the agency and a plan of correction (PoC) is required for areas found to be in noncompliance. Agencies are notified in writing of the acceptance or non- acceptance of the plan of correction and the monitoring staff continues to follow up until an acceptable plan of correction is submitted. Agencies who continue to submit an unacceptable plan of correction are referred to the Contract Monitoring Meeting for further action.

In addition to routine monitoring, a Contract Coordination meeting is held monthly to discuss issues such as outstanding PoCs, agencies needing technical assistance and other program concerns including underutilization. The Contract Coordination meeting includes representatives from the Monitoring, Prevention, Fiscal and Treatment program units within DMHAS.

The DMHAS fiscal office maintains a Manual that contains the various State and Federal grant policies and procedures with which the Division complies. These policies (promulgated by the State Office of Management and Budget, the State Department of Human Services, as well as SAMHSA) cover payments and obligations to third party vendors, required documentation to support payments, federal grant reporting, general contracting policies, grant monitoring activities, etc.

With respect to monitoring, the Division engages in various activities designed to confirm that third party providers are complying with established policies and that expenditures are proper. For example, with respect to Mental Health Fee for Service (FFS) payments (a portion of which is charged to the Mental Health Block Grant), the Division conducts quarterly reviews of

expenditures to confirm that consumers were not Medicaid-eligible. Letters are sent to all providers to recover funds for all clients who were identified by our staff as Medicaid-eligible. Since the Division's transition to FFS in 2017, roughly $4.6 million of recoveries have been realized through these efforts. Provider compliance in ***not*** billing for Medicaid-eligible clients has increased over time given the Division's consistent communications on this matter. Similar reviews are conducted by the Division's SUD Fee for Service Network Management unit, i.e., checking for billing of Medicaid-eligible clients, incorrect billing codes, etc. Recoveries are realized by "voids" of claims in the Division's billing system. In FY 2023, about $131,000 of such recoveries were realized with respect to two FFS initiatives funded by the federal SUPTRS Block Grant. In addition, one provider proactively identified an additional $68,000 of recoveries/voids in these initiatives.

More generally, the Division has been consistent in informing providers of the need to identify all other payer sources, e.g., Medicaid, private insurance, prior to charging the Division under State-funded, or federal grant-funded (either Block Grant or Discretionary) agreements. This is effected by standard NJ DHS contract language, Budget Language in the Appropriations Act and other communications. In addition, DMHAS has made efforts to train providers in Presumptive Eligibility. Presumptive Eligibility training and certification for agencies continues to be scheduled through the State's Medicaid agency, i.e., the Division of Medical Assistance and Health Services, as needed or requested by providers.

The Division also engages in regular monitoring of our cost-reimbursement contracts and Memoranda of Agreement (MOA's), many of which are funded by federal grants. With respect to the former, Contract Administrators review Reports of Expenditure (ROE) that are submitted on a quarterly basis to check for compliance and consistency with provider budgets. A sample of providers is also selected on an annual basis to be audited by the Department of Human Services Audit staff. These audits consist of very detailed reviews of provider spending during the contract year. In addition, more recently, the Division's own Audit staff have started to also conduct detailed reviews of provider expenditures, e.g., review of payroll records, invoice support for a sample of expenditures. With respect to MOA's, analysts in our Budget office are responsible for conducting detailed reviews of each invoice submitted by our third part providers. Wage and personnel records, including General Ledger support, as well as invoice support for significant expenditures, are provided and reviewed before payment is made.

The Division's Budget staff are also in regular communication with program leads to ensure agreement with the detailed budgets submitted by providers and to identify specific policies (e.g., on limitations to administrative/indirect costs) that may be in place for specific grants.

The Senate and General Assembly of the State of New Jersey enacted an Act concerning substance use treatment facility performance (N.J.S.A. 26: 2G-38.) requiring the annual preparation of Substance Use Treatment Provider Performance Report. The performance report shows and compares the overall performance of each substance use treatment provider in the State with the statewide average performance based on national outcome measures for each level of care. The performance report includes the following national outcome measures: (1) percentage of clients abstinent from alcohol on admission and discharge; (2) percentage of clients abstinent from drugs on admission and discharge; (3) percentage of clients employed on admission and discharge; (4)

percentage of clients enrolled in school or a job training program at admission and discharge; (5) percentage of clients who are homeless on admission and discharge; and (6) average length of client treatment.

By publicly reporting these outcomes, the DMHAS hopes to provide individuals with information on the outcomes achieved so they can make informed decisions about choosing a provider, and to help providers see how they are doing compared to their New Jersey peers and to the state so that they can identify areas that might need improvement. These performance reports are one strategy that DMHAS has adopted in its continuous quality improvement efforts focused on helping to improve services to the clients we serve. The NOMs are one way to monitor client outcomes, help direct system improvements and achieve better accountability.

The following activities are done for program integrity of the Mental Health Block Grant (MHBG). Letters are sent to provider agencies, on a state fiscal year basis, notifying them of their MHBG award amount, the CFDA number, and the restrictions on the use of the funds.

These agencies are also monitored by the DMHAS Office of Community Services (OCS). One of the responsibilities of the OCS is to ensure that the services provided by contracted programs meet contractual expectations, and that appropriate action is taken to address performance issues. For licensed programs, the Office of Licensing validates that standards are met to achieve and maintain licensure, which include standards for quality and life safety. The OCS, however, has a role in the review of staff qualifications, particularly if a waiver is sought, access to services, and also in monitoring the implementation of awards and best practices. Additionally, the OCS receives and responds to complaints and concerns from constituents, which often address issues of compliance with standards, safety considerations and access to services. By monitoring access to services, the OCS ensures that the target population is prioritized to receive contracted services.

The DMHAS Fee for Service (FFS) Unit collaborates with OCS to monitor program performance and adherence to FFS policy, billing practices, and programmatic performance. As a result of these monitoring visits, contracted providers will receive a summary of the visit, and may be required to submit corrective plans when deficiencies are noted.

The OCS uses Quarterly Contract Monitoring Reports (QCMR's) to compare actual volume of service to contracted volume of service where applicable. When discrepancies are noted, follow-up occurs to identify the reasons for the discrepancies, and to require corrective action as needed. If a Corrective Action Plan is required of a provider agency, the regional office monitors the implementation of the plan until such time as either satisfactory improvement is achieved, or alternatively, contract modifications are made. The OCS may issue a contract contingency where a contract will be renewed contingent on meeting stipulated requirements. The OCS may provide technical assistance to providers to help them to achieve the desired service outcomes and may engage other DMHAS staff to render technical assistance. It may be necessary to reduce or terminate a contract if the expected level of service is not achieved.

Technical assistance is provided through in-person trainings and webinars, specifically when implementing new initiatives or programming throughout the State and includes Medicaid and non-Medicaid services and providers.

The Medical Assistance Customer Service Centers conducts site reviews for Medicaid behavioral health providers that include chart reviews, program monitoring and regulatory compliance. Technical assistance is provided if warranted. Serious and extreme violations of a requirement are reported to the Office of Licensing or other governing authority, and if appropriate, the Medicaid Fraud Division for additional follow up with the agency. Site visit report is sent to the provider with a plan of correction (PoC) for areas found to be in noncompliance.

Environmental Factors and Plan

7. Tribes - Requested

Narrative Question

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the **2009 Memorandum on Tribal Consultation**[56] to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Improving the health and well-being of tribal nations is contingent upon understanding their specific needs. Tribal consultation is an essential tool in achieving that understanding. Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues.

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state's plan. Additionally, it is important to note that approximately 70 percent of American Indians and Alaska Natives do not live on tribal lands. The SMHAs, SSAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the states.

States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

[56] **https://www.energy.gov/sites/prod/files/Presidential%20Memorandum%20Tribal%20Consultation%20%282009%29.pdf**

Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?

2. What specific concerns were raised during the consultation session(s) noted above?

3. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

New Jersey does not have any federally recognized tribal governments or tribal lands within its borders.

Using SUBG COVID-19 Supplemental and ARPA funds, DMHAS has funded a Memorandum of Agreement (MOA) with the New Jersey Commission on American Indian Affairs to provide prevention services for NJ's three Native American tribes: Nanticoke Lenni-Lenape Indians, Powhatan Renape Indians, and the Ramapough Lenape Indian Nation. These tribes, while recognized by the state are not federally recognized. This is DMHAS' first collaboration with this important population.

Under this MOA, DMHAS will provide funds (Block Grant Supplement and ARP) to enable the tribes to implement evidence-based primary prevention programs. Tribes will be instructed in the use of the Strategic Prevention Framework and will identify prevention programs or

strategies that were developed by or for Native American communities. DMHAS will offer guidance and support to the tribes at their request.

Environmental Factors and Plan

8. Primary Prevention - Required SUPTRS BG

Narrative Question

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. ***Problem Identification and Referral*** that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. ***Community-based Processes*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental Strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Assessment

1. Does your state have an active State Epidemiological and Outcomes Workgroup(SEOW)? ◉ Yes ○ No

2. Does your state collect the following types of data as part of its primary prevention needs assessment process? (check all that apply) ◉ Yes ○ No

- **a)** ☑ Data on consequences of substance-using behaviors
- **b)** ☑ Substance-using behaviors
- **c)** ☑ Intervening variables (including risk and protective factors)
- **d)** ☑ Other (please list)

Social Indicator Data
Treatment Data
NJ State Police Data
NJ Prescription Drug Monitoring Data
State Medical Examiner Data – Drug-related Deaths
Naloxone Reversal Data

3. Does your state collect needs assesment data that include analysis of primary prevention needs for the following population groups? (check all that apply)

a) [x] Children (under age 12)

b) [x] Youth (ages 12-17)

c) [x] Young adults/college age (ages 18-26)

d) [x] Adults (ages 27-54)

e) [x] Older adults (age 55 and above)

f) [x] Cultural/ethnic minorities

g) [x] Sexual/gender minorities

h) [ ] Rural communities

i) [ ] Others (please list)

4. Does your state use data from the following sources in its Primary prevention needs assesment? (check all that apply)

a) [x] Archival indicators (Please list)

New Jersey Chartbook of Substance Abuse Related Social Indicators

b) [x] National survey on Drug Use and Health (NSDUH)

c) [x] Behavioral Risk Factor Surveillance System (BRFSS)

d) [x] Youth Risk Behavioral Surveillance System (YRBS)

e) [x] Monitoring the Future

f) [ ] Communities that Care

g) [x] State - developed survey instrument

h) [x] Others (please list)

New Jersey Middle School Risk and Protective Factor Survey
New Jersey Household Survey of Drug Use and Health
Young Adult Survey
Older Adult Survey
Survey of Returning Veterans

5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SUPTRS BG primary prevention funds? (●) Yes ( ) No

a) If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based?

DMHAS utilizes a Relative Needs Assessment Scale (RNAS) using social indicators with known correlations to estimate state

and county substance use prevention and treatment needs. 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.

b) If no, (please explain) how SUPTRS BG funds are allocated:

6. Does your state integrate the National CLAS standards into the assessment step? (●) Yes ( ) No

a) If yes, please explain in the box below.

DMHAS strives to maintain a current demographic, cultural, and epidemiological profile of the communities it serves as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.

b) If no, please explain in the box below.

7. Does your state integrate sustainability into the assessment step? (●) Yes ( ) No

a) If yes, please explain in the box below.

When assessing the needs and capacity of a community, it is imperative to build new relationships and foster existing relationships, with key stakeholders that show the interest and ability to see the programming through for several years. Community data are essential at this step, in order to assess the most prevalent issues and identify individuals and systems who can assist in programming, whether through hands-on work, funding, networking, etc.

b) If no, please explain in the box below.

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. ***Problem Identification and Referral*** that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. ***Community-based Processes*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental Strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Capacity Planning

1. Does your state have a statewide licensing or certification program for the substance use primary prevention workforce? ◉ Yes ○ No

a) If yes, please describe.

The Addictions Certification Board of NJ administers and awards the International Certification and Reciprocity Consortium (IC & RC) recognized Certified Prevention Specialist Credential.

2. Does your state have a formal mechanism to provide training and technical assistance to the substance use primary prevention workforce? ◉ Yes ○ No

a) If yes, please describe mechanism used.

Contracts with the New Jersey Prevention Network, Rutgers University School of Social Work – Center for Prevention Science, and the Northeast Prevention Technology Transfer Center.

3. Does your state have a formal mechanism to assess community readiness to implement prevention strategies? ◉ Yes ○ No

a) If yes, please describe mechanism used.

Various Instruments such as Community Prevention Readiness Index or Community Readiness Model are provided by the Rutgers Center for Prevention Science.

4. Does your state integrate the National CLAS Standards into the capacity building step? ◉ Yes ○ No

a) If yes, please explain in the box below.

Understanding culturally inclusive resources, people, partnerships, and skills are essential to the successful implementation of prevention and wellness. Capacity includes understanding the types, depth, breadth and levels of the resources needed to address the community's needs.

5. Does your state integrate sustainability into the capacity building step? ◉ Yes ○ No

a) If yes, please explain in the box below.

Building capacity involves increasing public awareness and garnering public support for programming while connecting with diverse partners and stakeholders who are reflective of the communities being served and who will be instrumental in the success and sustainability of evidence-based prevention programs.

b) If no, please explain in the box below.

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. ***Problem Identification and Referral*** that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. ***Community-based Processes*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental Strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Planning

1. Does your state have a strategic plan that addresses substance use primary prevention that was developed within the last five years? ○ Yes ● No

If yes, please attach the plan in BGAS by going to the **Attachments Page** and upload the plan.

2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SUPTRS BG? ● Yes ○ No ○ N/A

3. Does your state's prevention strategic plan include the following components? (check all that apply):

- **a)** ☑ Based on needs assessment datasets the priorities that guide the allocation of SUPTRS BG primary prevention funds
- **b)** ☑ Timelines
- **c)** ☑ Roles and responsibilities
- **d)** ☐ Process indicators
- **e)** ☑ Outcome indicators
- **f)** ☑ Cultural competence component (i.e., National CLAS Standards)
- **g)** ☑ Sustainability component
- **h)** ☑ Other (please list):

Plan is organized according to Five Steps of the SPF.

i) ☐ Not applicable/no prevention strategic plan

4. Does your state have an Advisory Council that provides input into decisions about the use of SUPTRS BG primary prevention funds? ◉ Yes ○ No

5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SUPTRS BG primary prevention funds? ◉ Yes ○ No

   a) If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based

   The SAMHSA Guidance Document on "Identifying and Selecting Evidence-Based Interventions" (January 2009), and SAMHSA's Evidence-Based Practices Resource Center.

6. Does your state have an Advisory Council that provides input into decisions about the use of SUPTRS BG primary prevention funds? ◉ Yes ○ No

7. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SUPTRS BG primary prevention funds? ◉ Yes ○ No

   a) If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based?

   The SAMHSA Guidance Document on "Identifying and Selecting Evidence-Based Interventions" (January 2009), and SAMHSA's Evidence-Based Practices Resource Center.

8. Does your state integrate the National CLAS Standards into the planning step? ◉ Yes ○ No

   a) If yes, please explain in the box below.

   A great deal of thought must be employed in the creation of the appropriate method of acting, doing and processing, to ensure cultural competence in addressing substance abuse in a community. It's important to include results of the Assessment and Capacity steps in developing the culturally competent comprehensive and data driven strategic plan to address the communities needs and/or challenges.

   b) If no, please explain in the box below.

   N/A

9. Does your state integrate sustainability into the planning step? ◉ Yes ○ No

   a) If yes, please explain in the box below.

   When providers and community members enter the planning stage of prevention programming, they must consider what interventions will best fit the needs and culture of the community. When programming meets these needs, sustainability is much more likely to occur.

   b) If no, please explain in the box below.

   N/A

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. ***Problem Identification and Referral*** that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. ***Community-based Processes*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental Strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Implementation

1. States distribute SUPTRS BG primary prevention funds in a variety of different ways. Please check all that apply to your state:

- **a)** ☐ SSA staff directly implements primary prevention programs and strategies.
- **b)** ☑ The SSA has statewide contracts (e.g. statewide needs assessment contract, statewide workforce training contract, statewide media campaign contract).
- **c)** ☐ The SSA funds regional entities that are autonomous in that they issue and manage their own sub-contracts.
- **d)** ☑ The SSA funds regional entities that provide training and technical assistance.
- **e)** ☑ The SSA funds regional entities to provide prevention services.
- **f)** ☐ The SSA funds county, city, or tribal governments to provide prevention services.
- **g)** ☑ The SSA funds community coalitions to provide prevention services.
- **h)** ☑ The SSA funds individual programs that are not part of a larger community effort.
- **i)** ☑ The SSA directly funds other state agency prevention programs.
- **j)** ☑ Other (please describe)

The state is in the process of finalizing a contract with the tribal communities to provide prevention services within their communities.

2. Please list the specific primary prevention programs, practices, and strategies that are funded with SUPTRS BG primary prevention dollars in at least one of the six prevention strategies. Please see the introduction above for definitions of the six strategies:

a) Information Dissemination:

Resource Directories, Health Fairs, Media Campaigns at County Level - Underage Drinking

b) Education:

Strengthening Families, Life Skills, WISE, Positive Parenting, etc.

c) Alternatives:

Drop-In Centers at the Mall, Drug/Alcohol Free Parties and Dances, Community Service Activities

d) Problem Identification and Referral:

Work in middle and high schools to provide education (in lieu of disciplinary action) to students who violate campus tobacco possession or use policies.

e) Community-Based Processes:

Recruitment and Training of Coalition Members, Collaboration with the Governor's Council on Alcoholism and Drug Abuse

f) Environmental:

Regional Coalitions: Work has led to 800+ Policy Changes in NJ
Cops in Shops
Sticker Shock
Server Training

3. Does your state have a process in place to ensure that SUPTRS BG dollars are used only to fund primary prevention services not funded through other means? ◉ Yes ○ No

a) If yes, please describe.

Program Managers conduct quarterly reviews of each funded agency's programs to assure that providers adhere to the program deliverables specified in the agency or coalition’s contract.

4. Does your state integrate National CLAS Standards into the implementation step? ◉ Yes ○ No

a) If yes, please describe in the box below.

Assure that:
• Key documents, brochures, e-mails, websites, manuals, curricula, etc., are available in culturally specific languages and/or literacy levels of the people and communities served?
• Implementation plans, social media and/or social norms campaigns, activities specifically mention and/or display pictures, icons, approaches that are culturally relevant?
• Meeting locations are accessible and welcoming to people from diverse communities, abilities and cultures?

b) If no, please explain in the box below.

5. Does your state integrate sustainability into the implementation step? ◉ Yes ○ No

a) If yes, please describe in the box below.

When implementing evidence-based programming, providers work to monitor their interventions closely, making mindful adaptations as needed, and celebrate successes along the way. This helps to ensure that the interventions become ingrained into the daily processes of the community.

b) If no, please explain in the box below

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. ***Problem Identification and Referral*** that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. ***Community-based Processes*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental Strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Evaluation

1. Does your state have an evaluation plan for substance use primary prevention that was developed within the last five years? ○ Yes ● No

If yes, please attach the plan in BGAS by going to the **Attachments Page** and upload the plan.

2. Does your state's prevention evaluation plan include the following components? (check all that apply):

a) ☑ Establishes methods for monitoring progress towards outcomes, such as targeted benchmarks

b) ☑ Includes evaluation information from sub-recipients

c) ☑ Includes SAMHSA National Outcome Measurement (NOMs) requirements

d) ☑ Establishes a process for providing timely evaluation information to stakeholders

e) ☐ Formalizes processes for incorporating evaluation findings into resource allocation and decision-making

f) ☐ Other (please list:)

g) ☐ Not applicable/no prevention evaluation plan

3. Please check those process measures listed below that your state collects on its SUPTRS BG funded prevention services:

a) ☑ Numbers served

b) [x] Implementation fidelity

c) [x] Participant satisfaction

d) [x] Number of evidence based programs/practices/policies implemented

e) [x] Attendance

f) [x] Demographic information

g) [ ] Other (please describe):

4. Please check those outcome measures listed below that your state collects on its SUPTRS BG funded prevention services:

a) [x] 30-day use of alcohol, tobacco, prescription drugs, etc

b) [x] Heavy use

c) [x] Binge use

d) [x] Perception of harm

e) [x] Disapproval of use

f) [x] Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)

g) [ ] Other (please describe):

5. Does your state integrate the National CLAS Standards into the evaluation step? (•) Yes ( ) No

a) If yes, please explain in the box below.

Foster a welcoming environment. Set an expectation that all members of diverse race, ethnicity, age, language, disability, etc. are invited, welcomed and encouraged to share views, perspectives and discomforts with all phases of the planning process. This ensures buy-in and alignment in the evaluation of an effective culturally competent plan.

b) If no, please explain in the box below.

6. Does your state integrate sustainability into the evaluation step? (•) Yes ( ) No

a) If yes, please describe in the box below.

Honest and open evaluation of prevention programming will help to ensure that changes are being made as needed, community members are all on the same page with modifications that should occur, and all are striving for long-term sustainability.

b) If no, please explain in the box below.

Footnotes:

POMS (Prevention Outcomes Management System) is the web-based system (developed by DMHAS) to collect data from DMHAS-funded providers and coalitions. The system consists of three modules:

• SPF-SIG: in which coalitions report on their activities as they related to the five steps of the Strategic Prevention Framework.

• Environmental: in which coalitions report on environmental approaches that they are using to address DMHAS' prevention priorities. Includes details about activities, dates, number of participants.

• Curriculum-Based: collects demographic and process data about individual and family, curricular programs (i.e., Strengthening Families, LifeSkills) being delivered by DMHAS-funded prevention agencies throughout the state. These data are used when preparing the Block Grant reports and application.

Environmental Factors and Plan

9. Statutory Criterion for MHBG - Required for MHBG

Narrative Question

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental and substance use disorders. Describes available services and resources within a comprehensive system of care, provided with federal, state, and other public and private resources, in order to enable such individual to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Please respond to the following items

Criterion 1

1. Describe available services and resources in order to enable individuals with mental illness, including those with co-occuring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

SMHA funds eight levels of service along the mental health continuum of care with Community Mental Health Block Grant, and other federal or state funds. They are: Prevention and Early Intervention Services, Crisis Stabilization Services < 24 hours, Crisis Stabilization and Diversionary Services > 24 hours, Acute Care Services, Peer Recovery Support, Family Support, Treatment and Rehabilitative Services, and County and State Psychiatric Hospitals. NJ funds four State Psychiatric Hospitals, operated by the Department of Health and partially funds four County Psychiatric Hospitals, operated independently of the state. The SMHA Office of Olmstead, works collaboratively with the state and county hospitals to help integrate patients back into the community.

(1) Prevention and Early Intervention includes Coordinated Specialty Care services and Suicide Prevention. New Jersey has utilized the MHBG 10% set-aside funds for providing service to individuals with first episode psychosis (FEP) since FY 2017 and will increase access to CSC services in FY 2024-2025 by funding up to six CSC programs and six step down programs and expanding the access to CSC to include both FEP and affective psychosis.

(2) Crisis Stabilization Services < 24 hours: 988 Call centers, Mobile Crisis Outreach Response Teams (MCORTS), Crisis Receiving and Stabilization Centers,

(3) Crisis Stabilization and Diversionary Services > 24 hours: Crisis Diversion Homes, Crisis Diversion Beds, Peer Respite Beds, Diversionary Beds,

(4) Acute Care Services. The SMHA funds and regulates a variety of acute mental health care programs for individuals with acute mental health needs and for those experiencing psychiatric crises. They include Designated Screening Centers (DSC), Affiliated Emergency Services (AES), Early Intervention Support Services (EISS), Involuntary Outpatient Commitment (IOC), Intensive Outpatient Treatment and Support Services (IOTSS), and Projects for Assistance in Transition from Homelessness (outreach to persons who are homeless) and Short Term Care Facility (STCF) beds.

(5) Peer Recovery Support.
Extended/ongoing Recovery Supports: Consumer-operated Services including Self-help Centers and Wellness Recovery Centers. There are currently 33 Community Wellness Centers/Self-Help Centers/Recovery Centers throughout the 21 counties of the state funded by DMHAS, including 3 centers located on the grounds of the regional state hospitals.

(6) Family Support.
The SMHA contracts for Intensive Family Support Services (IFSS) and Acute Family Support Programs (AFS).

(7) Treatment and Rehabilitative Supports.
The SMHA contracts for Intermediate and Rehabilitative services including: Intensive Outpatient Treatment Support Services (IOTSS); Project for Assistance in Transition for Homelessness (PATH); Community Support Services (CSS); Residential Services; Supported Employment (SE); Supported Education (SEd); Illness Management and Recovery (IMR); Justice Involved Services (JIS); Integrated Case Management Services (ICMS); Outpatient Services (OP); Partial Care (PC) ; Statewide Clinical Outreach Program for the Elderly (S-COPE) and Legal Services.

(8) State and County Psychiatric hospitals.
State hospitals, county hospitals, Olmstead Initiatives (Validation of Vacancy Tracking Systems; Enhancements to Community Capacity, Continued Utilization of the Intensive Case Review Committee (ICRC), Continued Utilization of Hospital Project Teams, Utilization Management of Statewide Residential Vacancies and Community Referrals, Hospital Diversion Initiative)

2. Does your state coordinate the following services under comprehensive community-based mental health service systems?

a)	Physical Health	(●) Yes ( ) No
b)	Mental Health	(●) Yes ( ) No
c)	Rehabilitation services	(●) Yes ( ) No
d)	Employment services	(●) Yes ( ) No
e)	Housing services	(●) Yes ( ) No
f)	Educational Services	(●) Yes ( ) No
g)	Substance misuse prevention and SUD treatment services	(●) Yes ( ) No
h)	Medical and dental services	(●) Yes ( ) No
i)	Support services	(●) Yes ( ) No
j)	Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA)	(●) Yes ( ) No
k)	Services for persons with co-occuring M/SUDs	(●) Yes ( ) No

Please describe or clarify the services coordinated, as needed (for example, best practices, service needs, concerns, etc.)

The New Jersey's CSC programs for individuals with FEP emphasize a team approach with the following components: outreach, low-dosage medications, cognitive and behavioral skills training, Individualized Placement and Support, Supported Employment and Supported Education, case management, and family psycho-education. Each CSC team is comprised of a Masters level clinical team leader, masters level clinicians, a supported employment and education specialist, a pharmacotherapist, an masters level outreach and referral clinician; and a certified peer support specialist.

PACT is an evidence-based model of service delivery in which a multi-disciplinary, mobile, treatment team provides a comprehensive array of mental health and rehabilitative services to a targeted group of individuals with SMI. The program is designed to meet the needs of consumers, who are at high risk for hospitalization, are high service users and who have not been able to benefit from traditional mental health programs. In order to meet the unique needs of this targeted population, PACT teams offer highly individualized services, employ a low staff to consumer ratio, conduct the majority of their contacts in natural community settings (e.g. consumer's residence) and are available to help individuals address psychiatric crises 24 hours a day. Service intensity is flexible and regularly adjusted to consumer needs.

All New Jersey PATH programs provide outreach, screening and assessment, case management and referral services for community mental health and substance abuse treatment services, financial benefits, primary health services, job training/vocational and educational services and relevant housing services including; emergency housing, transitional housing and permanent housing services.

3. Describe your state's case management services

Consumers are linked to Integrated Case Management Services (ICMS) upon discharge from a state hospital, county hospital or Short Term Care Facility (STCF) for 12 months post-discharge from the inpatient setting. ICMS services work collaboratively with the consumer, their family/significant others (as appropriate) and other collateral contacts to assesses the individual's strengths and needs, develop a service plan based on this assessment, refer and link individuals to needed services and monitor their engagement in services. ICMS services are available for a minimum of 12 months and can be extended beyond 12 months pursuant to the individual's specific needs.

In addition, PACT, PATH, and CSC programs also provide case management services.

4. Describe activities intended to reduce hospitalizations and hospital stays.

The Division of Mental Health and Addiction Services (DMHAS) is in the process of revising Administrative Bulletin 5:11 in an effort to reduce hospital length of stay. Under this bulletin, person receiving services in state psychiatric hospitals are assigned to community service providers whom have the option of either accepting the persons receiving services or requesting additional supports from DMHAS. In addition to community providers, state psychiatric hospitals have the option within their discharge planning process of collaborating with community service providers to request additional supports for the person receiving services in their potential new living situations outside the institutions. Such requests and other efforts toward successful discharge are to be documented within the Individual Needs for Discharge Assessment (INDA). Assignments are based on hospital treatment team recommendations as well as persons receiving services choice, and the assigned provider is expected to participate in every treatment team meeting from the person receiving services first to his/her last while in the hospital. The early involvement of community providers in the treatment planning process fosters familiarity between provider and person receiving services, allowing for immediate planning on the part of the provider to prepare to meet the individualized needs of each person receiving services upon discharge into their care. This preparation is critical to ensuring that the person receiving services is provided with necessary community supports and thereby maximizing his/her chances of sustained integration within the community. It is born

out of high-level interagency collaboration. Proposed revisions to the AB 5.11 aim to further strengthen the collaborative discharge planning process between the community providers and state psychiatric treatment teams with more clearly defined expectations of the outcomes during the initial team meeting of an assignment and for enhanced oversight of assignments with significant clinical concerns and discharge barriers.

As part of its Home to Recovery II Plan, DMHAS focused its efforts on enhancing community-based resources available to its person receiving services. One such enhancement was the implementation of Community Support Services (CSS). A Medicaid rehabilitative service, CSS offers education to person receiving services in the community on navigating daily activities, rather than performing these activities on their behalf. The goal of these services is to nurture independence and self-reliance on the part of the person receiving services, empowering them to thrive as functional and competent members of a community outside of an institutional setting.

DMHAS has enhanced its Supported Employment services to include an in-reach pilot within the three regional state hospitals. Implemented in July 2015, this pilot program targets individuals who are ready for discharge and examines their interest in competitive employment outside the hospital. This in-reach is supplemental to the Division’s existing Supported Employment services, which are available in each of New Jersey’s 21 counties. Supported Employment services include assistance accessing benefits counseling; identification of occupational skills and interests; and the development and implementation of a job search plan based on the consumer’s strengths, interests, needs, and abilities. The ultimate goal for person receiving services receiving Supported Employment services is to obtain meaningful and competitive employment as a means of further ensuring sustained integration within the community. According to the SMHA’s Quarterly Contract Monitoring Report (QCMR) database, updated numbers show 53% of person receiving services referred from state psychiatric hospitals were accepted into Supported Employment during SFY 2020. In SFY 2023, data indicates 58% acceptance rate of person receiving services referred to Supported Employment from state psychiatric hospitals.

The Home to Recovery II Plan includes outcomes geared toward monitoring sustainability of the Division's community integration efforts. These outcomes include, but are not limited to enhanced utilization of Supportive Housing, expansion of CSS opportunities, a reduction in census; fewer admissions to state hospitals; and a decrease in the number of individuals on CEPP. The average state hospital census for the 4 regional state hospitals in SFY 2008 (year of the settlement agreement) was 2,051, there was an average of 2,763 admissions per year, and the CEPP census on 6/30/2008 was 938. The percentage of individuals on CEPP of the total census was 50.05% on 6/30/2008. Additionally, there were four regional hospitals, Hagedorn Psychiatric Hospital closed in SFY 2012. The average state hospital census for the three regional state hospital in SFY 2022 was 960 (a decrease of 53% from 2008), there was an average of 706 admissions (decrease of 74% from 2008), and the CEPP census on 6/30/22 was 273 (decrease of 70.9% from 2008). The percentage of individuals on CEPP of the total census was 27.94% on 6/30/2022 (decrease of 44.2% from 2008). In SFY 2008, there were 3,051 individuals receiving services in supportive housing. In 2022, there were 5,658 individuals served by CSS. The average state hospital census for the three regional state hospital in SFY 2023 was 964 (a decrease of 53% from 2008), there were an average of 563 admissions (decrease of 79.62% from 2008), and the CEPP census on 6/30/23 was 244 (decrease of 74% from 2008).

Vacancy Tracking Systems. The Bed Enrollment Data System (BEDS) was developed in 2013 for the furtherance of deliverables to the Olmstead lawsuit settlement agreement with Disability Rights NJ to facilitate the communication of accurate information between state hospitals and community residential providers regarding bed needs and available housing inventory. The system has replaced the process of cold calls to agencies and the utilization of quickly outdated paper tracking sheets. In the Spring of 2021 BEDS was updated to contain many functional improvements, including streamlined search features, and the addition of short-term care facility (STCF) beds, to give the SMHA a better view of the acute care system.

Most recently, BEDS has been used in conjunction with the Provider Weekly Report (PWR) and housing subsidy lists to give the SMHA a more complete picture of community-based housing resources and utilization. The Provider Weekly Report (PWR) is a data reporting protocol where over 73 different community based residential programs submit detailed data on: current housing capacity, vacancies, assignments, and updates on placements on a weekly basis. This data is compiled on a weekly basis to give the SMHA a more complete, and timely picture on the housing landscape—as it is self-reported by the contracted agencies themselves and provides information on the status of the referrals, barriers, delays, etc. The PWR provides capacity data, vacancy information, referral tracking, monitoring tool, and a communication tool. DMHAS provider submission rate for the PWR reports averages 95-98% compliance in weekly submission of the data to the OPREPO office.

Beginning in 2023, DMHAS will be utilizing Covid Supplemental and ARPA funding to procure a web-based electronic referral system and crisis management module. The crisis management module expedites access to assessment and treatment for those in crisis, tracks their journey from crisis call to treatment, and coordinates all stakeholders’ information within a crisis management system. The crisis module, combined with the vacancy treatment and referral system, supports collaboration between the state, law enforcement organizations, local community organizations, faith-based organizations, and other behavioral health stakeholders in their efforts to ensure the integrated delivery of culturally competent, evidence-based, and family-centered services. The system provides a real-time connection between crisis call center professionals, crisis response teams, and treatment providers.

Enhancements to Community Capacity. From 2010 through 2014, DMHAS was charged with the creation of 695 beds expressly for the community placement of person receiving services on CEPP status in the regional state hospitals and 370 beds to be created for person receiving services who are already in the community and at high-risk for hospitalization and/or homelessness. This equates to a total of 1,065 placements to be created over the five-year period covered by the settlement. The SMHA met and exceeded this goal, creating 1,436 new placements. Of these, 941 were set aside for the discharge of CEPP person receiving

services from state hospitals (exceeding the settlement target of 695 by 246 or 35%), and 495 were reserved for person receiving services at risk of hospitalization (exceeding the target of 370 by 125 or 33.78%). In total, the SMHA exceeded its targets for placement creation by 34.83%, which amounts to 371 placements above its required deliverable. The Division continued creating new placements for these targeted populations, reaching a total of 1,808 new placements by the end of SFY 2016, with 1,274 reserved for CEPP discharges and 534 set aside for person receiving services at risk of hospitalization. There were 900 number of new placements created from SFY2017 to SFY2023. This would also include recycled subsidies and multiple re issuance of subsidies. DMHAS will be funding 150 new subsidies in 2024.

Continued Utilization of the Intensive Case Review Committee (ICRC). All individuals receiving services in the state hospital are reviewed by ICRC once every month to ensure that consumer assignments have been made in preparation for discharge in a timely manner, barriers to discharge are addressed, systemic issues are addressed, and compliance with length of stay targets are maintained. The purpose of these meeting is to develop strategies for resolution of barriers and systems issues.

Continued Utilization of Hospital Project Teams. Project Team meetings are higher-level meetings that occur immediately after ICRC and are typically chaired by the hospital CEO/DCEO or Medical Director. Follow-up on systems raised by ICRC and discussion of resolution strategies are discussed. In addition, policy or systems that may involve collaboration with another Division or state Department, are discussed at these meetings and elevated to Olmstead leadership to address. Olmstead staff also use these meetings to update the hospital leadership on any new administrative bulletins, requests for proposals, updates or changes to the vacancy tracking system, and/or trends identified in the data.

Utilization Management of Statewide Residential Vacancies and Community Referrals: Meetings are held three times weekly between the Olmstead Unit staff and State Psychiatric Hospital Placement Entities to review residential vacancies and community referral requests. This frequent communication promotes efficiency in filling residential vacancies and managing the various requests for housing from Centralized Admissions, STCFs, and other entities who submit requests for DMHAS housing.

Hospital Diversion Initiative. The Olmstead Office has worked collaboratively with Centralized Admissions within the state psychiatric hospitals on a process for providing diversionary activities for individuals that do not meet criteria for commitment to the state hospital and are in need of less restrictive community settings. Regional Olmstead staff assist Centralized Admissions in securing additional supports needed for applicable persons receiving services as a means of addressing their individualized circumstances and needs in the most integrated setting possible within their required level of care. This collaboration allows for reduced hospital census as well as enhanced community re-integration of persons receiving services.

Please indicate areas of technical assistance needed related to this section.

NJ will begin receiving technical assistance for Coordinated Specialty Care (CSC), Crisis Receiving Stabilization Centers, and Olmstead/Nursing Home Diversion in FFY23. DMHAS will continue to need technical assistance for CSC, CRSC, Olmstead/Diversion, Crisis Diversion, Development and Implementation of the crisis continuum. The SMHA also seeks technical assistance for DMHAS providers including training, implementation and reporting outcomes of evidence-based practices.

Criterion 2: Mental Health System Data Epidemiology

Contains an estimate of the incidence and prevalence in the state of SMI among adults and SED among children; and have quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

Criterion 2

In order to complete column B of the table, please use the most recent SAMHSA prevalence estimate or other federal/state data that describes the populations of focus.

Column C requires that the state indicate the expected incidence rate of individuals with SMI/SED who may require services in the state's M/SUD system.

MHBG Estimate of statewide prevalence and incidence rates of individuals with SMI/SED

Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1.Adults with SMI	392,858	n/a
2.Children with SED	159,404	n/a

Describe the process by which your state calculates prevalence and incidence rates and provide an explanation as to how this information is used for planning purposes. If your state does not calculate these rates, but obtains them from another source, please describe. If your state does not use prevalence and incidence rates for planning purposes, indicate how system planning occurs in their absence.

The SMHA uses a combination of methods for planning purposes including federal prevalence methodology, state needs assessment, and data from various systems such as NJ State Health Assessment Data from the New Jersey Department of Health. Other data include those from the National Survey of Drug and Health, Quarterly Contract Monitoring Reports, the Systems Review Committee data and the URS data.

New Jersey currently uses the federal definition of SED and SMI: Children with SED refers to persons from birth to age 18 and adults with SMI refers to persons age 18 and over; who (1) currently meet or at any time during the past year has met criteria for a mental disorder – including within developmental and cultural contexts – as specified within a recognized diagnostic classification system (e.g., most recent editions of DSM, ICD, etc.), and (2) display functional impairment, as determined by a standardized measure that impedes progress towards recovery and substantially interferes with or limits the person's role or functioning in family, school, employment, relationships, or community activities.

Prevalence:
According to the Federal methodology proposed for estimating the prevalence of SMI, the proportion of adults within the state with a SMI is 5.4% (Federal Register, Volume 64, No. 121, p. 33890). According to figures released by the United States Census Bureau, the 2022 adult population of New Jersey was 7,275,144. The size of the New Jersey child population was 1,992,555. Using the SAMHSA's SMI prevalence rate among persons 18 and older (5.4%) the estimated number of adults with SMI in New Jersey in 2022 was 392,858. Using the upper SMI limit of 7.1%, the estimated number of adults with SMI in New Jersey in 2020 was 516,535. Accordingly, using the lower SMI limit of 3.7%, the estimated number of SMI adults in New Jersey in 2022 was 269,180.

Using the SAMHSA's SED prevalence rate (8.0%), the estimated number of children with SED in New Jersey in 2022 was 159,404.

Please indicate areas of technical assistance needed related to this section.

• SAMHSA Requirements and Reporting
• Block grant training for new staff
• Reporting client level data
• MH TEDS data
• Utilization of URS data for planning
• Accessing and use of Medicaid data and including Medicaid data in URS reporting
• Exploration of other state models and their use of client level data
• NJ DMHAS is looking for TA on best practices related to client level data (CLD) systems. We are interested in topics such as: 1. What do some well-functioning CLDs look like? 2. "Lessons learned" from statewide rollouts. 3. "Cautionary tales" about issues states have with implementing new CLDs. 4. How are states making best use of CLD? 5. How are states developing a unique client ID 6. How are states developing a unique provider and site ID 7. How are states dealing with the issue of submitting CLD data timely so that discharges are entered when a person is discharged and it does not back up another agency from entering an admission into another program as the system is showing that the person is still admitted somewhere else.

Criterion 3

Provides for a system of integrated services in order for children to receive care for their multiple needs. Does your state integrate the following services into a comprehensive system of care*?

a)	Social Services	◉ Yes	○ No
b)	Educational services, including services provided under IDEA	◉ Yes	○ No
c)	Juvenile justice services	◉ Yes	○ No
d)	Substance misuse preventiion and SUD treatment services	◉ Yes	○ No
e)	Health and mental health services	◉ Yes	○ No
f)	Establishes defined geographic area for the provision of services of such systems	◉ Yes	○ No

Please indicate areas of technical assistance needed related to this section.

None needed.

**A system of care is: A spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life.*
https://gucchd.georgetown.edu/products/Toolkit_SOC_Resource1.pdf

Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults
Provides outreach to and services for individuals who experience homelessness; community-based services to individuals in rural areas; and community-based services to older adults.

Criterion 4

a. Describe your state's targeted services to rural population. **See SAMHSA's Rural Behavioral Health page for program resources**

The SMHA defines a county as "rural" if, according to U.S. Census figures, 25% or more of its population lived in rural areas. Using this definition, New Jersey does not have any rural counties. Since there are no federally recognized rural areas in New Jersey, the Office of Rural Health Policy's Rural-Urban Community Area (RUCA) definition was utilized.

Community-based services for rural populations were enhanced and expanded by Block grant funding and other federal grants. In December, 2016 New Jersey was selected as one of eight states from the Substance Abuse and Mental Health Administration (SAMHSA), Center for Mental Health Services (CMHS) to participate in a two-year Certified Community Behavioral Health Center (CCBHC) demonstration program. The program was funded as part of a comprehensive effort to bring behavioral health care in parity with physical health care and to improve community behavioral health services overall as part of the Protecting Access to Medicare Act of 2014 (PAMA, § 223).

New Jersey selected seven CCBHCs in six counties, including six CCBHCs in five metropolitan counties plus AtlantiCare in Hammonton, a rural underserved pocket of Atlantic County. The CCBHCs offer services within an integrative, holistic framework, thereby closing a treatment gap that frequently results in inadequate service provision for individuals with co-existing social, physical and behavioral health care needs. New Jersey's CCBHCs offer 24-hour crisis care, treatment for co-occurring substance use disorder and mental illness, ambulatory and medical withdrawal management, evidence-based outpatient counseling, case management, and family support services. CCBHC populations of focus include individuals with serious mental illness (SMI), those with severe substance use disorders (SUD), children and adolescents with serious emotional disturbance (SED), former or current military personnel experiencing Post Traumatic Stress Disorder (PTSD), and youth and adults with physical health risk factors and/or mental health diagnoses such as anxiety and depressive disorders other than Major Depressive Disorder who are not already covered in the target population.

Atlanicare's CCBHC has served an increasing number of clients through the CCBHC Demonstration Project, the numbers are below:

Demonstration Year Numbers Served in the CCBHC
Year 1 575
Year 2 549
Year 3 479
Year 4 772

AtlantiCare has also Demonstrated success in the very important performance metric on time to care. Atlanticare was above average in both percentage of clients seen within 10 days of initial contact as well as average days from first contact to evaluation in DY4.

Atlanticare provides significant amounts of case management services. 95% of AtlantiCare CCBHC consumers received case management in Demonstration Year 4 which spanned the time period July 1, 2020 to June 30, 2021 up from 84% in Demonstration Year 3 which spanned the time period July 1, 2019 to June 30, 2020.

The CCBHC Demonstration Program is scheduled to end on September 2025. The state is currently pursuing plans to sustain the program through Medicaid.

b. Describe your state's targeted services to people experiencing homelessness. **See SAMHSA's Homeless Programs and Resources for program resources**

SMHA operates Projects for Assistance in Transition from Homelessness (PATH) program using a combination of federal and state funds. The target population is homeless adults or those at risk of homelessness who have a serious mental illness, including those with co-occurring substance use disorders who are not currently engaged in and are resistant to mental health and other community support services.

All New Jersey PATH programs provide outreach, screening and assessment, case management and referral services for community mental health and substance abuse treatment services, financial benefits, primary health services, job training/vocational and educational services and relevant housing services including; emergency housing, transitional housing and permanent housing services. A limited number of PATH programs also provide some of the following services directly; security deposits and payment of back rent, mental health assessment and treatment, representative payee services and staff training. Recovery, community integration and housing stability are the long-term goals of the program, achieved through client-centered treatment planning.

The SMHA contracts with 25 non-profit agencies to operate PATH programs within the state's 21 counties. A small number of PATH programs use PATH funding to directly provide psychiatric assessment and outpatient mental health services. Many PATH providers are Community Mental Health Centers and link their consumers to mental health in their agency outpatient or partial care programs. All PATH programs link individuals to behavioral health and co-occurring services within their communities.

In SFY 2022, the PATH programs in New Jersey provided outreach to 2,561 individuals and served a total of 3,629 persons. 637 program participants were linked to mental health services, 101 to substance use treatment services, 236 to primary health/dental care, 301 to financial

services, 266 to temporary housing/shelter, 296 to long term housing and 107 were linked to employment or vocational and educational services.

Services provided under the CCBHC initiative are available to all who meet programmatic criteria without regard for race, ethnicity, age, gender identity, sexual orientation, religious affiliation, or place of residence. Policies such as "no wrong door" allows any consumer access to CCBHC services regardless of insurance or pay status, place of residence, or lack of a permanent address. An average of three percent of CCBHC consumers at each CCBHC provider reported being homeless or living in a shelter during Demonstration Year 1. The two CCBHCs located in Trenton, Oaks Integrated and Catholic Charities, served the highest homeless populations at 10 percent and five percent, respectively.

In 2019, SMHA has created approximately 50 At-Risk Tenant Based Rental Subsidies for individuals with mental illness intended to promote: housing stability; engagement with mental health services and primary healthcare; community inclusion and wellness and recovery.

c. Describe your state's targeted services to the older adult population. **See SAMHSA's Resources for Older Adults webpage for resources.**

Statewide Clinical Outreach Program for the Elderly (S-COPE) provides a multidisciplinary treatment team approach to address the statewide crisis needs of older adults with SMI. In 2011, DMHAS saw a need to develop specialized services to assist screening centers and nursing homes to respond to an increasing number of older adults with behavioral problems. In 2012, DMHAS awarded a contract for the development of a program to provide specialized clinical consultation, assessment, treatment and intervention to older adults who were at risk for presentation to ERs for psychiatric hospitalization. Trinitas Regional Medical Center in Elizabeth, New Jersey was the recipient and has been administering this Statewide Clinical Outreach Program for the Elderly (S-COPE), which is fully funded by DMHAS and has been in operation since April 2012.

S-COPE provides crisis intervention and stabilization, consultation, and training for the management of mental health and behavioral health issues in older adults (55+) residing in nursing homes and State-funded residential care facilities. S-COPE functions as a multidisciplinary team consisting of a geriatric psychiatrist (consultant), a gero-psychologist, geriatric advanced practice nurse, and masters level clinicians. Outcomes are carefully monitored and reported to DMHAS on a monthly basis.

The S-COPE program is available 24 hours/7 day a week to offer face-to-face clinical consultative services. S-COPE staff also provide training and technical assistance to screeners, administrators, clinical staff, direct care staff and support staff, primarily in nursing facilities to improve staff's ability to assess, provide treatment, manage behavioral disturbances and stabilize crises for this population. The multidisciplinary clinical team advocates for acute care treatment of older adults who need psychiatric hospitalization and advocates within the facility for management of behavioral issues for individuals who would not benefit from inpatient psychiatric stays.

Prior to S-COPE's inception, individuals with dementia were more likely to be referred to mental health crisis screening centers and emergency rooms, and many were subsequently being admitted to inpatient psychiatric facilities, including state psychiatric hospitals. In 2018, there were 921 referrals to S-COPE and 189 were diverted from screening centers. There were 1,532 face to face visits conducted and 2,770 phone consultations. S-COPE continues to provide support in maintaining clients in facilities by closely working with nursing staff. With S-COPE involvement, at least 12 individuals have been diverted from state hospitals. S-COPE equips staff by sharing best practices and offering trainings. All trainings, assessments, and treatments offered are consistent with promising practices and/or evidence-based practices.

Trainings are delivered by S-COPE interdisciplinary team members consisting of Master level clinicians, Advanced Practice Nurse, Psychiatrist, Psychologist, and/or Licensed Clinical Social Workers. Trainings are conducted on-site at facilities, via ECHO on ZOOM platform, and at regional locations. In 2018, there were 177 trainings completed to over 2,300 people. There were 75 trainings completed in northern region, 47 trainings in the central region, and 55 trainings completed in the southern region. Trainings are open to all professionals including, but not limited to, Social Workers, Nurses, Psychiatrist, CNAs, and other professionals. In 2018, S-COPE exceeded the training contracted goals and it continues to find innovative ways to deliver evidence based trainings.

S-COPE ensures that the program is culturally and linguistically competent, accessible, and responsive to agencies, consumers and families. The older adult mental health service system in New Jersey does not discriminate with regard to diverse racial, ethnic and sexual /gender minorities.

Please indicate areas of technical assistance needed related to this section.

DMHAS is seeking technical assistance for our Olmstead/Diversion management team and staff regarding community re-integration and diversionary strategies for older adults with an SMI as well as an SMI and co-occurring SUD or medical comorbidities, followed by trainings for our community providers based upon an evidence based practices.

Criterion 5: Management Systems

States describe their financial resources, staffing, and training for mental health services providers necessary for the plan; provides for training of providers of emergency health services regarding SMI and SED; and how the state intends to expend this grant for the fiscal years involved.

Telehealth is a mode of service delivery that has been used in clinical settings for over 60 years and empirically studied for just over 20 years. Telehealth is not an intervention itself, but rather a mode of delivering services. This mode of service delivery increases access to screening, assessment, treatment, recovery supports, crisis support, and medication management across diverse behavioral health and primary care settings. Practitioners can offer telehealth through synchronous and asynchronous methods. A priority topic for SAMHSA is increasing access to treatment for SMI and SUD using telehealth modalities. Telehealth is the use of telecommunication technologies and electronic information to provide care and facilitate client-provider interactions. Practitioners can use telehealth with a hybrid approach for increased flexibility. For instance, a client can receive both in-person and telehealth visits throughout their treatment process depending on their needs and preferences. Telehealth methods can be implemented during public health emergencies (e.g., pandemics, infectious disease outbreaks, wildfires, flooding, tornadoes, hurricanes) to extend networks of providers (e.g., tapping into out-of-state providers to increase capacity). They can also expand capacity to provide direct client care when in-person, face-to-face interactions are not possible due to geographic barriers or a lack of providers or treatments in a given area. However, implementation of telehealth methods should not be reserved for emergencies or to serve as a bridge between providers and rural or underserved areas. Telehealth can be integrated into an organization's standard practices, providing low-barrier pathways for clients and providers to connect to and assess treatment needs, create treatment plans, initiate treatment, and provide long-term continuity of care. States are encouraged to access, the SAMHSA Evidence Based Resource Guide, **Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders**.

Criterion 5

a. Describe your state's management systems.

The DMHAS is dedicated to community--based mental health services and is advancing community supports for individuals no longer in need of hospital based psychiatric treatment and those at risk of hospitalization. The DMHAS coordinates with community-based providers to administer behavioral health services, including prevention and early intervention, screening services, outpatient counseling, partial and day treatment services, case management, residential and supported housing, family support, self—help centers and supported employment. In SFY 2023, State appropriations for mental health community providers were $440 million. A significant source of the increase has been the State's investment in the Olmstead – Home to Recovery Initiative, which has primarily provided funding for supportive housing placements for clients discharged from state hospitals, as well as for clients at risk of hospitalization. Additionally, DMHAS is now over six years into the transition of moving select community based mental health services from cost-reimbursement contracts to fee-for-service contracts, also known as the Mental Health Fee-for-Service Program (MH-FFS Program). This transition, which began January 1, 2017, represented an historic transformation for the New Jersey public mental health system. The State has transitioned providers and clients to Fee for Service reimbursement, and away from fixed cost or overall cost reimbursement contracts. Concurrent with this, reimbursement rates were enhanced for many services and additional state funding (roughly $20 million) was appropriated for this purpose. Further, DMHAS received $27 million of additional annualized State funding to increase rates and cost-based contract ceilings during SFY23. The proposed SFY 24 Governor's Budget also reflects an incremental annualized $27 million of growth for this purpose ($6.3 million of which would be house in the Division of Medical Assistance and Health Services/Medicaid, with the rest to DMHAS.) DMHAS believes that the combination of more attractive Medicaid rates and the transition to a direct Fee for Service reimbursement approach for non-Medicaid services (with enhanced rates), will lead to greater access for clients and a more transparent, accountable and efficient behavioral health service delivery system. DMHAS continues its commitment to consumers and providers, by ensuring reimbursement opportunities to providers when staff resources are deployed. DMHAS reimburses MH FFS contracted providers for non-Medicaid covered services. This reimbursement accomplishes 2 important things: 1. these ancillary but critical services support consumers' community tenure and 2. it incentivizes the provision of services.

As part of its remaining cost reimbursement contract base, DMHAS continues to fund training and technical assistance that many community providers are able to access. The total contracted amount for SFY 2023 was approximately $5.7 million. In addition, DMHAS hosts regular meetings and webinars that served as training opportunities for the provider community. DMHAS staff deliver these trainings, which are funded by our State General Fund appropriations.

Goals

While New Jersey currently has cost-based contracts and Fee for Service arrangements with approximately 116 unduplicated agencies that provide eligible Block Grant services, to facilitate reporting, administration and minimize the audit burden on our providers, DMHAS has allocated the available Block Grant funding to a selected group of approximately 24 provider agencies. This group of agencies and the amounts allocated to each have been revised over the years to reflect changes in Block Grant requirements, funding and service levels, changes in the agencies' service programs due to mergers, name changes, and other reasons. In order to ensure that we are in compliance with the requirement to expend such funds only for services to adults with SMI and children with SED, DMHAS first reviews data on consumers served by each of the selected agencies' contracts to identify the percentage of total consumers receiving services who are either adults with SMI or children with SED. Based on these results, we calculate the portion of each agency's total contract ceiling that represents Block Grant eligible costs. The result of this calculation yields a total pool of eligible costs, just for the above noted selected group of agencies, of about $42 million for state fiscal year 2022 (FY23 data unavailable until August of 2023). Consequently, the Block Grant funding for contracted services is then

allocated to each of the agencies in the selected group, based on the relative percentage of their eligible costs to the total eligible costs of all agencies in the group.

Telehealth is a mode of service delivery that has been used in clinical settings for over 60 years and empirically studied for just over 20 years. Telehealth is not an intervention itself, but rather a mode of delivering services. This mode of service delivery increases access to screening, assessment, treatment, recovery supports, crisis support, and medication management across diverse behavioral health and primary care settings. Practitioners can offer telehealth through synchronous and asynchronous methods. A priority topic for SAMHSA is increasing access to treatment for SMI and SUD using telehealth modalities. Telehealth is the use of telecommunication technologies and electronic information to provide care and facilitate client-provider interactions. Practitioners can use telehealth with a hybrid approach for increased flexibility. For instance, a client can receive both in-person and telehealth visits throughout their treatment process depending on their needs and preferences. Telehealth methods can be implemented during public health emergencies (e.g., pandemics, infectious disease outbreaks, wildfires, flooding, tornadoes, hurricanes) to extend networks of providers (e.g., tapping into out-of-state providers to increase capacity). They can also expand capacity to provide direct client care when in-person, face-to-face interactions are not possible due to geographic barriers or a lack of providers or treatments in a given area. However, implementation of telehealth methods should not be reserved for emergencies or to serve as a bridge between providers and rural or underserved areas. Telehealth can be integrated into an organization's standard practices, providing low-barrier pathways for clients and providers to connect to and assess treatment needs, create treatment plans, initiate treatment, and provide long-term continuity of care. States are encouraged to access, the SAMHSA Evidence Based Resource Guide, Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders.

b. Describe your state's current telehealth capabilities, how your state uses telehealth modalities to treat individuals with SMI/SED, and any plans/initiatives to expand its use.

The state has full capability to use telehealth to provide services, including for individuals with SMI/SED. Outpatient mental health providers and licensed mental health practitioners continue to utilize telehealth as an option in the provision of services, as a result of the flexibilities allowed for telehealth by state and federal regulations in response to the COVID-19 pandemic and the Public Health Emergency (PHE). The state's temporary rules have relaxed requirements regarding which technologies could be used to provide telehealth services, who may provide telehealth services, how the services are paid for, and where practitioners and patients may be located when the services are provided. A critical stipulation is that the telehealth services must be performed to the same standard of care as if the services were rendered in person.

The state is complying with changes in the federal requirements, as some federal telehealth relaxations ended on May 11, 2023, when the PHE ended. However, other relaxations have remained in place. Thus, HIPAA rules are back into full effect, as the Office of Civil Rights (OCR) ended its previous relaxation of penalties for HIPAA violations against health care practitioners when providing telehealth in good faith while using non-public facing audio or video communication products, such as, Zoom or Skype, as well as smart phones and other devises. It is too soon to determine if the end of this capability will affect those with SMI or SED. Meanwhile, SAMHSA and the DEA have specifically extended some of the flexibilities for medication assisted treatment for opioid use disorder because of the critical need to treat individuals with co-occurring disorders ongoing in the opioid crisis.

The state has also passed legislation that has extended the requirements adopted at the outset of the pandemic that Medicaid and health benefits plans reimburse health care providers for telehealth and telemedicine services at the same rate as in-person services, with limited exceptions. This will be helpful for those with commercial insurance. At the same time, the legislation charged the NJ Department of Health with conducting an in-depth study of the outcomes resulting from these changes.

Feedback from outpatient behavioral health providers suggests widespread satisfaction with the expansion of telehealth services, since it is an efficient way of providing services during a period when the programs are having significant staffing shortages. They do not believe that such use has had adverse effects on the quality of care, and believe that they can actually monitor individuals with SMI and SED who are at risk of relapse, as the technology provides real-time information about their clinical status. Providing telephone support and remote telemonitoring can also lead to improvements in medication adherence.

Please indicate areas of technical assistance needed related to this section.

No technical assistance is needed at this time, but the state would welcome input about policy, research, and practice standards that would assist it with providing telehealth services to individuals with SMI.

Footnotes:

The SMHA does not have the capability to collect the state incidence of SMI with its current USTF data system. The SMHA can explore the possibility of collecting this data with the new USTF+ data system in future phases and with technical assistance.

10. Substance Use Disorder Treatment - Required SUPTRS BG

Narrative Question

Criterion 1: Prevention and Treatment Services - Improving Access and Maintaining a Continuum of Services to Meet State Needs

Criterion 1

Improving access to treatment services

1. Does your state provide:

a) A full continuum of services

i)	Screening	(•) Yes ( ) No
ii)	Education	(•) Yes ( ) No
iii)	Brief Intervention	(•) Yes ( ) No
iv)	Assessment	(•) Yes ( ) No
v)	Detox (inpatient/residential)	(•) Yes ( ) No
vi)	Outpatient	(•) Yes ( ) No
vii)	Intensive Outpatient	(•) Yes ( ) No
viii)	Inpatient/Residential	(•) Yes ( ) No
ix)	Aftercare; Recovery support	(•) Yes ( ) No

b) Services for special populations:

i)	Prioritized services for veterans?	(•) Yes ( ) No
ii)	Adolescents?	(•) Yes ( ) No
iii)	Older Adults?	(•) Yes ( ) No

Criterion 2

Criterion 3

1. Does your state meet the performance requirement to establish and/or maintain new programs or expand programs to ensure treatment availability? ◉ Yes ○ No

2. Does your state make prenatal care available to PWWDC receiving services, either directly or through an arrangement with public or private nonprofit entities? ◉ Yes ○ No

3. Have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care? ◉ Yes ○ No

4. Does your state have an arrangement for ensuring the provision of required supportive services? ◉ Yes ○ No

5 Has your state identified a need for any of the following:

- **a)** Open assessment and intake scheduling ◉ Yes ○ No
- **b)** Establishment of an electronic system to identify available treatment slots ◉ Yes ○ No
- **c)** Expanded community network for supportive services and healthcare ◉ Yes ○ No
- **d)** Inclusion of recovery support services ◉ Yes ○ No
- **e)** Health navigators to assist clients with community linkages ◉ Yes ○ No
- **f)** Expanded capability for family services, relationship restoration, and custody issues? ◉ Yes ○ No
- **g)** Providing employment assistance ◉ Yes ○ No
- **h)** Providing transportation to and from services ◉ Yes ○ No
- **i)** Educational assistance ◉ Yes ○ No

6. States are required to monitor program compliance related to activities and services for PWWDC. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

The Division of Mental Health and Addiction Services (DMHAS) Monitoring Unit's Program Management Officers (PMO) conduct annual site visits to the women's set aside funded licensed substance use disorder treatment providers. The DMHAS Women's Treatment Coordinator (WTC) is invited to attend the annual site visits. The Annual Site Monitoring Report has questions specific to Specialized Services. The PMO provides a copy of the Annual Site Monitoring Report findings to the WTC. If a women's set aside funded provider is in noncompliance, a plan of correction (PoC) is required, and the PMO provides a copy of the PoC to the WTC on the status of the findings. The Monitoring Unit's PMO and DMHAS WTC will reach out to the provider if there continue to be areas of concern. The WTC will provide technical assistance in an effort to address areas of concern. Additionally, DMHAS holds monthly contract coordinating meetings to discuss any new or ongoing issues and concerns across all DMHAS units.

The DMHAS grants monitoring program monitor Substance Use Block Grant (SUBG) recipients. Onsite visits are made to each SUBG Block Grant recipient a minimum of one time per calendar year. More frequent reviews are conducted on an as needed basis for agencies recommended by the contract coordination meeting for additional technical assistance or monitoring because of violations, other deficiencies, or special grant requirements. The contract coordination meeting includes representatives from the Monitoring, Prevention, Fiscal and Treatment program units within DMHAS.

Site visits may be anywhere from one to five days in duration depending on the size and scope of the program. The reviewer conducts chart reviews for the selected sample and completes an Annual Site Monitoring Report. The Annual Site Monitoring Report addresses at a minimum five core areas of performance: facility, staff, treatment records, quality assurance, specialized services, and other contract requirements. A site visit report is submitted to the agency and a PoC is required for areas found to be in noncompliance. Agenices are notified in writing of the acceptance or non- acceptance of the plan of correction and the monitoring staff continues to follow up until an acceptable plan of correction is submitted. Agencies who continue to submit an unacceptable plan of correction are referred to the contract monitoring meeting for further action.

In addition to routine monitoring, a contract coordination meeting is held monthly to discuss issues such as outstanding PoCs, agencies needing technical assistance and other program concerns including underutilization. The contract coordination meeting includes representatives from the Monitoring, Prevention, Fiscal and Treatment program units within DMHAS.

Criterion 4,5&6

Persons Who Inject Drugs (PWID)

1. Does your state fulfill the:

		Yes	No
a)	90 percent capacity reporting requirement	●	○
b)	14-120 day performance requirement with provision of interim services	●	○
c)	Outreach activities	●	○
d)	Syringe services programs, if applicable	●	○
e)	Monitoring requirements as outlined in the authorizing statute and implementing regulation	●	○

2. Has your state identified a need for any of the following:

		Yes	No
a)	Electronic system with alert when 90 percent capacity is reached	○	●
b)	Automatic reminder system associated with 14-120 day performance requirement	○	●
c)	Use of peer recovery supports to maintain contact and support	●	○
d)	Service expansion to specific populations (e.g., military families, veterans, adolescents, LGBTQI+, older adults)?	●	○

3. States are required to monitor program compliance related to activites and services for PWID. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

DMHAS requires licensed SUD treatment agencies to submit their Interim Services Policies.

DMHAS requires contracted SUD treatment agencies to submit monthly rosters.

DMHAS requires that treatment agencies provide timely reporting on the Service Capacity Management System (SCMS) that is reported to Rutgers University Behavioral Health Care (UBHC), the entity that operates the Interim Managing Entity (IME) Addictions Access Center.

Tuberculosis (TB)

		Yes	No
1.	Does your state currently maintain an agreement, either directly or through arrangements with other public and nonprofit private entities to make available tuberculosis services to individuals receiving SUD treatment and to monitor the service delivery?	●	○

2. Has your state identified a need for any of the following:

		Yes	No
a)	Business agreement/MOU with primary healthcare providers	○	●
b)	Cooperative agreement/MOU with public health entity for testing and treatment	○	●
c)	Established co-located SUD professionals within FQHCs	●	○

3. States are required to monitor program compliance related to tuberculosis services made available to individuals receiving SUD treatment. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

The DMHAS Program Monitoring Unit conducts annual site visits to all licensed contracted SUD treatment programs where compliance to TB Services is monitored.

TB Surveillance Procedures devised by the NJ Department of Health are incorporated into the residential and ambulatory regulations followed by all licensed SUD treatment agencies.

DMHAS works closely with the Senior Public Health Advisor at the NJ Department of Health, Division of HIV/AIDS, STDs and Tuberculosis Services (DHSTS) to keep updated on any updates to the Center of Disease Control (CDC) guidance that may affect

clients or staff at licensed SUD agencies.

Early Intervention Services for HIV (for "Designated States" Only)

1. Does your state currently have an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIV in areas that have the greatest need for such services and monitoring such service delivery? ○ Yes ○ No

2. Has your state identified a need for any of the following:

a) Establishment of EIS-HIV service hubs in rural areas ○ Yes ○ No

b) Establishment or expansion of tele-health and social media support services ○ Yes ○ No

c) Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS ○ Yes ○ No

Syringe Service Programs

1. Does your state have in place an agreement to ensure that SUPTRS BG funds are NOT expended to provide individuals with hypodermic needles or syringes(42 U.S.CÂ§ 300x-31(a)(1)F)? ● Yes ○ No

2. Do any of the programs serving PWID have an existing relationship with a Syringe Services (Needle Exchange) Program? ● Yes ○ No

3. Do any of the programs use SUPTRS BG funds to support elements of a Syringe Services Program? ○ Yes ● No

If yes, plese provide a brief description of the elements and the arrangement

Criterion 8,9&10

Service System Needs

1. Does your state have in place an agreement to ensure that the state has conducted a statewide assessment of need, which defines prevention and treatment authorized services available, identified gaps in service, and outlines the state's approach for improvement — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

- **a)** Workforce development efforts to expand service access — (●) Yes ( ) No
- **b)** Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services — (●) Yes ( ) No
- **c)** Establish a peer recovery support network to assist in filling the gaps — (●) Yes ( ) No
- **d)** Incorporate input from special populations (military families, service memebers, veterans, tribal entities, older adults, sexual and gender minorities) — (●) Yes ( ) No
- **e)** Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, i.e. primary healthcare, public health, VA, community organizations — (●) Yes ( ) No
- **f)** Explore expansion of services for:
  - **i)** MOUD — (●) Yes ( ) No
  - **ii)** Tele-Health — (●) Yes ( ) No
  - **iii)** Social Media Outreach — (●) Yes ( ) No

Service Coordination

1. Does your state have a current system of coordination and collaboration related to the provision of person -centered and person-directed care? — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

- **a)** Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services — ( ) Yes (●) No
- **b)** Establish a program to provide trauma-informed care — (●) Yes ( ) No
- **c)** Identify current and perspective partners to be included in building a system of care, such as FQHCs, primary healthcare, recovery community organizations, juvenile justice systems, adult criminal justice systems, and education — (●) Yes ( ) No

Charitable Choice

1. Does your state have in place an agreement to ensure the system can comply with the services provided by nongovernment organizations (42 U.S.C.§ 300x-65, 42 CF Part 54 (§54.8(b) and §54.8(c)(4)) and 68 FR 56430-56449)? — (●) Yes ( ) No

2. Does your state provide any of the following:

- **a)** Notice to Program Beneficiaries — (●) Yes ( ) No
- **b)** An organized referral system to identify alternative providers? — ( ) Yes (●) No
- **c)** A system to maintain a list of referrals made by religious organizations? — ( ) Yes (●) No

Referrals

1. Does your state have an agreement to improve the process for referring individuals to the treatment modality that is most appropriate for their needs? — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

- **a)** Review and update of screening and assessment instruments — ( ) Yes (●) No

b) Review of current levels of care to determine changes or additions — (●) Yes ( ) No

c) Identify workforce needs to expand service capabilities — (●) Yes ( ) No

d) Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background — (●) Yes ( ) No

Patient Records

1. Does your state have an agreement to ensure the protection of client records? — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

   a) Training staff and community partners on confidentiality requirements — (●) Yes ( ) No

   b) Training on responding to requests asking for acknowledgement of the presence of clients — (●) Yes ( ) No

   c) Updating written procedures which regulate and control access to records — (●) Yes ( ) No

   d) Review and update of the procedure by which clients are notified of the confidentiality of their records including the exceptions for disclosure: — (●) Yes ( ) No

Independent Peer Review

1. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers? — (●) Yes ( ) No

2. Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C.§ 300x-52(a)) and 45 § CFR 96.136 require states to conduct independent peer review of not fewer than 5 percent of the block grant sub-recipients providing services under the program involved.

   a) Please provide an estimate of the number of block grant sub-recipients identified to undergo such a review during the fiscal year(s) involved.

   FFY 2024: 3
   FFY 2025: 3

3. Has your state identified a need for any of the following:

   a) Development of a quality improvement plan — ( ) Yes (●) No

   b) Establishment of policies and procedures related to independent peer review — (●) Yes ( ) No

   c) Development of long-term planning for service revision and expansion to meet the needs of specific populations — ( ) Yes (●) No

4. Does your state require a block grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, such as the Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for block grant funds? — ( ) Yes (●) No

   If Yes, please identify the accreditation organization(s)

   i) ☐ Commission on the Accreditation of Rehabilitation Facilities

   ii) ☐ The Joint Commission

   iii) ☐ Other (please specify)

Criterion 7&11

Group Homes

1. Does your state have an agreement to provide for and encourage the development of group homes for persons in recovery through a revolving loan program? — (●) Yes ( ) No
2. Has your state identified a need for any of the following:
   a) Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service — ( ) Yes (●) No
   b) Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing — ( ) Yes (●) No

Professional Development

1. Does your state have an agreement to ensure that prevention, treatment and recovery personnel operating in the state's substance use disorder prevention, treatment and recovery systems have an opportunity to receive training on an ongoing basis, concerning:
   a) Recent trends in substance use disorders in the state — (●) Yes ( ) No
   b) Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services — (●) Yes ( ) No
   c) Performance-based accountability: — (●) Yes ( ) No
   d) Data collection and reporting requirements — (●) Yes ( ) No
2. Has your state identified a need for any of the following:
   a) A comprehensive review of the current training schedule and identification of additional training needs — (●) Yes ( ) No
   b) Addition of training sessions designed to increase employee understanding of recovery support services — (●) Yes ( ) No
   c) Collaborative training sessions for employees and community agencies' staff to coordinate and increase integrated services — (●) Yes ( ) No
   d) State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort — ( ) Yes (●) No
3. Has your state utilized the Regional Prevention, Treatment and/or Mental Health Training and Technical Assistance Centers (TTCs)?
   a) Prevention TTC? — (●) Yes ( ) No
   b) Mental Health TTC? — (●) Yes ( ) No
   c) Addiction TTC? — (●) Yes ( ) No
   d) State Targeted Response TTC? — ( ) Yes (●) No

Waivers

Upon the request of a state, the Secretary may waive the requirements of all or part of the sections 1922(c), 1923, 1924. and 1928 (42 U.S.C.§ 300x-32 (f)).

1. Is your state considering requesting a waiver of any requirements related to:
   a) Allocations regarding women — ( ) Yes (●) No
2. Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus:
   a) Tuberculosis — ( ) Yes (●) No
   b) Early Intervention Services Regarding HIV — ( ) Yes (●) No

3. Additional Agreements

a)	Improvement of Process for Appropriate Referrals for Treatment	○ Yes ● No
b)	Professional Development	○ Yes ● No
c)	Coordination of Various Activities and Services	○ Yes ● No

Please provide a link to the state administrative regulations that govern the Mental Health and Substance Use Disorder Programs.

http://www.nj.gov/humanservices/providers/rulefees/regs/

If the answer is No to any of the above, please explain the reason.

Footnotes:

Criterion 1: Services for adolescents are provided by the NJ Department of Children and Families, Children's System of Care.

Criterion 6: New Jersey is not a "Designated State".

Environmental Factors and Plan

11. Quality Improvement Plan- Requested

Narrative Question

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2022-FFY 2023? (x) Yes ( ) No

Please indicate areas of technical assistance needed related to this section.

n/a

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Environmental Factors and Plan

12. Trauma - Requested

Narrative Question

Trauma[1] is a common experience for adults and children in communities, and it is especially common in the lives of people with mental and substance use disorders. For this reason, the need to address trauma is increasingly seen as an important part of effective behavioral health care and an integral part of the healing and recovery process. It occurs because of violence, abuse, neglect, loss, disaster, war, and other emotionally harmful and/or life-threatening experiences. Trauma has no boundaries regarding age, gender, socioeconomic status, race, ethnicity, geography, ability, or sexual orientation. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in M/SUD services. People in the juvenile and criminal justice system and children and families in the child welfare system have high rates of mental illness, substance use disorders and personal histories of trauma. Similarly, many individuals in primary, specialty, emergency, and rehabilitative health care also have significant trauma histories, which impacts their health and responsiveness to health interventions. Also, schools are now recognizing that the impact of traumatic exposure among their students makes it difficult for students to learn and meet academic goals. As communities experience trauma, for some, these are rare events and for others, these are daily events. Children and families living in resource scarce communities remain especially vulnerable to experiences of trauma and thus face obstacles in accessing and receiving M/SUD care. States should work with these communities to identify interventions that best meet the needs of their residents. In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink how practices are conducted. These public institutions and service settings are increasingly adopting a trauma-informed approach distinct from trauma-specific assessments and treatments. Trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues with a focus on equity and inclusion. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma[2] paper.

[1] Definition of Trauma: *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.*

[2] *Ibid*

Please consider the following items as a guide when preparing the description of the state's system:

		Yes	No
1.	Does the state have a plan or policy for M/SUD providers that guides how they will address individuals with trauma-related issues?	◉	○
2.	Does the state provide information on trauma-specific assessment tools and interventions for M/SUD providers?	◉	○
3.	Does the state provide training on trauma-specific treatment and interventions for M/SUD providers?	◉	○
4.	Does the state have a plan to build the capacity of M/SUD providers and organizations to implement a trauma-informed approach to care?	◉	○
5.	Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations?	○	◉
6.	Does the state use an evidence-based intervention to treat trauma?	◉	○

7. Does the state have any activities related to this section that you would like to highlight.

Please see attached.

Please indicate areas of technical assistance needed related to this section.

Footnotes:

Trauma –Requested

7. Does the state have any activities related to this section that you would like to highlight.

Division of Mental Health and Addiction Services (DMHAS)

The Division of Mental Health and Addiction Services (DMHAS) contract language for licensed substance use disorder (SUD) treatment providers receiving women's set aside block grant funds requires the providers to be trauma informed with trauma specific services. All women must be screened for trauma with one of the DMHAS recommended evidence-based screening tools, and providers are required to use the "Seeking Safety" curriculum. The DMHAS Monitoring Unit conducts annual site visits to the women's set aside providers. The monitoring review form has a module for specialized services that lists all requirements for gender specific treatment including "Seeking Safety" curriculum.

DMHAS recognizes the national statistics that indicate that 43%-81% of adults in psychiatric hospitals and up to 2/3 of individuals in SUD treatment have experienced trauma. As DMHAS embarked on becoming trauma-informed, we identified work groups comprised of providers, administrators, and individuals with lived experience to advise us as we adapt the materials from the national level to needs in New Jersey. DMHAS includes trauma awareness as a governing principle in addressing policy making, service system design and implementation, workforce development, and professional practice. We advocate for all of our agencies to adopt similar practices using the following five values of Trauma-Informed Care (TIC) as developed through the efforts at a national level.

1. Safety, meaning: "Do no harm." Trauma sensitive and compassionate care is given from initial contact.
2. Trustworthiness, meaning: The system provides care with the least amount of risk for re-traumatization.
3. Choice, meaning: Individuals have input into decisions made in treatment, and that input is taken seriously.
4. Collaboration, meaning: Recognize that trauma-related symptoms and behaviors originate from adaptation to traumatic experiences.
5. Empowerment, meaning: Promoting resilience; providing opportunities and understanding that all of us are competent and capable to grow and heal.

Department of Children and Families/ Children's System of Care (DCF/CSOC)

The mission of the Department of Children and Families (DCF) is to work in partnership with NJ's communities to ensure the safety, well-being, and success of NJ's children and families. DCF's child welfare workforce and contracted service providers work with vulnerable children and families who have experienced complex trauma-related challenges. There is a growing awareness across disciplines about the need for systems working with traumatized children to be healing-centered. Likewise, there is a call for child prevention and protection systems to be healing-centered. As such, the primary goal of the DCF is to improve outcomes for children and

families and to position all who interface with and support the work of the Children's System of Care (CSOC) to understand, prevent, and mitigate the impact of trauma that children, youth, and young adults and their families experience.

Office of Resilience

The mission of The Office of Resilience is to be an incubator and advocate for community-developed solutions, grounded in positive and adverse childhood experiences Science, that help to create a healing-centered ecosystem where all NJ residents thrive. Created in June 2020, this Office is located within the NJ Department of Children and Families while being a resource across State agencies.

DREAMS Project

The DREAMS Project is a year-long initiative of NJ Children's System of Care with the support of NJ Department of Education. "DREAMS" stands for Developing Resiliency with Engaging Approaches to Maximize Success. With a focus on Six Core Strategies as a foundation, coupled with the relationship building style of the Nurtured Heart Approach and grounded by the Trauma Foundational Training Series, DREAMS will provide layering of training, coaching and resources to support and engage staff while assisting them in creating healing centered environments to identified schools. It looks to serve up to 45 districts identified by NJ DCF in collaboration with NJ DOE based on available community-based resources and district application.

Adverse Childhood Experiences Action Plan

New Jersey's first Adverse Childhood Experiences Action Plan provides a comprehensive statewide strategy to prevent and reduce childhood trauma and adversity. The action plan outlines several initiatives to identify, coordinate, and advance programs and services across state government to reduce and prevent adverse childhood experiences (ACEs) that negatively impact the developing brain and lead to lifelong social, physical, emotional, and economic challenges.

The ACEs Action Plan was shaped in partnership with New Jersey families, community and legislative leaders, health care professionals, and the NJ ACEs Collaborative, which includes the Department of Children and Families, Burke Foundation, The Nicholson Foundation, and Turrell Fund, with support from the Center for Health Care Strategies. The Office of Resilience within the Department of Children and Families will lead the State's work in raising awareness and engaging communities in ACEs education. The New Jersey ACEs Action Plan's goals are to:

- Help children and families in New Jersey reach their full potential by growing and developing in relationships that are safe, healthy, and protective.
- Reduce ACE scores in future generations.
- Continually develop resource programs and services based on the research, rather than focusing on rigid metrics of success or failure.
- Look at solutions based on community input that address root causes rather than symptoms.

The key elements to implementing New Jersey's ACEs Action Plan include:

- Gathering information about current efforts to address ACEs in the state.
- Meeting with non-governmental organizations to let them lead and contribute to the work.
- Expanding leadership to include communities directly impacted by ACEs into the design process.
- Collecting data on the project so people can engage with it.
- Letting individuals impacted by ACEs know that an online community is available for them to share their own thoughts, contributions, and opinions on the ongoing work.

The NJ ACEs Statewide Action Plan can be found here: https://www.nj.gov/dcf/documents/NJ.ACEs.Action.Plan.2021.pdf

Promising Path to Success

In 2015, DCF was awarded a $12 million grant by the Substance Abuse and Mental Health Services Administration (SAMHSA) to expand mental health services for children with complex behavioral health challenges. Entitled Promising Path to Success, the project was funded to run four years, from September 2015 to September 2019, to help CSOC achieve the following goals:

- Reduce the percentage of youth in the system of care who require multiple episodes of out-of-home treatment.
- Reduce the percentage of youth who re-enter treatment after discharge from an initial treatment episode.
- Reduce the average length of stay for youth in out-of-home treatment from 11.5 to 9 months.
- Analyze and understand the impact of each type of system investment to make future resource allocation decisions.

The project's main components include two trauma-informed interventions, *Six Core Strategies for Reducing Seclusion and Restraint Use* (an evidenced-based practice) and *The Nurtured Heart Approach*. These interventions have been introduced system-wide through CSOC's training partner, Rutgers University Behavioral Health Care (UBHC), to approximately 146 out-of-home treatment programs as well as all of CSOC's other System Partners (Care Management Organizations, Family Support Organizations, Mobile Response and Stabilization Services, and county-based Children's InterAgency Coordinating Councils). Another key component of the project is a return on investment (ROI) study being conducted by Rutgers University's Center for State Health Policy. The ROI study will enable CSOC to determine the relative success of the project in achieving its identified goals and help DCF make future decisions concerning resource allocation.

The milestones CSOC was able to reach in the project's third full year include the following:

- Hosted two *Nurtured Heart* Certified Trainers' Institutes that certified 117 new trainers.
- Hosted one *Six Core Strategies* two-day training for over 300 partners around the state.
- Provided *Nurtured Heart* training to over 5,400 individuals in year 3 with a total of 16,536 individuals trained since the grant's inception. Groups that received this training include

NJ CSOC funded programs and system partners as well as other entities outside the original scope of the grant, such as Juvenile Detention Centers, Division of Child Protection and Permanency, Office of Education, ARC NJ, and Children's InterAgency Coordinating Council Education Partnerships.
- NJ CSOC's first youth ambassador was hired and is providing a youth voice and perspective to the grant's goals and training initiatives.

Promising Path to Success 2.0 spans from September 2019 to September 2023. The grant has four goals:

1. Improve youth and family engagement and satisfaction within the Children's System of Care while ensuring Wraparound Fidelity.
2. Reduce restraints and disciplinary incidents within Office of Education and Out of Home schools.
3. Increase youth and family participation and voice within Children's InterAgency Coordinating Councils.
4. Reduce placement disruptions within kinship and resource homes.

Individual coaches have been assigned to each Care Management Organization, Mobile Response and Stabilization Service, Family Support Organization, and Office of Education and Out of Home Schools. Coaches are using the Six Core Strategies Framework to support these organizations in reaching their goals. A Lead Family Coordinator is working with the Children's InterAgency Coordinating Councils to elevate youth and family voice in their meetings. All Division of Child Protection and Permanency staff and Resource/Kinship families will have opportunities to receive Nurtured Heart Approach training. Local and regional learning communities are planned in order to establish and sustain trauma-informed, healing centered services and supports.

Six Core Strategies to Prevent Conflict and Violence: Reducing the Use of Seclusion and Restraint

1. Leadership toward organizational change.
2. The use of data to inform practice.
3. Workforce development.
4. Full inclusion of individuals and families.
5. The use of seclusion and restraint reduction tools, which include the environment of care and use of sensory modulation.
6. Rigorous debriefing after events in which seclusion and restraint might have been used.

Nurtured Heart Approach

"The Nurtured Heart Approach® is a relationship-focused methodology founded strategically in The 3 Stands™ for helping children (and adults) build their Inner Wealth® and use their intensity in successful ways. It has become a powerful way of awakening the inherent greatness in all children while facilitating parenting and classroom success.

The essence of the Approach is a set of core methodologies originally developed for working with

the most difficult children. It has a proven impact on every child, including those who are challenged behaviorally, socially and academically. The Nurtured Heart Approach has been shown to create transformative changes in children diagnosed with ADHD, Oppositional Defiant Disorder, Reactive Attachment Disorder and other behavioral, emotional and anxiety related symptoms – almost always without the need for long-term mental health treatment. Even children experiencing social cognitive challenges, like Autism Spectrum Disorder and Asperger Syndrome greatly benefit from the Approach, reducing the need for traditional mental health and medical interventions.

Traditional approaches often fall short of promoting the Inner Wealth essential for children to build successful relationships. This method has helped thousands of families, educators, and child advocates channel a child's intensity in beautifully creative and constructive ways – helping children achieve new emotional portfolios of confidence and enduring levels of competency." http://childrenssuccessfoundation.com/about-nurtured-heart-approach/

Although the Promising Path to Success grant concludes in 2023, the work of the grant has been taken up by the newly created CSOC Office of Engagement and Service Excellence, ensuring the Six Core Strategies and Nurtured Heart Approach continue to permeate the system on an ongoing and sustainable basis.

Training and Technical Assistance

CSOC offers a broad array of training and technical assistance to system partners through contracts with several entities including Rutgers University Behavioral HealthCare, the Boggs Center, and Autism New Jersey. DCF/CSOC funds the Technical Assistance Center through University Behavioral Health Care - Rutgers, the State University, to provide training statewide. CSOC, through the UMDNJ Training contract, offers training to all children's system of care providers free of charge. In addition, CSOC staff provides training on working with individuals with behavioral health challenges to staff of the Juvenile Justice Commission.

Biopsychosocial Assessments

CSOC continues to support the need for high quality, timely, and focused assessments as a part of the continuum of care available to children, youth, and young adults and their families in New Jersey. Biopsychosocial assessments provide critical information from the child, youth, or young adult and their immediate supports about strengths, needs, preferences, and vulnerabilities and, as such, are fundamental to ensuring youth and their families become engaged in the most appropriate type, intensity, and frequency of care. Biopsychosocial assessments are conducted solely by independently licensed clinicians who have been certified by CSOC as possessing the capacity to complete the Information Management Decision Support Needs Assessment, which has been revised to incorporate a trauma-specific module.

ARC-Grow Model

CSOC, through the Intensive In-Community (IIC) service line, in partnership with the Children's Center for Resilience and Trauma Recovery (CCRTR), and Care Management Organization and

Mobile Response Stabilization Service partners, offers access to and delivery of the ARC-Grow model. The ARC-Grow Model is an adaptation of the Attachment, Regulation, and Competency (ARC) framework for intervention with youth and families who have experienced multiple and/or prolonged traumatic stress. The ARC framework is a core-components treatment model, developed to provide a guiding framework for thoughtful clinical intervention with complexly traumatized youth from early childhood to adolescence and their caregiving systems. ARC Grow is a caregiver skill building intervention designed to enhance resilient outcomes for families who are impacted by chronic adversity or stress.

Evidence Based Treatments

The Children's System of Care has a focused strategic priority to ensure capacity to provide behavioral health services that are based on the best evidence available with a goal of improving outcomes and the quality of life for children, youth, and young adults receiving services through the Division. The following are examples of EBPs available through CSOC: Multisystemic Therapy (MST), Functional Family Therapy (FFT), Wraparound approach, Trauma Focused Cognitive Behavioral Therapy (TF CBT), Six Core Strategies and Nurtured Heart Approach, and the ARC framework and ARC Grow Model.

Traumatic Loss Coalitions for Youth (TLC) – UBHC Suicide Prevention

The Traumatic Loss Coalitions for Youth Program (TLC) at Rutgers-University Behavioral HealthCare is an interactive, statewide network that seeks to reduce suicide attempts, deaths by suicide, and to promote recovery of persons affected by suicide by offering collaboration and support to professionals working with school-age youth and direct crisis response services to staff and youth at youth-serving organizations following a traumatic event. The TLC offers county, regional, and statewide conferences, training, consultation, on-site traumatic loss response, and technical assistance. Since its inception, the TLC has trained thousands of individuals throughout the state with the purpose of saving lives and promoting post trauma healing and resiliency for the youth of New Jersey. The TLC website can be accessed at http://ubhc.rutgers.edu/tlc/

Environmental Factors and Plan

13. Criminal and Juvenile Justice - Requested

Narrative Question

More than a third of people in prisons and nearly half of people in jail have a history of mental health problems.[1] Almost two thirds of people in prison and jail meet criteria for a substance use disorder.[2] As many as 70 percent of youth in the juvenile justice system have a diagnosable mental health problem.[3] States have numerous ways that they can work to improve care for these individuals and the other people with mental and substance use disorders involved in the criminal justice system. This is particularly important given the overrepresentation of populations that face mental health and substance use disorder disparities in the criminal justice system.

Addressing the mental health and substance use disorder treatment and service needs of people involved in the criminal justice system requires a variety of approaches. These include:

- Better coordination across mental health, substance use, criminal justice and other systems (including coordination across entities at the state and local levels);
- Data sharing and use of data to identify individuals in need of services, improve service delivery and coordination, and/or address disparities across racial and ethnic groups;
- Improvement of community capacity to provide MH and SUD services to people involved in the criminal justice system;
- Supporting the ability of law enforcement to respond to people experiencing mental illness or SUD (e.g. Crisis Intervention Teams, co-responder models, and coordinated police/emergency drop-off)
- Partnering with other state agencies and localities to improve screening and assessment for MH and SUD and standards of care for these illnesses for people in jails and prisons;
- Supporting coordination across community-based care and care in jails and prisons, particularly upon reentry into the community;
- Building crisis systems that engage people experiencing a MH or SUD related crisis in MH or SUD care instead of involvement with law enforcement and criminal justice (including coordination of 911 and 988 systems);
- Creating pathways for diversion from criminal justice to MH and SUD services throughout the criminal justice system (before arrest, at booking, jails, the courts, at reentry, and through community corrections);
- Coordination with juvenile court systems and development of programs to improve outcomes for children and youth involved in the juvenile justice system;
- Developing interventions during vulnerable periods, such as reentry to the community from jail or prison, to ensure that MH, SUD, and other needs are met;
- Addressing other barriers to recovery for people with M/SUD involved in the criminal justice system, such as health insurance enrollment, SSI/SSDI enrollment, homelessness and housing insecurity, and employment challenges;
- Partnering with the judicial system to engage in cross-system planning and development at the state and local levels;
- Providing education and support for judges and judicial staff related to navigating the mental health and substance use service system; and
- Supporting court-based programs, including specialty courts and diversion programs that serve people with M/ SUD.
- Addressing the increasing number of individuals who are detained in jails or state hospitals/facilities awaiting competence to stand trial assessments and restoration.

These types of approaches can improve outcomes and experiences for people with M/SUD involved in the criminal justice system and support more efficient use of criminal justice resources. The MHBG and SUPTRS BG may be especially valuable in supporting a stronger array of community-based services in these and other areas. SSAs and SMHAs can also play a key role in partnering with state and local agencies to improve coordination of systems and services. This includes state and local law enforcement, correctional systems, and courts. SAMHSA strongly encourages state behavioral health authorities to work closely with these partners, including their state courts, to ensure the best coordination of services and outcomes, especially in light of health disparities and inequities, and to develop closer interdisciplinary programming for justice system involved individuals. Promoting and supporting these efforts with a health equity lens is a SAMHSA priority.

[1]Bronson, J., & Berzofsky, M. (2017). Indicators of mental health problems reported by prisoners and jail inmates, 2011–12. Bureau of Justice Statistics, 1-16.

[2]Bronson, J., Stroop, J., Zimmer, S., & Berzofsky, M. (2017). Drug use, dependence, and abuse among state prisoners and jail inmates, 2007–2009. Washington, DC: United States Department of Justice, Office of Juvenile Justice and Delinquency Prevention.

[3]Vincent, G. M., Thomas Grisso, Anna Terry, and Steven M. Banks. 2008. "Sex and Race Differences in Mental Health Symptoms in Juvenile Justice: The MAYSI-2 National Meta-Analysis." Journal of the American Academy of Child and Adolescent Psychiatry 47(3):282–90.

Please respond to the following items

1. Does the state (SMHA and SSA) engage in any activities of the following activities:

- [x] Coordination across mental health, substance use disorder, criminal justice and other systems
- [x] Data sharing and use of data to identify individuals in need of services, improve service delivery and coordination, and/or address disparities across racial and ethnic groups
- [x] Improvement of community capacity to provide MH and SUD services to people involved in the criminal justice system, including those related to medications for opioid use disorder
- [x] Supporting the ability of law enforcement to respond to people experiencing mental illness or SUD (e.g. Crisis Intervention Teams, co-responder models, and coordinated police/emergency drop-off)
- [x] Partnering with other state agencies and localities to improve screening and assessment for MH and SUD and standards of care for these illnesses for people in jails and prisons;
- [x] Supporting coordination across community-based care and care in jails and prisons, particularly upon reentry into the community
- [x] Building crisis systems that engage people experiencing a MH or SUD related crisis in MH or SUD care instead of involvement with law enforcement and criminal justice (including coordination of 911 and 988 systems)
- [x] Creating pathways for diversion from criminal justice to MH and SUD services throughout the criminal justice system (before arrest, booking, jails, the courts, at reentry, and through community corrections)
- [x] Coordination with juvenile court systems and development of programs to improve outcomes for children and youth involved in the juvenile justice system
- [x] Developing interventions during vulnerable periods, such as reentry to the community from jail or prison, to ensure that MH, SUD, and other needs are met
- [x] Addressing other barriers to recovery for people with M/SUD involved in the criminal justice system, such as health insurance enrollment, SSI/SSDI enrollment, homelessness and housing insecurity, and employment challenges
- [x] Partnering with the judicial system to engage in cross-system planning and development at the state and local levels
- [x] Providing education and support for judges and judicial staff related to navigating the mental health and substance use service system
- [x] Supporting court-based programs, including specialty courts and diversion programs that serve people with M/SUD
- [x] Addressing Competence to Stand Trial; assessments and restoration activities.

2. Does the state have any specific activities related to reducing disparities in service receipt and outcomes across racial and ethnic groups for individuals with M/SUD who are involved in the criminal justice system? If so, please describe. (●) Yes ( ) No

DMHAS has 2 cultural competency centers of excellence who work with provider agencies and assist in the creation of cultural competency plans that are submitted along with their contracts describing efforts on engagement and reducing disparities for their agency.

CSOC was designed to ensure equitable access to all, regardless of ability to pay, other system involvement, and across racial and ethnic groups. Additionally, state and system partners engage with Juvenile Detention Alternative Initiative (JDAI) partnerships.

3. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address M/SUD and other essential domains such as employment, education, and finances? (●) Yes ( ) No

4. Does the state have any activities related to this section that you would like to highlight?

DMHAS

The SMHA is involved in very active collaborations with the Judiciary, Office of the Attorney General, local law enforcement, State Parole Board and Department of Corrections, and funds 15 JIS services and several other criminal justice initiatives. JIS is provided to a diverse mix of consumers, male and female as well as individuals of Caucasian, African American, Hispanic, Asian and Asian Indian backgrounds and from many different countries.

The SMHA funds a CIT Center of Excellence through the Mental Health Association of Southwest New Jersey. The Center facilitated the development of new county CIT efforts. There is at least one CIT officer in each county. These counties offer the training to other counties and municipalities as well as their own. During FY2023, there were a total of 43 forty-hour CIT programs in law enforcement, mental health professionals, dispatchers, security personnel, firefighters, and EMS. Of 1,358 trained, 1,064 were law enforcement personnel. Additionally, two veterans response team (VRT) training were conducted for 76 students as well as 11 dispatcher classes for 140 dispatchers.

The New Jersey Department of Human Services (DHS), Division of Mental Health and Addictions Services (DMHAS), The Division of New Jersey State Police (NJSP), the New Jersey Office of the Attorney General (OAG), both divisions within the New Jersey Department of Law and Public Safety (LPS), have partner together on the Alternative Responses to Reduce Instances of Violence & Escalation (Arrive) Together Program in piloted counties in New Jersey. The Arrive Program is designed to provide screening services in accordance with the Screening Law and the Screening Regulations which provides the NJSP and screeners with the legal authority to transport or authorize transport of individuals who are experiencing a behavioral health crisis to an emergency department for a full assessment where appropriate. It is envisioned that the Arrive Program will; (a) improve the outcomes in law enforcement's response to emergency behavioral health crisis calls; (b) divert individuals in crisis from unnecessary entry into the criminal justice system; and, (c) more efficiently employ the resources of both law enforcement and the Mental Health Service Provider in the community.

The ARRIVE Together Program has the ability to mitigate crisis, reduce the risk of physical harm, and bridge the gap and offer compassionate care for citizens in New Jersey who are struggling with mental health issues. The Arrive Together Program is expected to expand throughout various municipalities and counties in New Jersey in various phases. This will allow new law enforcement partners to join in, complement services for our most vulnerable residents, continue to improve public safety, prevent tragedies and serve New Jersey residents more effectively.

The New Jersey Department of Human Services (DHS), Division of Mental Health and Addiction Services (DMHAS) has developed a county based mental health pilot diversion program for justice involved defendants who are subject to the Criminal Justice Reform (CJR) Act and identified with a serious mental illness. A serious mental illness (SMI) is defined as a diagnosable mental, behavioral, or emotional disorder that causes serious functional impairment that has substantially interfered with or limited one or more major life activities (within the past year) of an individual 18 years old or over.

The piloted program includes collaboration with our mental health agencies, local social service organizations, the local county jail, the Administrative Office of the Courts (AOC)/Judiciary county-specific staff including judges, the pretrial services units, criminal division offices, and probation division offices, the County Prosecutor's Office, the local Public Defender's Office, and private defense attorneys. This is a voluntary mental health diversion program that is designed to support and connect individuals on pretrial monitoring, to critical mental health, co-occurring mental illness and substance use disorder (COD) treatment, housing, medical and other essential social services components. Individuals in the target population who choose to voluntarily engage with the behavioral health team shall receive a social determinants of health (SDOH) mental health screen. Based on the individuals identified needs will receive linkages to community-based services, behavioral health treatment and a mental health assessment or evaluation. Individuals with criminal charges and are eligible based on meeting the legal and clinical criteria can apply for admission into a current or newly created voluntary mental health diversion program track, integrated with the County Prosecutor's office and courts. It is anticipated that individuals who are agreeable to treatment will be referred and seen for an initial diagnostic assessment within seventy-two (72) hours.

This track of the diversion program will include supervision by a Judiciary diversion officer, case management by the behavioral health team, and oversight by a judge. As a result of the individual engaging in services, and, where applicable, successfully meeting other requirements of the diversion program, the prosecutor's office will dismiss and/or downgrade criminal or municipal charges as agreed upon with the defendant and his/her/their attorney.

The Department of Human Services (DHS), Division of Mental Health and Addiction Services (DMHAS) provided funding for MH/SUD community partners to provide direct services for a specialized population that are often underserved to help assist those

that may benefit from services, and could possibly be in crisis. The services provided to this population must ensure diversity, inclusion, equity, and cultural and linguistic competence to the target population they've identified (e.g. LGBTQ+, Homeless, Low Income, Black Indigenous People of Color/BIPOC, Veterans, etc.). The purpose and scope of work for our community partners is to continually assess and utilize demographic data of participants' service area in its development and delivery of programming, evaluation and program outcomes to ensure it is relevant and effective to the population they selected to serve. In addition, the data collected should be analyze to implement strategies to increase program participation and improve outcome measures.

MH/SUD community partners will focus on outreach to their identified population and how crisis services have minimized the negative impact of a crisis. These services are recovery-oriented and consumer-driven with the specific needs of the individual and special population in mind.
MH/SUD partners have also provided evidence of their commitment to equity and reduction of disparities in access, quality, and treatment/program outcomes of the marginalized underserved populations selected.

Recovery Court

The Department of Human Services, Division of Mental Health and Addiction Services (DMHAS) has a Memorandum of Agreement (MOA) with the Administrative Office of the Courts (AOC) Recovery Court (formally Drug Court) Program. Recovery Court is a special program for participants who have a drug addiction and have commit a crime. Participants accepted into Recovery Court must report to probation and attend treatment and be substance use tested. Participants eligible for the program are non-violent offenders who have a moderate to severe substance use disorder. There are four phases to the Recovery Court program that participants must complete in order to qualify for completion. The first phase has the most requirements for reporting to probation, treatment and the court. As the participant moves through the other phases, their requirements are decrease because it shows that they've been able to stay complainant with the program. A participant must meet all the goals before graduating and the program can be completed within two to three years if their goals are accomplished. Participants accepted into the program receive an evaluation/assessment throughout their participation from a court approved certified and/or licensed addiction specialist who determines the Level of Care (LOC) the participants needs. Participants can go to detox, outpatient and/or residential treatment and the level of treatment is determined on the participant's clinical needs for recovery. Treatment services are coordinated with community treatment providers who are contracted with the DMHAS to provide treatment to those court involved participants.

The Recovery Court team works with coordinating services for each participant as well as community resources to assist them in finding employment, education, and other barriers that have preventing them from achieving their recovery goals in the past. Participants are required to attend self-help meetings such as Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) meetings. There are also other types of self-help meetings available to them while they're in the program. An incentive that Recovery Court offers are expungements for those participants who are eligible.

Mutual Agreement Program

The Mutual Agreement Program (MAP) was implemented in 1984 as a cooperative effort between the New Jersey State Parole Board (SPB), and DHS/DMHAS. The goal of the MAP program provides SPB parolees with mental health and substance use disorder treatment as required under special conditions of parole, for the purpose of reducing the likelihood of returning to criminal behavior. MAP-SPB receives residential and ambulatory services from DMHAS licensed substance use treatment programs located throughout the state of New Jersey.

JIS Jail Medication Assisted Treatment (MAT) Initiative

The New Jersey Department of Human Services' Division of Mental Health and Addiction Services (DMHAS), in collaboration with the Department of Corrections (DOC), Department of Health (DOH) and our community partners to coordinate and deliver medication-assisted treatment (MAT) for opioid addiction to individuals serving within county based correctional facilities. This partnership has help facilitate the connections individuals need in order to sustain treatment services upon release.

This funding is being made available as part of Governor Murphy's initiative to combat the opioid epidemic in New Jersey and designed to encourage the use of or increase use of MAT in county correctional facilities for individuals with an opioid use disorder (OUD). Nationally, 75 percent of inmates with opioid use disorder are reported to have relapsed within three months of release and only 8 percent enter treatment after incarceration (Fox, 2015, https://ascpjournal.biomedcentral.com/articles/10.1186/s13722-014-0023-0). Few inmates receive MAT during incarceration despite MAT being the clinical standard for OUD treatment.

In New Jersey, a recent survey conducted by the DMHAS in collaboration with the County Jail Wardens' Association indicate that an average of 17 percent of jail detainees screen positive for a substance use disorder with a range of 10 percent - 69 percent among the jails reporting. (DMHAS/CJWA, 2018). Of particular concern are the rates of opioid overdose immediately following release from incarceration. In response to overdose deaths among its prison/jail population, the Rhode Island Department of Corrections initiated a model to screen and treat with MAT and sustain MAT post release through a community provider network. Results published in JAMA Psychiatry, researchers compared the pre- and post-intervention periods and found that "In the 2016

period, 26 of 179 individuals (14.5%) who died of an overdose were recently incarcerated compared with 9 of 157 individuals (5.7%) in the 2017 period, representing a 60.5% reduction in mortality." (Traci C. Green, et al., 2018, https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2671411?resultClick=1)

With the arrival of criminal justice reform in New Jersey, jail/prison wardens are seeing more rapid return of individuals to their communities, often within 24 - 48 hours. Therefore, individuals are more likely to be released prior to or while experiencing the onset of opioid withdrawal symptoms. This can put individuals at an increased risk for overdose. Nevertheless, MAT being introduced pre-release has been shown to improve the likelihood of recovery sustainability post-release and can mitigate the risk associated with shorter jail stays. This initiative is designed to collaborate with the wardens in the jails in building the capacity to deliver and sustain MAT for the impacted population.

CSOC

Juvenile Justice

Reducing the Number of Juvenile Justice Commitments

The Children’s System of Care (CSOC) is fully accessible to youth involved with the juvenile justice system and the services coordinated by care managers help to keep youth out of detention centers. There has been a significant decrease in the number of detention center admissions resulting in the reduction of the number of county detention centers from seventeen to six in the past few years (Burlington County Detention Center closed in 2020).

Detention Alternative Program/Youth Advocate Program (DAP/YAP)

CSOC funds Community Re-Integration Services through YAP (Youth Advocate Program) to maintain youth in their community who, without this program, would enter out-of-home treatment due to juvenile justice involvement. The program provides services both individually and in groups, along with a mentor, life skills groups, and employment skills. The program is located in the three counties (Middlesex, Camden, and Essex) with the highest rate of court ordered out-of-home referrals. Additionally, this program has enabled the Division of Child Protection and Permanency to successfully maintain youth in resource homes after their arrest.

Medicaid

Currently, youth in juvenile detention facilities are eligible for Medicaid or New Jersey FamilyCare (S-CHIP) only after adjudication and referral to a non-secure setting.

CSOC Representation on the New Jersey Council for Juvenile Justice Improvement

Diversion and the reentry processes are discussed by the Access to Treatment and Racial Disparities sub-committees of the Council. Formal recommendations are presented to the full Council by the individual sub-committees.

DCF Cooperative Relationships with the Juvenile Justice Commission (JJC)

Since December 2004, the Department has maintained a Memorandum of Understanding with the JJC that outlines a distinct process by which youth in the JJC can be referred directly to what is now known as the Children’s System of Care for services that will be implemented upon the youth’s release from a JJC facility. Representation from both CP&P and CSOC participate in the JJC and Annie E. Casey Foundation driven Juvenile Detention Alternative Initiative (JDAI) in order to collaborate on developing alternatives to detention and to reduce the number of youth going into detention. Both systems participate in each other’s planning and case review processes.

The Juvenile Justice Commission is responsible for operating state services and sanctions for juveniles and for developing a statewide plan for the effective provision of juvenile justice services and sanctions at the state, county, and local levels. To emphasize New Jersey’s commitment to provide coordinated quality services and appropriate sanctions for youthful offenders while ensuring the public’s safety, the JJC established the State/Community Partnership Grant Program. These Partnership Grants provide funding to each county for services to reduce detention overcrowding, to provide treatment for sex offenders, to increase disposition options, and to provide aftercare to youth and their families.

Special Case Review Committee

The Special Case Review Committee (SCRC) reviews those youth, both male and female, who present multi-system needs/issues and the need for special attention or advocacy. Included are those who appear to have developmental disabilities, those who need placement by DCF/CP&P due to court orders for diversion or aftercare, and/or those who have special presenting problems, including homelessness, and those who are being referred, or are accepted by, DCF/CSOC.

The Office of Special Needs oversees the SCRC in terms of intra- and inter-agency planning. It is chaired by the Special Needs Assistant. Members include representatives from CP&P, Office of Adolescent Services, Children’s System of Care, the JJC Juvenile

Parole and Transitional Services (JP&TS), Pre-Release Teams, Regional Court Liaisons/designees, the JJC Child Study Teams, JJC community residential homes, and representatives from the New Jersey Training School at Jamesburg (NJTS), Juvenile Medium Security Facility (JMSF), and the Juvenile Female Secure Care and Intake Facility (Hayes Unit) Social Services Departments.

Meetings are held twice a month, for northern and southern regional cases, respectively. Referrals are primarily made from the Reception and Program Review committees, the Reception and Assessment Center (RAC), the New Jersey Training School (NJTS), and Juvenile Female Secure Care and Intake Facility. However, youth may be referred by any source identifying a special need for advocacy and planning, including the Institutional Classification Committees, JP&TS staff, court liaisons, supervisors, and program staff.

When youth in a JJC facility have permanency and treatment needs that require the intervention of DCF, the JJC Special Needs Review Committee will work with CSOC and CP&P to make appropriate referrals prior to time of discharge. In circumstances where CSOC is unable to access a timely treatment plan in accordance with mandatory release dates, CP&P will be expected to effectuate the most appropriate contingency plan until such time that a more feasible plan is developed. Care Management Organization (CMO) involvement is inclusive in this agreement, when appropriate.

CSOC maintains a “Protocol for Supervision of Juvenile Probationers Court-ordered to Attend and Complete a DCSOC Specialty Services Program.” This protocol was approved in 2012 by NJ Juvenile Probation Managers, NJ Conference of Chief Probation Officers, CSOC Representative for Specialty Programs, NJ Juvenile Committee of Family Presiding Judges, and the NJ Conference of Family Presiding Judges. Subsequent protocols were developed that address communication and collaboration for youth in either a residential treatment program or a substance use treatment program.

CSOC Training and Technical Assistance

CSOC offers a broad array of training and technical assistance to system partners through contracts with several entities including Rutgers University Behavioral HealthCare, the Boggs Center, and Autism New Jersey.

DCF/CSOC funds the Technical Assistance Center through University Behavioral Health Care - Rutgers, the State University, to provide training statewide. CSOC, through the UMDNJ Training contract, offers training to all children’s system of care providers free of charge.

In addition, CSOC staff provides training on working with individuals with behavioral health challenges to staff of the Juvenile Justice Commission.

____

Bibliography

Fox, A. D. (2015). Release from incarceration, relapse to opioid use and the potential for buprenorphine maintenance treatment: A qualitative study of the perceptions of former inmates with opioid use disorder. Addiction Science & Clinical Practice, 10(2). doi:10.1186/s13722-014-0023-0

Traci C. Green, P. M., Jennifer Clarke, M., Lauren Brinkley-Rubinstein, P., et al Brandon D. L. Marshall, P., Nicole Alexander-Scott, M. M., & Rebecca Boss, M. (2018). Post incarceration Fatal Overdoses After Implementing Medications for Addiction Treatment in a Statewide Correctional System. JAMA Psychiatry. doi:10.1001

Please indicate areas of technical assistance needed related to this section.

n/a

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Environmental Factors and Plan

14. Medications in the Treatment of Substance Use Disorders, Including Medication for Opioid Use Disorder (MOUD) – Requested (SUPTRS BG only)

Narrative Question

In line with the goals of the Overdose Prevention Strategy and SAMHSA's priority on Preventing Overdose, SAMHSA strongly request that information related to medications in the treatment of substance use disorders be included in the application.

There is a voluminous literature on the efficacy of the combination of medications for addiction treatment and other interventions and therapies to treat substance use disorders, particularly opioid, alcohol, and tobacco use disorders. This is particularly the case for medications used in the treatment of opioid use disorder, also increasingly known as Medications for Opioid Use Disorder (MOUD). The combination of medications such as MOUD; counseling; other behavioral therapies including contingency management; and social support services, provided in individualized, tailored ways, has helped countless number of individuals achieve and sustain remission and recovery from their substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based, or non-medication inclusive, treatment for these conditions. The evidence base for medications as standards of care for SUDs is described in SAMHSA TIP 49 Incorporating Alcohol Pharmacotherapies Into Medical Practice and TIP 63 Medications for Opioid Use Disorders.

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with substance use disorders demonstrate that they both have the capacity and staff expertise to offer MOUD and medications for alcohol use disorder or have collaborative relationships with other providers that can provide all FDA-approved medications for opioid and alcohol use disorder and other clinically needed services.

Individuals with substance use disorders who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments based upon each individual patient's needs. States should use Block Grant funds for the spectrum of evidence-based interventions for opioids and stimulants including medications for opioids use disorders and contingency management.

In addition, SAMHSA also encourages states to require equitable access to and implementation of medications for opioid use disorder (MOUD), alcohol use disorder (MAUD) and tobacco use disorders within their systems of care.

SAMHSA is asking for input from states to inform SAMHSA's activities.

Please respond to the following items:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding the use of medications for substance use disorders? — (•) Yes ( ) No
2. Has the state implemented a plan to educate and raise awareness of the use of medications for substance disorder, including MOUD, within special target audiences, particularly pregnant women? — (•) Yes ( ) No
3. Does the state purchase any of the following medication with block grant funds?
   - a) [x] Methadone
   - b) [x] Buprenophine, Buprenorphine/naloxone
   - c) [ ] Disulfiram
   - d) [ ] Acamprosate
   - e) [x] Naltrexone (oral, IM)
   - f) [x] Naloxone

4. Does the state have an implemented education or quality assurance program to assure that evidence-based treatment with the use of FDA-approved medications for treatment of substance use disorders is combined with other therapies and services based on individualized assessments and needs?

(●) Yes ( ) No

5. Does the state have any activities related to this section that you would like to highlight?

Please see attached.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

State funding along with SOR, PDO, SUPTRS Block Grant Covid-19 Supplemental, and SUPTRS ARPA federal grant funding support the purchase of Naloxone.

Medications in the Treatment of Substance Use Disorders, Including Medication for Opioid Use Disorder (MOUD) – Requested (SUPTRS BG only)

5. Does the state have any activities related to this section that you would like to highlight?

Vital Strategies is working with the state of NJ and conducted an MOUD survey "Medication for Opioid Use Disorder Capacity in New Jersey Specialty Substance Use Treatment" from November 2022 to January 2023, The purpose was to understand how state-licensed substance use disorder treatment programs are integrating medications for opioid use disorder (MOUD) into their treatment programs and what challenges are being encountered. The goal is to use the information collected to develop strategies that can help support the use of MOUD in treatment.

DHS has contracted with two Centers of Excellence (COE) to support and advance the use of Medication Assisted Treatment (MAT) in the State. Rutgers University covers Bergen, Essex, Hudson, Hunterdon, Middlesex, Monmouth, Morris, Passaic, Somerset, Sussex, Union, and Warren counties in the northern region. Rowan University in partnership with Cooper Health cover Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester, Mercer, Ocean, and Salem counties in the southern region. Both COEs provide a 24-hour call line, website information, a listserv for prescribers, prescriber training and support opportunities, a Project Echo, navigator support and trainings, coffee clubs, MAT lunch hours, links to toolkits and best practice resources. In addition, both COE serve individuals seeking treatment and MAT for opioids, alcohol or other substances.

DMHAS is in the process of developing an Alcohol Use Disorder Strategic Plan. Due to problem-drinking and diagnosed cases of Alcohol Use Disorder (AUD) within New Jersey showing an increasing trend following the COVID-19 pandemic, a workgroup of Division staff was convened to develop a strategic outline that would identify and prioritize areas of concern and objectives for January 2022 – December 2023. Our Substance Use Overview indicates that for the first time in many years, alcohol is now the leading primary drug at admission (37%), a 1 percent lead over heroin (36%). However, for the planned use of medication assisted therapy in treatment, only 3% indicates Vivitrol. One of the areas to be addressed is the under-utilization of Vivitrol to treat AUD.

DMHAS utilizes BG funds to support two initiatives, the Substance Abuse Prevention and Treatment Initiative (SAPTI) and the NJ Statewide Initiative (NJSI), in its Fee-for-Service (FFS) Network that pay for treatment services to include the use of methadone, buprenorphine and injectable naltrexone.

DMHAS, with SAMHSA funding, held an Opioid Summit on September 20, 2019 which focused on addressing discrimination/stigma regarding the use of MAT. The event included approximately 500 attendees who were mostly medical professionals, clinicians and criminal justice professionals. A virtual Opioid Summit was held on September 21 and 22, 2021. The 2021 Opioid Summit showcased the initiatives New Jersey has developed that aim to increase access to MOUD, increase awareness against stigma, and support the efforts of integrative care across the spectrum of recovery. Due to this Summit being held two days, there were two separate keynotes present. On the first day, Actress Marlee Matlin told her story of addiction, acting and being a

Deaf actor. The keynote speaker on the second day was Dr. Wilson Compton, the Deputy Director of the National Institute on Drug Abuse (NIDA). Dr. Compton spoke about NIDA and what they are doing to improve prevention and treatment of drug abuse and addiction. Attendance for the 2021 summit was higher than 2019 due to the two half-day format. In total, there were about 1,400 registered for the two-day event. The audience was comprised of medical professionals, family members, government officials, professional counselors, and other stakeholders.

In 2022, DMHAS kept the summit virtual due to the success of the 2021 summit. The 2022 Opioid Summit was a one-day event held on September 21, 2022. The theme for the 2022 Summit was "*The Evolving Opioid Crisis: A Collaborative Approach*". The purpose of the summit was to highlight the collaboration between various State Department and agencies in New Jersey to treat Opioid Use Disorder. The keynote speaker was Dr. Daniel Schneider, a pharmacist from Louisiana who lost his son to a drug deal gone wrong. The Netflix Docuseries, *The Pharmacist*, tells his family's story. Attendance for the 2022 Opioid Summit was just over 700 individuals. There were attendees from Virginia, Pennsylvania, Texas, Delaware, Maryland and New Jersey.

The 2023 Opioid Summit is themed "*Revitalizing Communities: Healing Together from the Opioid Crisis*". The summit will be held as a one-day virtual conference on September 20, 2023.

DMHAS mandates trainings on medication assisted treatment for licensed substance use disorder treatment providers. The trainings incorporate language requiring acceptance of clients on all forms of medication assisted treatment into contract requirements as well as all applications for new funding. DMHAS also mandates trainings for peers that are working in the field of addictions at licensed substance use disorder treatment programs as well as other entities. These trainings stress there is no wrong path to recovery.

DMHAS has language in its RFP templates that require bidders to provide a summary of their policies that prohibit discrimination against individuals who are assisted in their prevention, treatment and/or recovery from substance use disorders and/or mental illness with legitimately prescribed medication(s). Moreover, successful bidders are required to have these policies in writing, legible and posted in a clearly visible, common location accessible to all who enter the facility.

Bidders of treatment services must provide a description of their capacity to accommodate all individuals who take legitimately prescribed medications and who are referred to or present for admission. Capacity to accommodate individuals who present or are referred with legitimately prescribed medications can be accomplished either through direct provision of services associated with the provision or dispensing of medications and/or via development of viable networks/referrals/consultants/sub-contracting with those who are licensed and otherwise qualified to provide medications.

DMHAS had a Memorandum of Agreement (MOA) with Rutgers University and Cooper Medical School at Rowan University to coordinate statewide buprenorphine DATA 2000 waiver trainings in CYs 2019 and 2020 for eligible statewide practitioners (i.e. physicians, APNs). 31 trainings were held and over 1,000 eligible prescribers were trained. The agreement with both entities was discontinued in late 2020, as an adequate number of DATA 2000 waiver trainings were available

for free; therefore, the State no longer needed to contract for this service. Furthermore, in December 2022, the 2023 Consolidated Appropriations Act (P.L. 117-328) was signed into law that amended the Controlled Substances Act to eliminate the requirement for qualified practitioners to first obtain a special waiver to prescribe medications such as buprenorphine for the treatment of opioid use disorder (OUD). This ended a decades-long requirement, originally put in place through the Drug Abuse Treatment Act (DATA) of 2000.

Rutgers University, through a Memorandum of Agreement DMHAS, implemented a program called the Rutgers Interdisciplinary Opioid Trainers (RIOT). The RIOT is funded by the SOR grant and is designed as a train-the-trainer program by faculty who educate/train university students The university students provide a free 1-hour training to community members/groups to educate them about the opioid epidemic in NJ, how to manage an overdose, and increase education and reduce stigma and discrimination about Opioid Use Disorder (OUD) and the use of medications to treat the disease. Community trainings began in early 2020.

Through the State Opioid Response (SOR) grant, DMHAS funds a Low Threshold program facilitating buprenorphine treatment for participants who utilize Harm Reduction Centers (HRCs) for syringe access at the South Jersey AIDS Alliance (SJAA), Atlantic City, and the Visiting Nurse Association (VNA) of Central Jersey, Asbury Park. Through the Low Threshold program, individuals are offered immediate enrollment in buprenorphine treatment and care management. The program has provided low threshold buprenorphine services to over 100 individuals at the two site locations. DMHAS is looking to expand this program to all statewide HRCs in CY 2021. In July 2022, DMHAS executed a MOA with the NJ Department of Health, Division of HIV, STDs and Tuberculosis Services (DHSTS) to support funding at all current operating HRCs to support low threshold buprenorphine services for their participants.

DMHAS issued a Request for Letters of Intent in 2019 to all 19 county correctional facilities for plans to establish MAT programs or enhance existing MAT services for inmates with an OUD. Funding was made to all county jails beginning late in 2019 to promote clinical stability and effective recovery processes for inmates prior to release from incarceration.

DMHAS, in partnership with the Department Human Services (DHS), Office of Public Relations, awarded a contract to a vendor to deliver a campaign to help eliminate stigma and discrimination around the use of MAT. Various forms of messaging have been utilized including social media targeted to different audiences. A public awareness campaign was first launched in the Spring of 2020 and another one most recently in the Spring of 2021.

Messaging has continued to target multiple resident groups, and beginning in 2022 gave special emphasis to populations to include student-athletes, pregnant women, older adults and prescribers. NJ continued to see an increase in call volume at ReachNJ, the Addiction Hotline in NJ, as the campaign continued in both physical and digital platforms across the State.

“Reasons” is the name given to the latest campaign (2023) and the goal has been to highlight the reasons why many chose recovery and their motivations that got them to a stronger, healthier, and happier place. The newest approach emphasizes the importance of reaching out to the ReachNJ

hotline and expanding the value of having a person present 24 hours a day to speak with, to talk to, to listen to and to give possible solutions for next steps in a pathway to recovery.

DMHAS contracts with three organizations that established three regional Overdose Prevention Programs (OOPP) in 2015 and operate in all of NJ's twenty-one counties for the purpose of providing education to participants so that they can recognize an opioid overdose and subsequently be equipped to provide life-saving rescue measures to reverse the effects of an opioid overdose. Funded OOPPs provide individuals at-risk for overdose, their family members, friends, and loved ones with naloxone rescue kits and educate and train them on how to prevent, recognize and respond to an opioid overdose. Federal funding through STR and SOR helped to expand these trainings and distribution of kits to populations including, but not limited to schools, jails, fire departments, homeless shelters, offices of emergency management and HIV clinics. 9,971 naloxone kits were distributed CY 2019 through CY 2022 by this program.

In 2017, with Prescription Drug Overdose (PDO) funding from SAMHSA, DMHAS, in collaboration with the Robert Wood Johnson Medical School, established the Opioid Overdose Prevention Network (OOPN). Like the OOPP, the OOPN conducts community-based trainings on recognizing and responding to an overdose and provides naloxone kits to training attendees. Training is offered statewide, however, DMHAS focuses training on certain counties in which there is an urgent need for naloxone training and distribution – due to overdose rates and other factors. At any time after the training, attendees can receive additional naloxone upon request. As of June 30, 2023, the OOPN has trained 21,122 non-duplicated individuals and distributed 27,190 kits.

DMHAS, in partnership with the Department of Human Services (DHS) and other State Departments held a Naloxone Distribution Day on June 18, 2019, in which participating pharmacies in NJ distributed free naloxone throughout the State. There were 16,251 kits distributed.

Subsequently, DHS and DMHAS held a three-day Naloxone Distribution event at over 300 statewide pharmacies September 24-26, 2020 in which over 14,000 naloxone kits were distributed to the public.

Naloxone Direct (formerly called Naloxone Distribution Program) is a DHS naloxone distribution initiative that allows local government agencies, first responders and other eligible entities to place orders for naloxone though an online portal. The purpose of the program is to provide naloxone to first responders and other eligible agencies for the purposes of: general distribution in the community, emergency administration, and to make "leave behind" naloxone available for distribution by first responders for individuals post overdose. Registered agencies are able to log into the portal and request naloxone by the case (each case contains 12 two-dose kits). Orders received through the portal are sent to the manufacturer of Narcan, Emergent BioSolutions, who then ships the medicine directly to the agency. The Naloxone Direct portal was launched in June 2022 and has distributed 102,792 kits statewide during the period of June 1, 2022 – August 14, 2023

Current Eligible Agencies include: law enforcement, EMS/Fire, county correctional facilities, local health departments, prevention agencies, libraries, shelters, re-entry agencies, harm reduction agencies, institutes of higher education, county prosecutor's offices, family support services, mobile outreach vehicles, mental health agencies, universities, and substance use disorder treatment agencies.

Naloxone 365 is a DHS naloxone distribution initiative for individuals in the community. Launched in January 2023, DHS partnered with the NJ Board of Pharmacy and its Medicaid division to develop and implement this unique program. Individuals 14 years or older may obtain naloxone at no-cost to them at participating pharmacies in NJ. Anonymity, easy access, and free naloxone are the three cornerstones of the Naloxone 365 program. Individuals are not required to present a prescription for naloxone, nor are they asked to provide identification, personal information, or their insurance. Simply walk into a participating pharmacy and ask the pharmacist for naloxone and they will receive a package of naloxone 4mg nasal spray (2 doses per package) for free. Pharmacies must complete the NJ Board of Pharmacy's Naloxone Pilot Agreement to participate in the program. Once signed up, participating pharmacies would procure naloxone through their normal network of wholesalers and after dispensing, bill for reimbursement using the NJMMIS/Medicaid billing code by following the instructions in the pilot program agreement. Pharmacy reimbursement for naloxone is at the current Medicaid rate. This program is funded using federal grant dollars. Since the program's launch in January 2023, the number of naloxone kits dispensed is 46,852 kits. As of August 2023, there are 636 pharmacies participating in the program.

New Jersey has adopted a comprehensive network of programs as listed above to help ensure that naloxone kits are distributed to the individuals who need them the most: community members and first responders. Through the various programs of OOPN, OORP, Naloxone Direct (formerly called Naloxone Portal), and OOPP; a total of 94,074 kits were distributed over 2021 and 2022 with 536 training courses conducted and 6,924 individuals trained to administer Naloxone. In 2022 alone, 61,299 naloxone kits were distributed through these programs which surpassed the minimum number of naloxone kits required to achieve saturation under the highest target as set by a research paper following naloxone administration in Scotland.[1] On January 1st, 2023, a new program called Naloxone 365 started which is distributing naloxone kits through pharmacies. As of June 1st, 2023; naloxone saturation has been achieved in all 21 counties using the targets set by Bird et al. NJ also met with Dr Mike Irving on August 2, 2023 through SOR Grantee TA Session to find out about his methods of calculating naloxone saturation and are currently implementing his suggestions.[2]

---

[1] Bird SM, Parmar MK, Strang J. Take-home naloxone to prevent fatalities from opiate-overdose: Protocol for Scotland's public health policy evaluation, and a new measure to assess impact. Drugs (Abingdon Engl). 2015 Feb;22(1):66-76. doi: 10.3109/09687637.2014.981509. Epub 2014 Nov 18. PMID: 26045638; PMCID: PMC4438351.

[2] Irvine MA, Oller D, Boggis J, Bishop B, Coombs D, Wheeler E, Doe-Simkins M, Walley AY, Marshall BDL, Bratberg J, Green TC. Estimating naloxone need in the USA across fentanyl, heroin, and prescription opioid epidemics: a modelling study. Lancet Public Health. 2022 Mar;7(3):e210-e218. doi: 10.1016/S2468-2667(21)00304-2. Epub 2022 Feb 10. PMID: 35151372.

Environmental Factors and Plan

15. Crisis Services – Required for MHBG, Requested for SUPTRS BG

Narrative Question

Substance Abuse and Mental Health Services Administration (SAMHSA) is directed by Congress to set aside 5 percent of the Mental Health Block Grant (MHBG) allocation for each state to support evidence-based crisis systems. The statutory language outlines the following for the 5 percent set-aside:

> *....to support evidenced-based programs that address the crisis care needs of individuals with serious mental illnesses and children with serious emotional disturbances, which may include individuals (including children and adolescents) experiencing mental health crises demonstrating serious mental illness or serious emotional disturbance, as applicable.*
>
> *CORE ELEMENTS: At the discretion of the single State agency responsible for the administration of the program, the funds may be used to expend some or all of the core crisis care service components, as applicable and appropriate, including the following:*
>
> - *Crisis call centers*
> - *24/7 mobile crisis services*
> - *Crisis stabilization programs offering acute care or subacute care in a hospital or appropriately licensed facility, as determined by such State, with referrals to inpatient or outpatient care.*
>
> *STATE FLEXIBILITY: In lieu of expanding 5 percent of the amount the State receives pursuant to this section for a fiscal year to support evidence based programs as required a State may elect to expend not less than 10 percent of such amount to support such programs by the end of two consecutive fiscal years.*

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-intervention and response systems. Given the multi-system involvement of many individuals with M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination, stabilization service to support reducing distress, promoting skill development and outcomes, manage costs, and better invest resources.

SAMHSA developed **Crisis Services: Meeting Needs, Saving Lives**, which includes "**National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit**" as well as an **Advisory: Peer Support Services in Crisis Care** and other related National Association of State Mental Health Programs Directors (NASMHPD) papers on crisis services. SAMHSA also developed "**National Guidelines for Child and Youth Behavioral Health Crisis Care**" which offers best practicies, implementation strategies, and practical guidance for the design and development of services that meet the needs of children, youth and their families experiencing a behavioral health crisis. Please note that this set aside funding is dedicated for the core set of crisis services as directed by Congress. Nothing precludes states from utilizing more than 5 percent of its MHBG funds for crisis services for individuals with serious mental illness or children with serious emotional disturbances. If states have other investments for crisis services, they are encouraged to coordinate those programs with programs supported by this new 5 percent set aside. This coordination will help ensure services for individuals are swiftly identified and are engaged in the core crisis care elements.

1. Briefly narrate your state's crisis system. For all regions/areas of your state, include a description of access to the crisis call centers, availability of mobile crisis and behavioral health first responder services, utilization of crsis receiving and stabilization centers.

NJ's 3 Core Elements:

New Jersey is in the process of expanding its continuum of crisis services. The 988 Lifeline Crisis Centers are currently operational and there are plans to implement Mobile Crisis Outreach Response Teams (MCORTs) and Crisis Receiving Stabilization Centers (CRSCs).

Crisis Call Centers

New Jersey's 9-1-1 network, administrated by New Jersey's Office of Emergency Telecommunication Services since 1972, is comprised of over two hundred (200) Public Service Answering Points (PSAPs) statewide. 911 PSAPs are staffed by trained dispatchers 24/7/365. 911 call takers are trained to respond to a wide array of emergencies, including behavioral health emergencies.

New Jersey has five (5) 988 Lifeline crisis centers - CONTACT of Burlington County, Caring Contact, CONTACT of Mercer County (COMC), Mental

Health Association in New Jersey (MHANJ), and Rutgers University Behavioral Health Care (R-UBHC). Collectively, these centers offer 24/7 primary and secondary coverage statewide. The centers offer access to trained crisis counselors via call, chat and text. Crisis counselors are trained to assess individuals contacting 988 for risk of suicide, coordinate connection to current mobile response services, and ultimately connect individuals to appropriate care. Crisis counselors are trained to practice active engagement, use the least invasive interventions available, and initiate life-saving services to secure the safety of individuals who are at risk.

Mobile Crisis Response Teams

MCORTs will be comprised of a two-person unit in the field under remote supervision by a third professional from a centralized location. The professionals include: trained peer support specialists, bachelor's level professionals with related educational and professional experience (in the field), and master's level supervisors providing backup when needed. MCORTs will operate statewide, with multiple teams in designated regions of NJ. Posting of the MCORT funding opportunity is expected this summer and awards will be announced later this year.

Crisis Receiving Stabilization Centers

The DMHAS will award up to five (5) crisis receiving stabilization centers (CRSCs) which will advance the development of the crisis continuum in NJ based on the National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit. The objective is to develop an appropriate alternative to the use of local hospital emergency services and in-patient psychiatric hospitalization, by providing crisis services and placement support for those in need of permanent housing. The goal of this program is to decrease the utilization of local hospital emergency services, designated screening centers, and in-patient psychiatric hospitalization while maintaining crisis stabilization treatment. The Crisis Receiving Stabilization Centers (CRSCs) will serve individuals 18 years of age and older with a primary SMI and/or SUD experiencing a suicidal, mental health, or substance use crisis. DMHAS will be using the "no wrong door" concept and partnering with community crisis responders. Services will be available 24 hours per day, 7 days per week, every day of the year and include access to trained staff who can provide assessment, crisis stabilization, intensive supports, engagement, psycho-education, identification of strengths, collaborative problem solving, and individualized crisis planning. Services will be offered in a safe, clean, home-like environment conducive to the recovery process. Medication management, administration, and education will also be offered. Medication-Assisted Treatment will also be available at the CRSCs. Clinical staff in the program will strive to stabilize individuals and address their needs for further treatment or linkage. The program will offer continuity of care promoting continued stability and ensuring linkages are arranged that meet the needs of the individual.

Other Crisis Services in NJ Outside the Core Elements:

Beyond the core elements of NJ's Crisis Continuum, the SMHA has implemented a comprehensive crisis system including peer-run warmlines, crisis diversion homes, inpatient diversion, peer support diversion, and collaboration with law enforcement. The SMHA also provides technical assistance to improve the efficiency and effectiveness of crisis care services.

Crisis Diversion Homes

Crisis Diversion Homes are being developed in NJ to bridge the gap between homelessness and permanent housing, DMHAS will be developing up to four crisis diversion homes with 5-7 beds each which are staffed 24/7. This program will provide community-based stabilization in a home-like setting and is not long term or permanent housing, The length of stay for this program is dependent upon an individual's need and is anticipated to be up to 30 days. At a minimum, staffing will include licensed clinical social work staff, nursing coverage, behavioral health technician, and a prescriber. Although the crisis diversion housing is not permanent, individuals experiencing a recent psychiatric hospitalization or relapse will receive the support they need from professionally trained and dedicated staff to continue their recovery in the community in a home-like environment. The services and supports will be prioritized for individuals who are referred from Crisis Receiving Stabilization Centers and from Mobile Crisis Outreach Response Teams. By providing this additional level of care to the crisis continuum, the goal is to decrease the number of individuals in local emergency departments and emergency screening, including individuals longer than 23 hours while providing a mechanism for referral for crisis receiving and stabilization facilities for individuals with complex behavioral health needs that require significant services and supports to return to the community. Additional referrals may come from community inpatient programs as a step-down from short-term acute inpatient services providing the opportunity to further stabilize the client and connect the client with services and supports depending upon availability. The Crisis Diversion programs will include linkages to peer supports, clinical services, and housing with a goal of community re-integration to permanent or long-term housing and supports for the person receiving services.

Crisis Diversion Beds

The DMHAS contracts with mental health providers to provide 14 crisis beds in three different homes. These are residential settings that are staffed 24 hours a day 7 days a week. The homes focus on providing a recovery oriented residential setting for individuals to help avoid a mental health crisis. The length of stay in these homes is designed to be short term, and typically less than 30 days. The homes focus on rehabilitative skills, crisis planning, and individual recovery goals.

Peer Respite Beds

The DMHAS contracts with mental health providers to provide 20 peer respite beds across the state (4 homes with 5 beds each). These are residential settings that are staffed 24 hours a day 7 days a week. The majority of staff that work in these homes are peers. The homes focus on providing a recovery oriented residential setting for individuals that may need a respite from their current setting and/or may need this setting to

help avoid a mental health crisis. The length of stay in these homes is designed to be short term, and typically less than 30 days. The homes focus on rehabilitative skills, crisis planning, and individual recovery goals. These homes will either provide direct prescriber services as needed, or work to link individuals to services as needed. The staff will assist the individual with locating long term housing as well as other services where needed.

Diversionary Beds

The DMHAS contracts with inpatient providers to purchase bed-days in inpatient facilities, known as "Diversion" contracts. The purpose of the Diversion contracts is to afford individuals age 18 and older who would otherwise be admitted to a state or county psychiatric hospital the opportunity to receive treatment in an inpatient setting, which may enable the individual to stabilize and be discharged to the community. The primary goal of the purchase of bed-days is to reduce admissions to state hospitals. Individuals who do not stabilize and require continued inpatient treatment may be transferred to a state or county hospital at the conclusion of their approved length of stay in the contracted Diversion bed. The hospitals that contract for Diversion beds maintain additional bed capacity that is not governed by their DMHAS Diversion contract, and serve a similar population in this additional capacity.

Additional Suicide Prevention/Crisis Resources

New Jersey offers a service called ReachNJ which is a 24/7 addiction helpline for New Jersey residents who are seeking treatment for a substance use disorder. ReachNJ calls are answered by specialists who are trained to provide a caller with referrals to local treatment providers and/or other support services. ReachNJ is also available to people who are seeking support for a loved one with substance use disorder.

Staffed by mental health professionals and peer support specialists 24 hours a day, seven days a week, the New Jersey Suicide Prevention Hopeline is available to all ages for confidential telephone support (except when a suicide attempt is in progress), assessment, and referral. The NJ Hopeline offers call, text, chat, and email options. General information is available at: www.njhopeline.com

NJ 211 is a subsidiary of the United Ways of New Jersey. NJ 211 offers free, confidential 24/7 public information for individuals who require health and social service resources. NJ 211 provides referrals for housing, food, utility assistance, family services, behavioral health needs, and disaster support.

Finally, two (2) other call lines support the New Jersey crisis system. NJ Mental Health Cares is NJ's mental health information and referral service staffed by mental health professionals. The Peer Recovery Warmline is a peer-run service providing telephonic support to people in recovery from mental illness.

Designated Screening Centers

To ensure access to psychiatric emergency services statewide, there are 23 Designated Screening Centers (Screening and Screening Outreach) operating 24/7 in 21 Counties. These centers offer screening, assessment, crisis intervention, mobile screening, referral, linkage, and crisis stabilization services in all areas of the state.

Affiliated Emergency Services

Twelve (12) Affiliated Emergency Service (AES) programs are present in high-volume emergency departments. These programs provide immediate crisis intervention and support to individuals in distress, focusing on stabilizing their condition and facilitating their active involvement in service planning. The AES programs work in partnership with the Designated Screening Centers through formal agreements.

Early Intervention Support Services (EISS)

EISS programs are community-based mental health clinics that are open 6-7 days per week to deliver rapid access to short-term crisis intervention and stabilization services. They provide a comprehensive range of services, including medication, therapy, recovery support, and other supportive interventions, aiming to serve as a diversion to emergency room use and the need for inpatient treatment.

Crisis Services Provided by the Children's System of Care

Mobile Response and Stabilization Services (MRSS)

MRSS is the CSOC's urgent response service designed to help families stabilize youth in home and community settings. MRSS are available 24 hours per day, 7 days a week, year-round. MRSS provides immediate (within one hour) intervention designed to minimize risk, maintain the youth in his/her current living arrangement, prevent repeated hospitalizations, stabilize behavioral health needs, and improve functioning in life domains such as school and home routines. Mobile Response and Stabilization Services (MRSS) deliver services to youth vulnerable to or experiencing stressors, coping challenges, emotional or behavioral symptoms, difficulties with substance use as a coping strategy, or traumatic circumstances that may compromise the youth's ability to function optimally and thrive within their family/living situation, school, and/or community environments. MRSS is designed as an upstream intervention available to support families and youth when they first identify they need assistance based on their definition of need. Care is individualized, strengths-based, youth-centered, family-driven, community-based, trauma-informed, and culturally and linguistically mindful. MRSS provides engagement, crisis intervention, assessment, and planning designed to

stabilize presenting stressors, behaviors and/or emotional challenges, maintain youth in their home environment and community, build formal and informal supports, and prevent unnecessary psychiatric hospitalization, out of home care, and legal involvement. CSOC has collaborated with DHS to ensure access to CSOC services, inclusive of crisis intervention services delivered by system partners, i.e. Mobile Response Stabilization Services, in the event that a youth or their family member contacts 988.

Youth Suicide Prevention Resources

Every life lost to suicide is a tragedy and the New Jersey Department of Children and Families is committed to decreasing youth suicide and supporting youth who have attempted suicide. Suicide is the third leading cause of death for New Jersey youth between 10 and 24 years of age.

Traumatic Loss Coalitions for Youth (TLC) – UBHC Suicide Prevention

The TLC at Rutgers-University Behavioral HealthCare is an interactive, statewide network that seeks to reduce suicide attempts, deaths by suicide, and to promote recovery of persons affected by suicide by offering collaboration and support to professionals working with school-age youth and direct crisis response services to staff and youth at youth-serving organizations following a traumatic event. The TLC offers county, regional, and statewide conferences, training, consultation, on-site traumatic loss response, and technical assistance. Since its inception, the TLC has trained thousands of individuals throughout the state with the purpose of saving lives and promoting post trauma healing and resiliency for the youth of New Jersey. The TLC website can be accessed at http://ubhc.rutgers.edu/tlc/

Project Connect

In November 2020, the Garrett Lee Smith Youth Suicide Prevention Grant was awarded to the New Jersey Department of Health (NJDOH) from the Substance Abuse and Mental Health Services Administration (SAMHSA). This federal grant was awarded to implement NJDOH's Readiness to Stand United Against Youth Suicide (R2S Challenge). The Department of Children and Families (DCF) is collaborating with the DOH on a portion of the grant. This collaboration is to assist New Jersey hospitals to effectively connect youth to services following suicide attempts. DCF is developing Project Connect to increase engagement in community mental health services after hospital discharge, reduce unnecessary Emergency Department utilization through connection to appropriate community services, and improve safety and well-being for youth and families. Through the innovative role of the Regional Care Coordinator (RCC), Project Connect works in partnership with identified hospitals to enhance discharge planning for youth with suicide ideation and/or attempts. After youth are medically stabilized, screened, and determined to be safe for discharge, hospital staff will engage in a warm transfer process to connect families to PerformCare and community resources. Hospital staff will also be coached on how to obtain consent to connect the family to the RCC who will make contact with the caregiver post-discharge to provide the youth and family with follow up support and ensure linkage and engagement with community behavioral health services.

2NDFLOOR Youth Helpline

Accredited by the American Association of Suicidology, 2NDFLOOR is a confidential call/text helpline and message board platform serving youth and young adults. Youth who contact the 2NDFLOOR are assisted with their daily life challenges by professional staff and trained volunteers. The 2nd Floor website can be accessed at http://www.2ndfloor.org/

Crisis Text Line

The Children's System of Care has partnered with Crisis Text Line in New Jersey to provide another tool for constituents. Crisis Text Line is a free 24/7 support that connects anyone experiencing a self-defined crisis with a trained counselor. It can be accessed from anywhere in the United States. When texts are received, they are screened by an algorithm for severity, and texts that indicate imminent risk are placed at the top of the queue for faster response. Crisis counselors are trained to bring texters from "a hot moment to a cool calm," using empathic listening techniques. They collaboratively problem-solve to help the texter come up with a plan to stay safe. Calls are anonymous and confidential, unless referral to emergency services is necessary. For cell phone plans with AT&T, T-Mobile, Sprint, or Verizon, texts are completely free and will not show up on the phone bill. For plans with another carrier, normal text rates will apply and will appear on the phone bill as 741741. Additional information about Crisis Text Line can be found at http://www.crisistextline.org

New Jersey Youth Suicide Prevention Advisory Council

Established in, but not of, the Department of Children and Families, the New Jersey Youth Suicide Prevention Advisory Council is comprised of appointed New Jersey citizens and state government representatives. The New Jersey Youth Suicide Prevention Advisory Council examines existing needs and services and makes recommendations for youth suicide reporting, prevention, and intervention. It advises the development of regulations pursuant to N.J.S.A. § 30:9A-25 et seq.

2. In accordance with the guidelines below, identify the stages where the existing/proposed system will fit in.

*a) The **Exploration** stage: is the stage when states identify their communities' needs, assess organizational capacity, identify how crisis services meet community needs, and understand program requirements and adaptation.*
*b) The **Installation** stage: occurs once the state comes up with a plan and the state begins making the changes necessary to implement the crisis services based on the SAMHSA guidance. This includes coordination, training and community outreach and education activities.*
*c) **Initial Implementation** stage: occurs when the state has the three-core crisis services implemented and agencies begin to put into practice the SAMHSA guidelines.*

*d) **Full Implementation** stage: occurs once staffing is complete, services are provided, and funding streams are in place.*
*e) **Program Sustainability** stage: occurs when full implementation has been achieved, and quality assurance mechanisms are in place to assess the effectiveness and quality of the crisis services.*

Other program implementation data that characterizes crisis services system development.
1. Someone to talk to: Crisis Call Capacity
a. Number of locally based crisis call Centers in state
i. In the 988 Suicide and Crisis lifeline network
ii. Not in the suicide lifeline network
b. Number of Crisis Call Centers with follow up protocols in place
c. Percent of 911 calls that are coded as BH related
2. Someone to respond: Number of communities that have mobile behavioral health crisis mobile capacity (in comparison to the toal number of communities)
a. Independent of first responder structures (police, paramedic, fire)
b. Integrated with first responder structures (police, paramedic, fire)
c. Number that employs peers
3. Safe place to go or to be:
a. Number of Emergency Departments
b. Number of Emergency Departments that operate a specialized behavioral health component
c. Number of Crisis Receiving and Stabilization Centers (short term, 23-hour units that can diagnose and stabilize individuals in crisis)

a. Check one box for each row indicating state's stage of implementation

	Exploration Planning	Installation	Early Implementation Less than 25% of counties	Partial Implementation About 50% of counties	Majority Implementation At least 75% of counties	Program Sustainment
Someone to talk to	☐	☐	☐	☐	☐	☑
Someone to respond	☐	☑	☐	☐	☐	☐
Safe place to go or to be	☐	☑	☐	☐	☐	☐

b. Briefly explain your stages of implementation selections here.

DMHAS is in the process of finalizing an RFP to develop up to 5 Crisis Receiving Stabilization Centers throughout the state.

Someone to call - In New Jersey (NJ), five (5) centers have been providing services for the National Suicide Prevention Lifeline for many years (starting dates noted below). They were certified by Vibrant for meeting the minimum clinical, operational and performance standards. Those centers are: CONTACT of Burlington County (2009), Caring Contact (2005), CONTACT of Mercer County (COMC) (2005), Mental Health Association in New Jersey (MHANJ) (2013), and Rutgers University Behavioral Health Care (R-UBHC) (2013). As a result of work done during the Vibrant 988 Planning Grant, each of the five (5) NJ centers transitioned to the 988 Suicide and Crisis Lifeline system.

The five centers provide primary and secondary call coverage for all 21 counties in New Jersey. One center, COMC, offers 988 chat and text services, in addition to calls. COMC has been providing crisis chat services on the national level since 2014.

For May 2023, New Jersey's in-state answer rate for calls was 85% with 4.3% of calls flowing to back up centers. New Jersey's goal is to reach and maintain an in-state answer rate of at least 90% by June 30, 2024. Through a combination of State and federal funding, New Jersey has received approximately $17 million for 988 Lifeline operations. NJ DMHAS recently applied for an additional SAMHSA grant, which will total nearly $12 million over a 3-year period.

NJ DMHAS recently contracted with Carelon Behavioral Health, formerly known as Beacon Health Options, to be NJ's 988 Managing Entity. Carelon will be responsible for overseeing the operations of 988 Lifeline centers in NJ and dispatching Mobile Crisis Outreach Response Teams (MCORTs), when they are available.

Someone to respond – Mobile Crisis Outreach Response Teams (MCORTs) will be established as the "Someone to Come/Respond" for the NJ 988 system. The SFY23 budget includes $16 million for the establishment of statewide MCORTs. MCORTs are designed to respond in person, 24 hours a day, every day of the year to non-life-threatening mental health, substance use or suicidal crises in the community. Discussions have occurred among DMHAS and other state agencies including Medicaid (for funding) and the Office of Emergency Telecommunications Services (for interfacing with 911/PSAPs). Carelon, the 988 Managing Entity has been hired to handle dispatching of MCORTS once they are operational.

Safe place to go - Approximately $35 million has been allocated from State and federal funding for the development of up to five (5) Crisis Receiving and Stabilization Centers (CRSCs). The federal being used is from the Mental Health Block Grant 5% crisis set-aside, Covid Supplemental Funding, funding from the ARPA Plan, and funding from the Bipartisan Safer Communities Act. CRSCs will offer statewide service 24 hours a day,

every day of the year. CRSCs will provide short-term (less than 24 hour) community-based services to individuals experiencing a suicidal, mental health or substance use crisis. The CRSCs will be staffed by professionals, including professionals with prescription authority (Psychiatric Mental Health Nurse Practitioners and/or Psychiatrists), mental health and substance use clinicians, registered nurses, behavioral health technicians, and trained peer counselors. Licensed clinicians will screen for suicide risk and conduct more comprehensive violence risk assessments when clinically indicated. Individuals will be linked to aftercare services and offered follow-up support.

3. Based on SAMHSA's National Guidelines for Behavioral Health Crisis Care, explain how the state will develop the crisis system.

DMHAS plans to develop 5 Crisis Receiving Stabilization Centers (CRSC) statewide to serve individuals with a serious mental illness (SMI) diagnosis experiencing acute psychiatric symptoms and individuals with a substance use disorder (SUD) related crisis aged 18 and over. CRSC offers a no-wrong-door access to crisis stabilization, operating much like a hospital emergency department that accepts all walk-ins, law enforcement and fire drop offs, fire, police drop-offs (Note that EMS transfers to the program may not be made until arrangements for this are made). The individuals served in the CRSCs will receive community-based treatment and supportive services in an effective and timely manner 24 hours a day, 7 days a week, with the goal of mitigating the need to use the emergency room to access community-based services and preventing unnecessary or inappropriate hospitalization. The initiative will result in better care, better consumer outcomes and an improved consumer experience while accessing services. The program will also result in cost savings through the reduction in avoidable emergency department visits, psychiatric inpatient admissions, police engagement, arrests, incarcerations and 911 calls.

DMHAS will be developing up to 4 Crisis Diversion Homes that will serve individuals who have recently experienced a crisis and will prioritize referrals from Crisis Receiving Stabilization Centers (CRSC) or Mobile Crisis Outreach Response Teams (MCORT). The goal is to provide further stabilization, to divert hospital admissions and reduce emergency department (ED) visits. Crisis diversion can "promote access to less restrictive settings for residential crisis intervention and more effective utilization of scarce resources and expensive psychiatric beds [1]. CDHs offer recovery oriented temporary transitional housing for up to 30 days, within a 24-hour supervised setting that includes therapeutic and social supports in a warm and safe environment to individuals who do not need further hospitalization. DMHAS seeks proposals to develop residential capacity in an A+ service level structure which will provide 24/7 onsite staffing in the home for eligible individuals (in accordance with N.J.A.C. 10:37A).

New Jersey (NJ) has $10 million available in its budget for additional 988 Lifeline operations. NJ DMHAS plans to announce a funding opportunity soon for Lifeline centers to increase workforce capacity. NJ's goal is to expand the number of crisis counselors as well as the hours of current Lifeline centers to ensure full coverage 24/7, every day of the year. NJ DMHAS recently applied for an additional SAMHSA grant that will improve the NJ Lifeline centers' ability to respond to 988 contacts. NJ's allocation is expected to be $3.9 million per year for three years totaling $11.7 million. In addition to expanding the response capacity for calls, chats and texts, this funding would allow NJ DMHAS to improve public communication about 988 services, expand post-contact follow-up, and support the needs of high risk populations.

NJ is planning a 988 public awareness campaign to be launched this fall. Plans for the campaign include billboards, streaming ads, social media content, public transit ads, posters, etc. NJ's goal is to promote 988 to ensure all New Jersey residents are aware of this new service and have immediate access to crisis care.

Additionally, NJ plans to post the Mobile Crisis Outreach Response Teams (MCORTs) funding opportunity this summer. MCORTs will build upon NJ's current mobile crisis services with the goal of diversion from emergency departments and the justice system diversion whenever possible. MCORTs will meet individuals in an environment where they are comfortable with a focus on crisis resolution. MCORTs will incorporate peer professionals within the mobile teams, respond without law enforcement when it is deemed safe to do so, and schedule follow-up care with the individuals they serve. MCORTs will be dispatched by Carelon from a call center hub and will operate within a real-time GPS technology to track engagement.

____

[1] https://www.thenationalcouncil.org/wp-content/uploads/2022/02/042721_GAP_CrisisReport.pdf

4. Briefly describe the proposed/planned activities utilizing the 5 percent set aside.

With the mental health block grant 5% crisis set-aside and other funding sources, the DMHAS will develop up to 5 crisis receiving stabilization centers (CRSCs). The objective is to develop an appropriate alternative to the use of local hospital emergency services and in-patient psychiatric hospitalization, by providing crisis services and placement support for those in need of permanent housing.

Please indicate areas of technical assistance needed related to this section.

1) New Jersey is requesting technical assistance in order to develop a learning collaborative for the Crisis Receiving and Stabilization Centers. The learning collaborative model is an effective way for providers to receive training and ongoing support for the new programs, to disseminate and implement innovative treatments, improve quality of care and to promote implementation of evidence-based practices (EBPs). Providers would benefit from training and support in the following areas to enhance the smooth rollout and implementation of CRSCs:

- Developing a therapeutic facility design

- Development of culturally competent effective service models

- Adding to providers' therapeutic toolkit with treatment methods such as CBT and DBT for crisis intervention, suicide prevention, trauma informed care, and psychosis.

- Methods for collaboration with law enforcement, emergency services and 988;

- Addressing financial aspects of the program such as billing, calculating cost per chair, and moving towards future sustainability and expansion.

- Developing skills to promote accurate assessment of individuals and how to efficiently triage, treat, stabilize, and then discharge from the CRSC to an appropriate level of care.

- Program evaluation and development of outcome measures for national benchmarking with similar programs across the country.

- Use of Medicaid data and analyzing data from the Medicaid warehouse.

- Compliance with federal regulations

- Rate and policy development

- Development of a fidelity scale to ensure adherence to the best practices in crisis stabilization and receiving center programs.

- Workforce development and strategies for retention.

2) Training will be needed for Mobile Crisis Outreach Response Teams (MCORTs) once this program is operational. Carelon, NJ's 988 Managing Entity, has expertise in this area and would be available to provide training with additional funds from this grant.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Environmental Factors and Plan

16. Recovery - Required

Narrative Question

Recovery supports and services are essential for providing and maintaining comprehensive, quality M/SUD care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders.

Recovery is supported through the key components of: health (access to quality health and M/SUD treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery- guided the approach to person-centered care that is inclusive of shared decision-making, culturally welcoming and sensitive to social determinants of health. The continuum of care for these conditions involves psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder, and services to reduce risk related to them. Because mental and substance use disorders can become chronic relapsing conditions, long term systems and services are necessary to facilitate the initiation, stabilization, and management recovery and personal success over the lifespan.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see **SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders.**

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Technical assistance and training on a variety of such services are available through the SAMHSA supported Technical Assistance and Training Centers in each region. SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

Please respond to the following:

1. Does the state support recovery through any of the following:

   a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care? (●) Yes ( ) No

   b) Required peer accreditation or certification? (●) Yes ( ) No

   c) Use Block grant funding of recovery support services? (●) Yes ( ) No

   d) Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system? (●) Yes ( ) No

2. Does the state measure the impact of your consumer and recovery community outreach activity? (●) Yes ( ) No

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

   Please see attached.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state. i.e., RCOs, RCCs, peer-run organizations

   Please see attached.

5. Does the state have any activities that it would like to highlight?

   Please see attached.

   Please indicate areas of technical assistance needed related to this section.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Recovery – Required

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

Division of Mental Health and Addiction Services (DMHAS)

Office of Consumer Affairs

The Office of Consumer Affairs in the Medical Director unit has a key role in ensuring that individuals with mental illness, substance use disorder or co-occurring disorder receive a continuum of prevention, early intervention, treatment and recovery services delivered by a culturally competent and well-trained workforce. The Special Assistant for Consumer Affairs, who is a person with lived experience, leads the unit; oversees peer-run community wellness centers, respite programs, and other peer support programs; as well as contracts for peer training and other specialty services. With the development of new peer-delivered crisis services, her role will be expanded further. The Special Assistant for Consumer Affairs currently is a vocal member of the DMHAS' Executive Staff committee and is involved in leadership activities with providers. Feedback from the peer provider community is received directly in virtual meetings chaired by the Special Assistant that are held bi-monthly with peer providers, who share accomplishments and ideas, ask questions or raise concerns with each other and with DMHAS staff.

The Special Assistant supervises two full-time staff with lived experience. One staff member serves as DMHAS Ombudsman and as coordinator of a Secret Shopper program. The Ombudsman receives complaints or concerns about provider services, while the Secret Shopper program involves peers making calls to agency providers while presenting typical client scenarios. She also sits on panels that review and score RFPs and other proposals made to DMHAS, and is currently recruiting for a larger pool of potential peer candidates to help conduct these reviews. A second peer staff person works with individuals who have substance use and/or co-occurring mental health issues, and also to provide feedback to DMHAS staff overseeing co-occurring and SUD services. Because of the need to address the opioid crisis and related addiction concerns, this peer position was recently developed into full-time one in the unit.

Some Key Priorities for the Office of Consumer Affairs within the Medical Director's Unit

- Collaborate to raise awareness and to provide tools and resources to address health inequities that result from significantly shortened life spans and high rates of chronic medical conditions in persons with serious mental illness.
- Provide funding and support to the peer community to address the impact of loneliness and isolation and the other social determinates of health.
- Raise awareness and leverage resources in mental health programs about the prevalence of co-occurring substance use disorders and the pronounced need to provide integrated services to persons who struggle to recover from both disorders as well as complex physical health conditions.

- Advocate and inform DMHAS leadership about the need to treat people with compassion and dignity, and to design a system of services and supports that are trauma informed and trauma responsive.
- Empower and support peers in their chosen path to recovery by promoting shared decision making, peer recovery support and harm reduction models, peer respite programs, and peer recovery warm-lines.
- Promote and support the development of a competent and compassionate peer workforce in New Jersey. Peer providers have been identified in the literature as cost-efficient, efficacious and preferred providers of service delivery; and promoting peer providers will help in grow a robust behavioral health workforce in the face of increasing demands, which requires:
    - Getting "buy-in" at a leadership level to impact service design, delivery and agency policies and practices, as well as to support adequate levels of compensation for peer work
    - Elevating the peer-provider profession through education of non-peer staff and professionals about the unique qualities and value of the peers in delivery of care
    - Providing proper peer supervision, mentoring for positive self-care, and supportive networks for work and social life balance are critical in overcoming the challenges of the peer workforce

Collaborative Support Programs

Collaborative Support Programs of New Jersey, Inc. (CSPNJ), a peer-led not-for-profit organization, provides flexible, community-based services that promote responsibility, recovery, and wellness through the provision of community wellness centers, supportive and respite housing, human rights advocacy, educational and innovative programs for people with the lived experience of behavioral health conditions.

As a peer-led agency, CSP is committed to peer support and values the dignity and diversity of each individual; relationships as the means for growth and connection; inclusive communities that promote a sense of belonging; people's potential and their ability to grow and change; self-sufficiency through interdependence; and innovation as a challenge to the status quo.

The COVID-19 pandemic undoubtedly had a profound impact on mental health worldwide, resulting in an increased need for mental health and substance use supports and services. The uncertainty, fear, loss and disruptions caused by the pandemic led to a surge in anxiety and stress levels; while social distancing measures resulted in social isolation and increased feelings of loneliness. As a result, many individuals, for the first time in their lives, began seeking behavioral health service to cope with these heightened emotions. For individuals already living with behavioral health challenges, the pandemic exacerbated and worsened these conditions. Factors such as disrupted routines, limited access to social supports and providers, and increased stressors have contributed to the worsening of existing behavioral health conditions.

Because CSPNJ's services are low barrier, the community wellness centers were and are at the frontline of this surge in demand. Thus, CSPNJ has seen a dramatic increase in people seeking support and services to manage their behavioral health challenges at their Community Wellness Centers.

Recognizing the significant impact of the pandemic on emotional wellness, CSPNJ believes it is crucial to prioritize and invest in peer wellness and recovery services to meet the increased need and ensure the well-being of both individuals and communities.

CSPNJ's Hudson County Integrated Services (HCIS) is a Community Wellness Center that welcomes and supports people with mental health and substance use disorders who are seeking to improve their quality of life. This is accomplished through individualized, flexible services that promote respect, self-sufficiency, peer leadership, recovery, and community integration. The essence of HCIS is the integration of membership, services and staff in a Community Wellness Center setting designed to sustain and strengthen recovery, wellness and basic living skills for individuals who have mental health and substance use disorders, who lack housing and who have physical and behavioral health challenges.

People come to the Hudson Community Wellness Center to be part of its community, for a safe place to meet people, to get help with basic needs; for referrals to community resources, and to participate in a community that accepts and respects each individual's worth and dignity. The Center attracts over 150 individuals per day. The Center is a community, and through the community experiences, isolation and loneliness are reduced. The Center provides individualized support services, assists people in identifying their needs and aspirations and navigating service systems to move towards greater independence. Center membership is voluntary and it does not require participation in Center activities. However, often members who are moving towards making more positive life choices, come to the Center to give back to other members, which creates a cycle of peer support and mentoring.

The Hudson County Center provides a place for community members to access basic living needs, including food, clothing, housing referrals, financial services, counseling, recreation and socialization activities and self-help groups. The Center provides linkage and referrals to local and state community resources to help individuals obtain identification documents and mainstream entitlements, legal services, primary and acute physical and behavioral health care, literacy training, GED and educational opportunities, and services to reduce poverty. A partnership with the Community Court has also been established to allow members to attend virtual court to ensure they receive the assistance they need with their case. The Center currently supports approximately 90 members in Center sponsored permanent supportive housing and has continued working with the Hudson County Department of Corrections, the County Division of Housing and Community Development, and the County Continuum of Care Coordinated Assessment process to house more individuals and connect more center members to stable housing opportunities. Through this partnership, CSPNJ was able to offer Housing Navigation Services to individuals who have received a housing subsidy in Hudson County.

CSPNJ's Housing Navigation Program bridges a critical gap in services for individuals that need assistance due to current mental health challenges, as well as additional barriers such as poor credit, criminal, and eviction on their records. These individuals often struggle with housing search and placement also due to technology and literacy barriers, as well as difficulty in negotiating rents themselves and explaining the programs in ways that resonate with landlords. CSPNJ assists these members with application fees and transportation to the apartment viewing, as well as accompanying them if they request. The program provides assistance in way that helps people

served to feel comfortable during this process and also helps them reach their goal of housing. CSPNJ has operated a Housing Navigation Program in Hudson County for 2.5 years and has housed 150+ households in that time. The success of the program has allowed the program to expand from one housing navigator to two to better meet the need of Hudson County. CSPNJ seeks to replicate its Housing Navigator Program in Essex County where we anticipate serving 120 households within the first year of the program.

CSPNJ also operates Hudson County's Warming Center wherein low barrier services are provided to individuals experiencing homelessness, many of which are experiencing mental health and substance use challenges. The Warming Center assists in providing emergency shelter for over 120 guests a night and opens from November 15th through March 31 during Code Blue temperatures at a facility owned by Hudson County in Kearny, New Jersey. The goal of the Warming Center is to provide a low barrier, warm and safe place for unsheltered individuals to spend the night during the winter months despite their personal challenges and disabilities. CSPNJ serves the needs of the overflow of people who are without housing that are forced to live on the streets and in train stations during the winter months. CSPNJ's staff are trained and able to assist with the special needs of individuals who are lacking housing, and experiencing mental health issues, substance use issues, or intimate partner/domestic violence issues. The program provides peer services and connections to CSPNJ's Wellness Center services and Respite locations to assist individuals who may be in crisis or need additional services to help them work on their wellness. CSPNJ also partners with Bridgeway's Mental Health Services/Crisis Intervention and CCBH program to help warming center guests address their mental health needs and also access primary medical care and substance use assistance through this program as well. This year, the program expanded its services to include on-site medical care every evening.

A Better Life Community Wellness Center located in Newark, is truly its own community and has been able to follow CSPNJ's Integrated Model and connect members with a variety of services. It is a place where people of all walks of life can come for assistance with mental health and substance use challenges as well as peer services, support groups and activities, get a hot meal, cup of coffee, or some cheer to brighten their day. The doors to this facility opened in July 2018 and have continued to flourish ever since and serves an average of 150 each day. There is a resource specialist providing ID and birth certificate assistance, social service assistance, referrals to housing and recovery services. The wellness mentors who provide peer support to members in the areas of advocacy, resume writing, computer training, professional development, employment linkage, housing applications, obtaining mainstream benefits include NJSNAP, WFNJ / Cash Assistance, SSI / SSDI, free phones / tablets, etc., and assisting members with obtaining health insurance benefits.

The center provides linkages to substance use inpatient & outpatient detoxification and long-term treatment. Within these years, over 200 individuals have been referred to treatment through Better Life. Many have maintained their sobriety and recovery from this service offered. As a result of their recovery, many of the people served that were without a home and that were facing co-occurring behavioral health challenges have secured safe-housing. The Better Life CWC hosts outreach events on a regular basis to help members connect to services that may be available to them in their community. Some outreach services include COVID-19 testing, HIV testing, Hypertension & Glucose Screening, and Food & Clothing Giveaways. Better Life Community

Wellness Center is a fast-paced, thriving center that provides essential mental health peer services that provides hope and resources so that people served can work toward their wellness and recovery goals and valued life roles.

CSPNJ also assists and performs outreach from peers in the community with New Jersey Transit at multiple train stations within New Jersey. CSPNJ was approached by the NJ Transit Inspector after he became aware of CSPNJ's Community Wellness Centers and the services that are provided at the centers. This outreach initiative provides Peer Services and links individuals to CSPNJ's Centers and to a variety of services such as mental health and substance use referrals, Detox, Respite Services, as well as documentation and housing assistance. Five locations throughout New Jersey were identified and include Newark Penn Station, Hoboken terminal, Paterson, Camden and Atlantic City stations as transit stops that were seeing an increase in people experiencing homelessness with behavioral health challenges. During this outreach effort two CSPNJ peer staff are paired up with a designated Outreach Officer that accompanies them throughout their days there, both assisting and providing transportation to CSPNJ's nearby Community Wellness Centers and to any additional linkages needed. This has been extremely effective and productive in both connecting individuals with much needed services and with helping to model for the Outreach Officers how it is best to engage this population and how to use a peer led housing first/ harm reduction model. This project also has a Court component that we are using at the stations as well in conjunction with this effort, it allows for individuals that are experiencing mental health or substance abuse challenges to not receive a summons or ticket initially from these officers, but instead a referral to our Center services when appropriate. Collaborative virtual court services are provided with Newark Community Solutions out of the Better Life Community Wellness Center. This has helped create a productive and more positive person first and peer-based approach to what persons served are experiencing at the transit stations. CSPNJ aims to continue to grow this relationship with New Jersey Transit as it has been extremely helpful to individuals served and has also helped to encourage them to seek services and utilize CSPNJ's Community Wellness Centers to help them get through their current crisis and give them a safe space they can come to daily when in need. The transit terminals have also reported seeing a decrease in individuals using them as a place to stay instead of seeking assistance and has had an all-around positive effect on each of the transit locations.

The Learning Recovery Community Wellness Center (LRCWC) is located in Rio Grande. The Community Wellness Center was developed with the merger of the Center and the Wildwood Wellness and Recovery Center (W2R2). The W2R2 functions as an overnight retreat and training site for Community Wellness Center members and other persons receiving services statewide. The LRCWC has experienced an increase in membership of persons in recovery who cope with mental health issues as well as challenges of substance use, homelessness, shelter/motel residency and other special needs. The LRCWC of Wildwood has worked to develop more extensive and culturally sensitive services that meet the needs of their community. The services include Community Wellness Center activities and groups that are offered in person or virtually, linking members to and delivering food from the local community food pantries, linking members to community resources in order to obtain the services that are needed, and providing peer support and community outreach in the Wildwood/Rio Grande community and the surrounding area. The members and staff at the Learning Recovery Center have networked with various providers within the community. The LRCWC provides wellness and education groups that incorporate the eight

dimensions of wellness. These groups include topics such as dealing with anxiety, stress management, recovery, WRAP, budgeting, wellness choices, diabetes, hypertension, men's/women's groups, healthy eating, and exercise. Members and staff alike were also provided the opportunity to receive training in the use of nasal naloxone to prevent death in the event of opiate overdose to a friend, acquaintance, or family member. Over the past year, the LRCWC has been instrumental in providing naloxone training to 119 members and staff. Upon receipt of naloxone training, the individual receiving training is eligible to receive their own naloxone administration kit free of charge if desired. The naloxone kit is replaced free of charge if expiration date is reached, or kit is used for opiate overdose reversal.

NJ State Psychiatric Hospital-based Wellness Centers. These centers have been working to increase their membership. These centers created new half-page fliers with the hospital-based center's information on them to show-case SAMHSA's eight dimensions of wellness. They created business cards, newsletters, and weekly calendars to remind hospital staff and members that the centers are available resources for wellness and recovery services to the population at the hospitals where they work.

Centers continue to use "Welcome to the community cards" which remind a person receiving services that when they are ready and when they get discharged into the community, after a long-term hospitalization, they have friends, family, wellness centers, peer-operated warm lines, agency support, including paid professionals, that they can reach out to for support and assistance in order to avoid re-entering the hospital system.

Seeing the importance of the "Welcome to community cards" along with the isolation caused by COVID 19 and expansion of tele health services and supports led to a new pilot program to address the need to have access to communication and connection immediately upon discharge.

In April of 2021 Collaborative Support Programs of New Jersey Wellness Centers partnered with New Jersey Department of Health to implement the cell phone pilot program at three of their four state psychiatric hospitals. The project targeted individuals being discharged from the hospital who had also participated in vocational/supported employment services. In September of 2022 the cell phone project was expanded to include all individuals being discharged from any of the four state locations. In year one 165 phones were provided with a goal of 555 phones to be delivered in year two.

Prior to a person being discharged from the hospital they sign an agreement to have their new phone number provided to Community Wellness Center for ongoing peer support post discharge. Orientation and education are provided in collaboration with vocation teams on how to use the cell phone including: assist person with entering contact information for the community wellness center, providers, and natural supports, entering upcoming appointments in their calendar and set up a personal email account. There is also linkage to a Community Wellness Center located in county of residence pre discharge via telephone or virtual meeting. Brochures and calendars for Community Wellness Center and Peer Respites were also provided at time of discharge.

The hospital-based Wellness Centers have been working toward utilizing Personal Medicine cards. The Trenton Psychiatric hospital-based center has also been providing support to the Ann Klein

Forensic Center (AKFC) since it began operating eight years ago. Originally the staff provided groups to the Transitional Alternative Programming (TAP) program at Ann Klein. Most recently, groups are offered on the Rehab units at AKFC. Examples of the groups at the forensic site are groups focusing on the materials found in the Recovery Library, WRAP topics, 8 dimensions of Wellness, “Shared Recovery Stories”, “Coping in a locked environment”, and other topics as requested by engaged group members.

One-on-one peer-to-peer mentoring and support does happen on a regular basis, although sometimes it is at special request by staff or by patients who are serving time there. In the one-on-one encounters individuals have sometimes expressed an interest in becoming peer support specialists when they get back into the community. One of the original Anne Klein Forensic Hospital group members is currently working as a peer in a DMHAS funded agency that focuses on supporting individuals within the judicial system. Since his discharge he has received his Bachelor’s degree and is currently working on completing his Masters’ degree.

The expressed desire of center members to become peer mentors led to another new collaboration at Trenton Psychiatric Hospital to provide access and scholarships prior to discharge to enroll in peer certification programs. We have currently supported six individuals starting their new career path and will expand this project at all three locations.

<u>CSP’S Financial Services</u>. This program/service was developed in 2002 with the mission to give access to economic opportunities, people in recovery with psychiatric disabilities living in poverty will achieve financial stability, security and independence through increasing financial knowledge and net worth. Poverty is one of the key barriers to recovery and CSPNJ seeks to promote systems transformation that promotes asset building and economic prosperity.

These Financial Services “promotes self-determination, self-sufficiency, community integration and personal responsibility by offering products and services that increase a person’s wealth through financial education, personal assets and employment. This is done through a wellness and recovery approach”. The following are the services provided:

- <u>Financial Management Accounts.</u> This program provides financial management services to address the issues with budgeting, debt reduction and bill payment to an average of 135 supportive services recipients and community wellness center members across the state. To provide a more convenient service, debit cards have been provided to all money management participants from locations across the state and have proven to be a very convenient and successful tool for individuals.

- <u>Social Security Administration (SSA) Representative Payee Service.</u> This program is available to an average of 105 supportive housing recipients and community wellness center members across the state currently receiving the service.

- <u>Financial Coaching.</u> This program offers one-to-one coaching with supportive housing participants and community wellness center members to work on financial assessments, financial planning, debt reduction, addressing credit and tax issues and setting short and long terms savings goals.

- Savings Incentive Initiatives Accounts. These are offered to an average of 123 supportive housing recipients and community wellness center members across the state who are currently participating in one of the 3 match savings programs offered to acquire a productive asset, such as, car maintenance, apartment security deposit, furniture, household items, clothing for employment, etc.

- Emergency Micro-Loans. These are offered free of charge to assist supportive housing recipients and community wellness center members with short-term financial emergencies and unanticipated expenses. Participants are encouraged to participate and complete the financial education curriculum offered; develop a financial and savings plan that will ensure repayment of the loan; and establish financial security for the borrower by beginning or continuing to save towards a goal.

- Financial Literacy Education. This program provides a series of one-on-one web-based or group training that is offered at chosen locations every year to CSPNJ administered community wellness center and/or office locations utilizing the Money-wise curriculum designed to engage and change a person receiving services' attitude about money and their relationship with money.

The Vacation Club includes participants who are people with mental health and substance use challenges living in poverty. Participants will save money during the year and CSP coordinates the vacation club trips on a limited budget. The chance to get away, recharge and restore for even just a few days a year, is a critical step toward healing and recovery.

The Fall Festival is an annual event where 300-400 peers for all over the State, including those in the state psychiatric hospitals, get together to learn about different services available in the community and meet other members of the community. Presentations, games, talent shows are part of this event.

Peer Respite Centers. Three peer-run crisis respite programs are operating in New Jersey. The purpose of the peer-run crisis respite is to offer a low-stress, home-like environment to an individual who is experiencing either a crisis or an emotionally distressing episode to take a "time out" of life pressures to re-evaluate what is going on with him/her to understand the source of the difficulty and then to plan on how to move forward in a more deliberate, self-protective way in order to divert this type of situation from recurring. This is done with the help of a peer counselor as well as in group settings with other guests at the respite. Respite has diverted many people in crisis from going into the hospital--saving money compared to a typical psychiatric stay and providing by all accounts a less traumatizing experience.

Collaborative Support Programs of NJ (CSPNJ) operates three peer respite houses located within settings in New Brunswick, Newark, and Haledon, NJ. The Mission of CSPNJ's Wellness Respite Services is to provide an alternative to hospitalization which instills a sense of hope, empowerment, and self-determination in people in emotional distress fostering recovery and wellness in order to pursue valued life roles and personal goals. The peer-run respites are staffed 24 hours a day, seven days a week. They help Respite guests, i.e., people receiving services, to

restore capability and balance. The respite sites provide intensive short-term support for individuals in the community through an alternative environment to inpatient hospitalization. They empower a person in crisis to re-establish healthy habits and routines. The respite helps enhance coping skills to manage crisis or distress in order to resume valued roles. They encourage and strengthen wellness self-care so that the guest can be successful in managing the immediate crisis and resume valued life roles and responsibilities. The respites provide linkage to local Community Wellness Centers and assist guests to become or remain linked with their healthcare providers, jobs, schools and communities.

CSPNJ serves New Jersey residents who are 18 years of age and older and who are in crisis or emotional distress due to mental health and/or substance use issues. To date, CSPNJ's Peer Respites have had over 2,900 Respite guest stays. Because the program is peer-run, the relationship between staff and guest is a collaborative one as staff comes from the perspective of a fellow traveler. Thus, Respite staff view the guest as the expert on himself or herself. The program offers up to a 10-day stay in a warm, safe and tranquil setting where the guests receive intensive support from peers which includes working through a Wellness Plan that addresses their emotional distress and overall health. The Wellness Plan consists of individuals' self-defined recovery goals which address their current distress and help them to avoid future ones. The Wellness Plan is the primary focus of a guest's stay. Staff and guests meet daily to work on the Wellness Plan. All guests are eligible for 30 days of follow up services after their respite stay has ended, wherein guests continue to work on their wellness plan goals while transitioning back to their homes.

Referrals to CSPNJ's program come from a variety of settings including family physicians, case managers, therapists, psychiatrists, family members, and friends. However, anyone is able to self-refer to the program as CSPNJ seeks to speak directly to the person seeking services in order to complete an intake. All of the intakes occur directly over the phone and determinations are made during the intake process. CSPNJ respite staff members are actively involved in their communities. For example, the respite staff members are committee members of Middlesex County's Campaign to End Stigma. Respite staff also participate in a Behavioral Health and Justice Involved Taskforce and take part in multiple counties' Crisis Intervention Training for Law Enforcement which seeks to decriminalize mental health disorders and divert individuals from the criminal justice system. Furthermore, CSPNJ respite staff continue to collaborate with important groups such as NAMI and family supports such as IFSS. Additionally, in the Spring of 2022, CSPNJ staff wrote a journal article which was published in the Journal for Psychosocial Nursing titled "A Welcoming Space to Manage Your Crisis: The Wellness Respite Program" which distills the elements of Peer Respites which make them a vital and effective alternative to hospitalization (this article can be viewed at https://journals.healio.com/doi/full/10.3928/02793695-20220428-04)

Furthermore, in the Fall of 2023, CSPNJ will be hosting a Conference about Peer Respites which will share best practices and the successes of the programs.

<u>Residential Healthcare Facilities/Boarding Homes.</u> Outreach is provided by MHANJ and CSPNJ Wellness and Recovery Centers to individuals residing in Residential Healthcare Facilities and Boarding Homes. In Ocean County, the Journey to Wellness and Brighter Days centers have partnered with Ocean County Human Services, police, social service agencies, and the NJ Department of Community Affairs to expand access to the services offered and bringing peer

recovery services into the homes and transporting clients to community wellness centers. This effort has spawned legislation to create greater community engagement with the facilities. The residents have been assisted in setting up emails so that they can receive outside information that they sometimes request. The center staff are helping the boarding home residents with computer skills so that they can find phone numbers and addresses for various agencies in Ocean County. The centers provide groups based on the eight dimensions of wellness specifically for the Boarding Homes residents: Budgeting, Independent Living Skills, Health, Fitness, Nutrition, and Emotional Wellness. Center staff assist Boarding Home residents with transportation to and from MVC to obtain identification and to Social Services for Social Security benefits. There have been many outreaches to benefit related program opportunities, shopping opportunities, etc. Residents have been assisted with clothing, personal care kits, and are provided a meal by center staff when visiting the center. The residents enjoy many social/recreational activities at the centers and off site such as: playing board games, music groups, holiday parties, barbecues, minor league baseball games (tickets are donated by the team) CSP-NJ Fall fest, COMHCO Conference. There is much more that has been done in the past year to make the Boarding Home residents' lives just a little more hopeful and empowered.

Hearing Voices Self-Help Support Groups. These groups are transforming the lives of people all over the world by allowing them to understand and cope with the experiences that have long confused and frightened them. Statistics show that anywhere from 3-10% of the population hears voices that others cannot. Although the traditional attitude in the mental health system has been to eradicate these voices, research now indicates that voices should be viewed as a meaningful experience, linked to a person's life story, and that talking about the voices is in fact crucial to recovery. Studies have concluded that most people who hear voices have experienced some type of trauma. The New Jersey groups offer people a safe environment where they have the opportunity to share their experiences without the threat of censorship, loss of liberty, or forced medication. Hearing Voices groups are not only comprised of those who experience auditory hallucinations, but those who experience any sensation perceived to be unusual and separate from one self. These groups act as a source of information to voice hearers, caregivers, and the general community by offering coping skills, support, acceptance, validation, recovery, and most importantly hope. Currently groups are operating at most of the CSPNJ operated Wellness Centers. In addition to live, in-person groups, CSPNJ also provides virtual groups online. This online delivery method has proven popular within the community. We encourage anyone who hears voices or has unusual sensory experiences, caregivers, as well as anyone in the mental health field who may have an interest in the phenomenon of hearing voices, seek out HVN to determine firsthand whether the services we provide may offer some curative benefit. CSPNJ HVN is a welcoming community that encourages inquiries.

GROW Support Groups: CSPNJ has worked to expand the number of GROW support groups offered statewide. What makes GROW unique? The innovative way the GROW groups are run. They're a twelve-step program that encourages and supports participants to become the person they want to be. The groups meet weekly, and participants are charged with working on something that they choose for themselves. Reports on progress are discussed weekly and positive reinforcement and suggestions are given. Each member is free to discuss any problem they encounter or to talk about how their feelings and where they're at in their recovery. It's all about

people helping each other where they're at in any given time and developing healthy coping skills. It's another alternative to achieve good mental health strategies!

Coalition of Mental Health Consumer Organizations of New Jersey Incorporated (COMHCO). COMHCO is a statewide membership organization comprised of adults dedicated to improving the quality of life for themselves and their peers with serious and persistent mental illness through education, empowerment, and advocacy. The goal of COMHCO is to provide education on the key issues of self-determination, wellness and recovery and to work toward ending the stigma associated with mental illness. COMHCO is a forum for the presentation and discussion of information that guides mental health survivors in their quest to achieve empowerment and advocacy for themselves and their peers. The ideal of personnel development, education, employment, and public awareness are central to the values needed for individuals to become full and responsible members of the larger society. COMHCO General Membership consists of 4,000 NJ person receiving services. An Annual COMCHO Consumer Conference is held each year. This year's conference COMHCO Going L.I.V.E. (Listening, Informing, Voicing and Educating) was held in April with a focus on advocacy and the peer movement: history and future. There were 14 workshops offered on various topics including: Self-Advocacy, Individual Rights and CEPP status, Legal Advocacy, Legislative Advocacy, Systems Advocacy, History of Peer Movement, and development of 988. The Conference also offered a Resource room with both peer and professional groups sharing information.

Workshops were selected based on input from the membership and mirror ideas, as well as suggestions that were raised during the monthly meetings and from past conference evaluations. With an attendance of 265 person receiving services representing a cross section of state and county hospitals, Community Wellness Centers, Recovery Centers, Support Groups and other consumer organizations throughout the state, the conference offers not only topical workshops but affords the opportunity for inter-county networking, information sharing and gathering, as well a forum to share strategies used for both advocacy and wellness. A highlight of the conference is not only the yearly keynote address, which supports the yearly theme-based on suggestions and the approval of the membership, but the NJ Assistant Commissioner of the Division of Mental Health and Addictions Services Annual State of Mental Health in New Jersey presentation. The presentation provides an update to ongoing issues of importance and informs members of new initiatives. This forum reinvigorates members to the value of their partnership in their personal recovery and reinforces the place that NJ Mental health, addiction, and co-occurring person receiving services hold as stakeholders in NJ Wellness and Recovery Programs.

Person receiving services are encouraged to become active in developing and supporting COMHCO's organizational activities and network strategies. Monthly meetings provide a regular forum for persons with lived expertise to share their experiences while encouraging newer members to see the value of both personal and systems advocacy to strengthen the mental health system and to ensure that programs are aiding them in meeting their own Wellness and Recovery Plans while also reinforcing the values of the Psychiatric Advanced Directives in daily living. These monthly membership meetings, which are combined with quarterly Board Meeting, strengthen the person receiving services' involvement.

COMHCO has developed working relationships with: Collaborative Support Programs of New Jersey, Disability Rights of New Jersey, State Consumer Advisory Committee, NAMI-New Jersey, Mental Health Association of New Jersey, Depression Bipolar Support Alliance of New Jersey, Consumer Provider Association of New Jersey, National Coalition for Mental Health Recovery, Supportive Housing Association of New Jersey. Members hold representation on various State and county boards and committees, such as: NJ DMHAS Behavioral Health Planning Council, New Jersey Mental Health Citizen Advisory Council, NAMI-New Jersey Board and Committee, Consumer Public Policy Committee, New Jersey Mental Health Coalition, NJ State Consumer Advisory Committee, NJ Suicide Prevention Advisory Committee, and County Mental Health and Addiction Boards.

Wellness Dollars: DMHAS reallocated some of its already existing funding dollars to create a competitive opportunity for Wellness Centers/Self-help Centers to apply for additional "Wellness Dollars." Through an application process in which the managers had to explain how they would use these particular funds to address the memberships needs surrounding specific dimensions from SAMHSA's Eight Dimensions of Wellness, and how that additional funding would assist to enhance services in dimensions that were important to the members of each Center. This funding for these wellness directed projects plays a crucial role in supporting individuals in their recovery journeys by providing resources, services, and opportunities that are essential for their well-being and progress. For example, one Center chose Physical Wellness and used Wellness Dollars to purchase exercise equipment, (a treadmill and 2 exercise bikes) as the membership identified that having access to this equipment would help them reach their physical wellness and recovery goals.

The CSPNJ Wellness Institute under the direction and leadership of Dr. Peggy Swarbrick , the developer and leader of the 8 dimensions of wellness model adopted by SAMHSA, the Wellness Institute continues providing expertise and support to help implement the wellness in 8 D model for people at risks and living with a range of behavioral health, and stress related challenges.
In collaboration with UIC develop and help to disseminate state of the art wellness resources https://www.center4healthandsdc.org/solutions-suite.html.

The following are some of the training and publications of the Wellness Institute.

Peer Support Training
Fall 2022 Dr. Swarbrick developed an Ethics for Peer Support staff at CSPNJ Wellness Centers and facilitated small groups sessions to train 65 peer support staff working at the community wellness centers.

Dr. Swarbrick has developed a *Peer Recovery Specialist Supervisor Training Manual (Swarbrick 2022. Peer Recovery Specialist Supervisor Training Manual Collaborative Support Programs of New Jersey).* Many have been seeking training and technical support guidance to ensure that all peer support supervisors are adequately prepared to fulfill the role especially masters prepared supervisors who have not completed the peer support training program.

New Wellness Products
The UIC Solutions Suite for Health & Recovery offers tools, curricula, and implementation manuals for free and immediate use in mental health centers, peer-run programs, or one's own life.

The Suite is Co-Directed by Dr. Peggy Swarbrick. Its products are co-developed with the Collaborative Support Programs of New Jersey.

- *Wellness Activities* introduces people to strategies that help them create new health habits of their own choosing. Each lesson has been constructed as a group activity that maximizes learning through building positive interpersonal relationships and actively involving participants.
  https://www.center4healthandsdc.org/wellness-activities.html

- *Physical Wellness for Work:* Success at work requires a level of stamina, energy, and concentration that can be challenging to sustain without attention to daily wellness habits and routines. Physical Wellness for Work offers manageable activities to augment health and wellness. Its underlying philosophy is that even small changes in daily habits can result in increased energy and health for a better and more satisfying workday.
  https://www.center4healthandsdc.org/physical-wellness-for-work.html

Dr Swarbrick was an invited attendee at the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services (CMHS). RECOVERY NOW: SAMHSA Recovery Summit 2022, August 9-10, 2022.

Mental Health Association in New Jersey

The Mental Health Association in NJ (MHANJ) has been a leader in the creation and development of peer services in New Jersey since the late 1980's. Through grassroots partnership with consumers and organizations, Collaborative Support Programs of NJ, Coalition of Mental Health Consumer Organizations, and the Division of Mental Health and Addition Services sparked and operated the first drop-in centers, first consumer supported housing, peer case management, lead the wellness and recovery movements, certification of peer specialists, and launch peer run services independently and in partnership. Empowering the voice of peers is the overarching goal and continues to be the foundation of all their work today and in the future.

MHANJ operates three Wellness Centers: (Individuals in Concerted Effort (ICE) in Atlantic County, Journey to Wellness in Ocean County, and Esperanza- in Union County).

- Each center has emerged from the COVID Pandemic as a stronger-more integrated community center. During the pandemic- the centers combined resources to create "United by Wellness"- UBW is a virtual wellness center-that offers 7-day week menu of peer delivered support, education, recovery (including co-occurring), and socialization groups. Today UBW continues offering an average of 50 groups a week to each of the center's members and is open to consumers across the state. The shift back to face-to-face services from COVID has been slow, as the advantages of virtual support for many eliminated the barriers of transportation, childcare, and limited access to meetings and services. The return to more in person services has not decreased the engagement virtually, with these centers needed to maintain both tracts of services to meet the need of individuals.
- Outcomes: This project has more than doubled the reach of each wellness centers creating a large vibrant recovery community of over 2000 registered virtual members, specialize support groups include LGBTQI, Black Women, Co-occurring, and those with physical

disabilities, Veterans, and a wide variety of music and fun groups. It has opened new partnerships to support the growth of peer support- and attracted a more engaged membership.

- Opportunity and challenge: United by Wellness project could be expanded in both size, scope, and level of recovery support to partner directly with case management, crisis response, and to targeted populations needing a broad level of community recovery support. MHA sponsored centers have the framework to grow and expand services- especially with the co-occurring populations but lack the intra-structure, resources and staffing to meet the need, and to partner more with addition focused recovery centers. The lack of cost of living increases in core wellness center budgets has further deteriorated the resources needed to address the growing need in the communities served.

Peer Outreach Support Teams (POST) are operated by MHANJ in four counties- Atlantic, Hudson, Ocean, and Union counties. Each county POST program provides peer to peer one on one support and short-term basic case management services. The peers providing these services are certified as a mental health peer (CRSP) and many as a substance abuse peer (CPRS)and receive supervision from a more experienced peer, as well as ongoing training. Referrals to this project can come through Division funded programs, community and family programs, and self-referrals. During the COVID pandemic the program operated in a hybrid format with virtual video, text, and telephone support, with limited face to face contact. During COVID services expanded to assist with delivery of food, medication, and other necessities to those isolated. Client engagement focuses on peer-to-peer support- to promote wellness, recovery, whole health, employment, and community integration. POST workers are the "experts on accessing local services – and mentoring of peer support, and they work extensively with persons with co-occurring substance use disorders.

- Outcomes: POST is funded in each county for between 1.5 FTE and 2 FTE and provided services averaging 60 clients per year, for a total of 220 in the previous year, with outcome surveys showing significant positive changes in both mental health and life situations The demand for peer support services- POST continues to grow – especially with MHANJ integrating it into other county based programs and contracts, especially in the Ocean county program- where POST is funded to provide specific peer services to family members, aging out youth, seniors, physically disabled and individuals with both housing and food insecurities- each on a fee for services basis. POST's certified peer support and case management, and behavioral health experiences fits a growing need in the community. POST program staff are integrated with re-entry programs, participate in Crisis Intervention Training (CIT) and are key referral sources in other criminal justice efforts.
- Challenges and Opportunities: Funding to expand POST within the mental health system either by direct positions or allow Medicaid reimbursement is the major barrier. MHANJ has established a strong program model that can work within the traditional treatment system, but also work effectively with the large number individuals with mental health and substance use disorders who are not receiving services. MHANJ is using the POST model with other funding sources to engage individuals with emotional issues and is currently involved with a pilot project with Horizon BlueCross/Shield to offer Peer Support services to its commercial clients. Once Medicaid funding to peer support flows MHANJ is in the position to significantly expand these peer support services.

Wellness Recovery Action Plan (WRAP) and Whole Health Action Model (WHAM) has been MHANJ primary vehicles to provide wellness tools to our adult and family communities. MHANJ's use of WRAP began in 1998 as MHA sponsored a WRAP Conference with founder, Mary Ellen Copeland. WRAP has been integrated across all programs, messaging, and training- with completion of the WRAP 18 Hour Seminar #1 a requirement for all staff- as well as a pre-requisite for the CRSP peer certification. MHANJ is the only accredited provider of Certified WRAP Facilitator training in the state.

- Outcomes: Last year provided two- 35-hour Facilitator Training for peers working in eight different organizations in the state. MHANJ has integrated WHAM into its' peer training portfolio with 15 staff members accredited in Whole Health Action Management (WHAM) working across all peer services, as well as providing WHAM training in the peer community. The pairing of these two models has created a strong interwoven toolkit for MHA staff to work effectively and consistently to support an individual in their recovery journey.
- Challenges and Opportunities: The challenges to expand WRAP as a peer centered tool are the lack of WRAP trained facilitators to implement the program to its fidelity. WHAM is a strong toolkit, but again, requires a commitment by organization to fully train their staff. Opportunities exist for both tools to be used to expand the footprint of peer services outside of traditional treatment and recovery services. As both programs easily apply to everyone, they have proven to be excellent tools to engage new partners and communities – and funding to support the effort. Certified peers are excellent role models for both toolkits.

Building a strong Peer Workforce has been the Goal of MHANJ Consumer Connections program since it was founded in 1997. Consumer Connections began training peers to work in paid positions within NJ's mental health system over 25 years ago. Since that time the program has evolved to a full-scale workforce development program, creating, and supporting NJ's only mental health peer certification- recognized by Medicaid – the CRSP- Certified Recovery Support Practitioner. During the COVID Pandemic, Consumer Connections became a fully virtual training platform- providing the CRSP training, weekly continuing education webinars, peer support groups, and continued to support provider agencies in the hiring process of peers. Consumer Connections also provides the CPRS- the NJ substance use certification training to all its CRSP graduates- to provide them with dual expertise and dual certification to work with co-occurring clients across NJ's system.

- Outcomes: Last year Consumer Connections graduated over 120 peers for Certification, provided 44 webinars, and multi-day specialty training for peers, and for supervisors of peers, and 35 receiving the CPRS SUD training for certification. The project continues only to be able to train for the CRSP certification less than 50% of those who apply. This has been one contributing factor to the growing peer workforce crisis in NJ.
- Challenges and Opportunities: The program's staff of only 2.5 FTE is limited in the number hours needed to address all the needs of such a comprehensive program. The cost of certification and bi-annual recertification of $175 is a barrier for many peers. DMHAS providers have not been required to hire only certified peers. Thus, many peers hired in the

field complete the CRSP- have not been required to fulfill the other qualification for certification or who have to bear the cost involved. With sufficient funding and strong policy leadership, MHANJ has created an experienced foundation as a key component in meeting the growing needs of the peer workforce in NJ. DMHAS has obtained funding to cover the costs of CRSP certification and recertification costs so peers will not need to incur any out of-pocket expenses between the years 2023 – 2025.

Peer Recovery Warm line was launched in 2008 to provide a safe place for peer support. The Peer Recovery Warm line (PRW), as it is entering its 15th year of operation, continues to be hub for peers looking for support. Last year, over 39,000 calls were made to our staff of 15 certified peer counselors, seven days a week, including holidays. Using the Individual Peer Support (IPS) model, coupled with WRAP- the team provide support on a one-time basis, as well as providing weekly, and even daily support to individuals in the community. Working in partnership with NJ MentalHealthCares Call line and NJ Self Help Clearinghouse callers have access to a vast data base of services and support groups. In addition, PRW offers GOMO a text/chat component that proactively engages callers (upon their registration for the service) in daily messaging around maintaining one wellness, access and to support and resources in their lives. PRW has become a significant referral source this past year from 988- as the awareness grows of the value of peer support. Demand for these services continues to grow outside of fiscal resources.

- Outcomes: PRW received over 36,000 calls but were only able to answer 37% of the calls directly. Peer staff returned messages that increased the call response rate to 51%. This has been a consistent level of performance for the line. The PRW staff continues to focus on the needs of the callers, spending an average of 14 minutes on each call. Surveys of callers continue to report that having access to PRW is an alternative to seeking high intensity crisis support, calling 911 or going to the emergency room.
- Challenges and Opportunities: The greatest challenge continues to be the resources needed to fully fund the PRW to answer and return call up to the industry standard goal of 90%. MHANJ has in the place the structure and technical capacity to expand the PRW to dramatically grow the program. The increased referrals from 988 will continue to grow the volume of calls. This is an opportunity to introduce many individuals experiencing a crisis to the value and effectiveness of peer support and provides callers with education and support until and after access to counseling services to support recovery. PRW is a proven effective method of providing evidence-based peer delivered services.

Empowering Peer Advocacy is A critical element of all MHANJ Peer Services. MHANJ embeds the value of peer advocacy across all peer specialist program staff- via their training, access to the latest advocacy issues, and involvement in legislative and public policy development. Peers have active roles in the development of MHANJ advocacy via the Peer Public Policy Committee, led a partnership between MHANJ, Collaborative Support Programs of NJ, and other consumer-oriented organizations. This group provides direct input into proposed legislation, policy development, public testimony, and visits with Legislators on a state and national basis. Internal to the operations of all MHA peer services, empowerment of clients and staff to impact individual client needs- advocacy within systems, agencies and local government is a critical element of peer work. This has included developing strong partnerships with the substance use disorder network of programs and peer specialists to work together to address the needs of the peer movements and

those with co-occurring disorders. MHANJ provides Psychiatric Advance Directive (PAD) training to MHA staff, peers in the community and service providers.

- Outcome: Peers have established strong leadership positions within MHANJ, taking on role of Director of our Ocean County Programs, nine peers in supervisor and leadership roles across the agency, and creating opportunities for new peer leadership development. Including peers in the development and delivery of testimony to legislators is effective in the community the impact and needs of services- such as 988, mobile crisis response, and the importance of peer certification in the delivery of services.
- Challenge and Opportunities: Communication and engagement with younger and diverse populations of peers is a challenge, along with creating new leadership- especially bringing communities of color, LGBTQI+, Spanish speaking peers, and the growing diverse cultural and spiritual communities. MHANJ has established a bilingual team of peers to develop outreach across NJ into multiple communities using a weekly virtual education/support zoom programs, creation of two LGBTQI+ virtual support groups, and participation in PRIDE parades (peer resource booth and marching), and sponsoring of BIPOC events. These efforts engage mental health peers into these communities in an effective manner that builds relationships and community partnerships.

NJ Self Help Clearinghouse connects peers to peer support. The NJ Self Help Clearinghouse (NJSHCH) was created over 45 years ago and became a national model of developing community bases self-help groups across mental health, substance use, and growing to a wide variety of specialized emotional support groups ranging from grief to domestic violence to physical and chronic illness supports. Today, support groups are integrated across all behavioral and physical healthcare, spiritual and wellness groups, and generally every area of our society. The NJSHCH continues today as a strong resource to provide training and technical assistance to help organizations start and grow their local group. With a small staff of 1.25 FTE, the Clearinghouse works to maintain a listing of active support groups across the state that is available to the public via its toll-free number and website.

- Outcomes: The Clearinghouse is working with many of the state's wellness centers to provide training to peer specialists to better facilitate groups and sharing this knowledge with partner organization in the community. Partnering with family support organization within the substance use community has been effective in expanding the number of family facilitated groups. The use of virtual training has expanded the reach of the NJSHCH to reach a new audience- large and small to provide technical assistance and support.
- Challenges and Opportunities: The growth of peer specialists across healthcare and community systems will generate new peer support programs. The development of strong peer facilitators representing these groups, and the training of members to continue and grow groups is a challenge to the system. This can be a growing opportunity for NJSHCH to continue to lead the growth of this invaluable part of New Jersey's community recovery system.

MHANJ's commitment to build a strong and viable peer workforce is demonstrated by the empowerment of peer leadership across the organization. MHA-NJ is one of the leading employers of self-identified peer providers with 45% of staff members in the state and country having lived experience. Training for the entire staff is focused on the values of peer recovery support-

wellness and recovery, and mission, vision, and values- are models for other organizations that partner with MHA, especially those new to understanding the value of peer recovery services and supports. An internal peer support meeting run by MHA staff- Coffee Connections, as well as a majority of peer serving on its' Cultural Competency Committee, and established members of its' Public Policy Committee. MHANJ has expanded its peer delivered services to new communities working with seniors, the without housing, and colleges- and they have been funded and accepted openly. The peer movement is growing across New Jersey, as a key part of service delivery and empowerment.

Consumer Parent Support Network. Parents with mental illness face the same challenges that all parents face; however, they encounter the additional challenges of medication, hospitalization, the fear of loss of custody of their children and the isolation created by the stigma of mental illness. The Consumer Parent Support Network (CPSN) is an award-winning program whose purpose is to support parents with a diagnosis of a mental illness in their parenting efforts. The services offered include bilingual case management, one to one Peer Parent support, referral and linkage to other services, parenting education and advocacy.

The Consumer Parent Support Network (CPSN) program has a long-standing reputation for providing quality services to parents 18 years and older diagnosed with a mental illness. The CPSN program addresses the critical needs of these underserved and unrecognized parents with mental illness who are caring for their children. Overall CPSN strives to assist the Parent with managing their mental health and wellness needs. Parents typically enroll in CPSN when they are in crisis with multiple complex issues to address. The CPSN program has the opportunity to work with parents who are caring for their children from birth to age 18. This allows them to offer support and intervention to the parent at different developmental stages and establish a longer-term relationship.

The majority of the parents who are served live in unsafe neighborhoods in Paterson and Passaic and are living well below the poverty line. The remainder live throughout Passaic County. Due to their mental illness and its impact, the parents often place their children at risk and they struggle to provide basic shelter, food, safety and care. Often the severity of the parents' mental illness causes them to misinterpret typical childhood behavior and desire for attention as misbehavior. CPSN provides parents with education about their own mental health needs so that they can effectively fulfill their desired parenting goals.

COVID-19 had a significant impact on the parents served and as a result, CPSN provided the majority of support services virtually or by phone. The need to interact with parents in that manner was a challenge because most of the parents live below the poverty line and did not have the necessary internet services, phones, available data or minutes and equipment to receive services from the program. MHA of Passaic County was able to ensure that each parent had internet, phone and equipment needed to function during this period. Essential basic needs such as rent, food, electricity, diapers, medication, masks, sanitizer, wipes and reliable phone service was assessed with each parent. Any parent that required assistance received referrals or direct assistance obtaining essential services and needs.

In response, CPSN continued to communicate with all clients regarding food pantry availability,

food bag distributions, school/YMCA/Houses of Worship and other food distributions. Furniture, clothing, winter coats, scarves, gloves and hats were provided through donation and purchases. Legal advocacy was secured when needed due to property owner rental issues; illegal utility shut offs or threats to shut off water or power. The parents many of whom are Spanish speaking struggled to assist their children with their classes and schoolwork. Often these parents expressed increased mental health symptoms and received support, coping strategies and engagement with counseling as needed. CPSN provided additional direct assistance by purchasing supplies of masks, toilet paper, wipes, hand sanitizer, toiletries, cleaning supplies, grocery gift cards and clothing.

Despite these challenges and overwhelming needs, the program was able to complete the outcomes by supporting parents and intervening as needed to allow parents to provide a home environment that was safe, structured, and reduced the risk of abuse and neglect; and with stability during crisis periods by advance planning and decision-making. Parents were able to see that their children's needs were met in the following domains: mental health, basic needs health, legal issues, family system and school environment.

Parents were unable to participate in groups until January 2023 due to repeated episodes of COVID but received individual support and educational materials in the following areas: mental health, wellness, child development, stress and anger management, self-care, discipline, structure and establishing routines. They were encouraged to communicate with other parents in the program and join available virtual groups. Parents were able to access CPSN for guidance related to managing their mental health needs related to their parenting role.

CPSN was also able to provide some fun for the families by decorating the office for trick or treating and providing Halloween treat bags. Each parent received four donated wrapped holiday gifts and 3 books to give to each child. Toiletries, laundry detergent and other household necessities were distributed on 4 occasions. The staff, Board of Directors and the Clifton PBA collected and donated toys, scarves, gloves, hats and gift cards. There is a continued need for clothing, shoes, school uniforms, and car seats, booster seats. Many parents struggled to provide the basic necessities. Food Insecurity is an ongoing concern and CPSN works with each parent to provide individual assistance in this area. Personal hygiene and basic household supplies such as toilet paper, laundry detergent, soap, toothpaste, diapers, feminine hygiene supplies, dish soap, shampoo and conditioner, deodorant, and all-purpose cleaners continue to be unaffordable. CSPN was able to secure and distribute feminine hygiene supplies to the parents who could not afford supplies and at times, they said they would need to stay home from work until they had supplies. The prices of food, personal hygiene and other essential goods has gone up to the point that parents are faced with difficult decisions in prioritizing spending. This year they will try to obtain a grant towards school uniforms since historically all the children need new uniforms and shoes. The cost of these mandatory items has gone up. Parents with multiple children are particularly effected.

Outcomes of this project are as follows:

Outcome #1- Decreased out of home placements for children.
Parents will provide a home environment that is safe, structured, and reduces the risk of abuse and neglect; and with stability during crisis periods by advance planning and decision-making.

Outcome #2 **-** Enhanced family self-determination
CPSN bases the self-determination-oriented programming on concepts and recommendations from "Self-Determination in Mental Health Recovery: Taking Back Our Lives," by Mary Ellen Copeland and The Temple University Collaborative on Community Inclusion of Individuals with Psychiatric Disabilities Self-Determination materials. Wellness and Recovery materials and WRAP plans Self-Advocacy Planning workbooks, Psychiatric Advanced Directives and other Peer and research informed practices.

Outcome #3 **-** Decreased hospitalizations for parents
Parents will participate in parenting education and support groups with topics based on child development, resiliency, mental health, Stress and Anger Management, developing support networks and social emotional skills. They will identify when their emotions are interfering with parenting. Develop pro-social and non-violent methods of stress and anger management. Access help when their stress interferes with parenting.

CHOICES (Consumers Helping Others Improve their Condition by Ending Smoking), an innovative peer outreach program targeting smokers with mental illness in NJ, which employs mental health peer counselors, is now ending it's eighteenth year and still going strong. Consumer Tobacco Advocates (CTA) work tirelessly to deliver the vital message to smokers with mental illness that addressing tobacco is important and to motivate them to seek treatment. For this year the CTAs approach continues to be both an in-person and virtual outreach presentation, to provide consumers and agencies with linkages to tobacco treatment, referrals, support and provision of education materials.

- For Grant year 2022-2023, as of April 21, 2023, CHOICES provided 91 site visits (32 virtual) to NJ mental health treatment providers, interacting with 2,345 consumers who smoke. CHOICES published two newsletters which were distributed to over 1,500 individuals with lived experiences and mental health agencies. A major accomplishment achieved during the 2022-2023 funding year was the updated and revamped CHOICES PPT presentation, which now includes information on Tobacco Risk Reduction, also referred to as Harm Reduction, strategies. These strategies include the discussion of cigarettes per day reduction with and without Nicotine Replacement therapy, along with the recent FDA authorization of certain electronic cigarettes being used for cessation efforts.
- Another effort, which was initiated during the previous grant year and has continued to evolve, was the incorporation of educational information about the intersection between tobacco and cannabis use into the CHOICES presentation. This section includes points on potency, as well as the impact that regular cannabis use can have on mental health outcomes. The Risk Reduction Strategy and Cannabis sections of the presentation has been well received by staff and consumers alike and has provoked much discussion among attendees.
- Since 2005, as of April 21, 2023, CHOICES has conducted over 2,090 community visits reaching more than 58,000 smokers with mental illness. Over 13,013 individuals have received the CHOICES individual feedback session. As pandemic restrictions have been lifted and then reinstated in some locations, CHOICES has continued to offer both in person and virtual presentations. One component of the program, which was reinstated in April 2023, was the use of Carbon Monoxide Meters. This was discussed by the CHOICES team, and

seemed to be acceptable, with less concerns about transmission of Covid 19 and other illness at this time.

- This year, CHOICES was nominated by a partnering agency, George Otlowski Mental Health Center for the Social Innovations Journal "Community Voice Impact" Award, this was awarded for the recognition of CHOICES as a novel strategy to promote community voice inclusion and being a part of that influence program and/or policy with a focus on improving health equity for medically-underserved populations at greatest risk for poor health outcomes. This was a competitive award and voted on by the community members from various sectors. Additionally, CHOICES was invited to offer a presentation to members of the Middlesex County Professional Advisory Committee in March, to provide an overview of the revamped CHOICES presentation, along with ideas for how programs may begin to address tobacco among the population they serve.

Riverbank Self-help Center. In 1977 a grant was awarded to Catholic Charities, Delaware House from the Division of Mental Health and Addiction Services to open a peer run "Drop-in Center" to serve the needs of consumers in Burlington County who had a mental health diagnosis. Catholic Charities had already opened a small drop-in center two year's prior where the consumers cooked and served dinner, played games, participated in recreational activities and planned groups. These activities continue today along with more recovery- focused groups following the guidelines of SAMHSA's eight dimensions of wellness. The center continues to grow and make changes based on research and trends in the mental health field and recently met with staff from the Whole Health Learning initiative and are taking advantage of those offered trainings. Each month the center invites outside resources to make presentations to the members. CHOICES, presented last month on smoking cessation and the County library has presented on technology and using cell phones and computers. Riverbank is working on getting a guest speaker from the police to discuss fraud concerns and reached out to the local hospital to include the self-help calendar with discharge information from the mental health unit.

The center fosters environmental wellness by creating a welcoming space that encourages growth and positivity. Each month there are several groups on emotional wellness including SMART recovery, Emotions in motion and a Men's and Women's group. There is a financial group every other month while intellectual wellness is encouraged through our cultural trips such as seeing the Philadelphia Youth orchestra at the Kimmel Center, going to the Franklin Institute and spending a day at the Aquarium. The center is hosting on-going technology groups run by the Burlington County Library. Occupational wellness is made possible by the various work opportunities made available to the members. This helps people develop a sense of ownership in the center while encouraging them to practice work skills that can use in competitive employment. Daily walks help maintain physical wellness and as the weather warms, more outside activities are planned such as nature hikes and outdoor games. Spiritual and physical health are both promoted by yoga and Tai Chi each month led by a professional yoga teacher. Lastly, and maybe the most important point, social wellness is fostered through an inclusive environment where people are free to express themselves and make social connections with the ultimate outcome of helping individuals reach their full potential, to become independent and move forward in their recovery.

Along with the success of the center there have also been some challenges. One of them is meeting the center's transportation needs. Having two drivers every day would allow for more people to

attend and shorten the travel time on the van. The purchase of an extra van has been helpful, but filling the positions for drivers and budgetary constraints has made hiring problematic. The center currently averages 20 people each day the center is open; however, it is accommodating 30 people on Wednesdays.

This number continues to grow as Riverbank Self-help Center partners with the food bank and are now able to serve meals every day the center is open. In addition, the center provides canned goods and other items each week to the members to help supplement their needs. During COVID staff presenting Zoom groups and were delivering a full meal each week to members. They no longer deliver a meal, but have maintained a weekly zoom group for those who are unable to attend in person.

Peer-Oriented Transportation Service

As the self-help center grew, the state made additional funds available to create a peer-run business that would expand employment opportunities to consumers. The Riverbank Transportation program (RBT) was created in 2001 to provide transportation services to mental health consumers who wanted to work, but were unable to access public transportation. The services, exclusive to Burlington County, has been a dependable and affordable alternative to other county transportation. The individuals using the service have benefitted by gaining independence through employment. For the past 22 years, the service has provided over 40 people employment opportunities. Many of the drivers who have started out part-time have moved on to full-time employment, having gained work experience while working on their recovery. Satisfaction surveys are completed twice a year, with 100% reported satisfaction. With budget constraints only two drivers are being utilized at maximum capacity. A third driver would add service capacity and Riverbank Transportation Services (RBT) is currently partnered with Catholic Charities Supported Employment to seek a candidate. RBT provides an average of 48 rides per week. Monday through Fridays, from 8:00 am until 9:00 pm, and is a door-to-door service for the cost of $2.00 per trip.

With the success of the Riverbank Transportation service, the self-help members were asked to identify other community needs peer transportation could offer them. The program expanded with Roads to Recovery (RTR) offers a transportation service to community recovery groups such as AA, NA and other recovery-focused groups. Over the years, other community groups included Gamblers Anonymous, Sex-addicts Anonymous and Over Eaters Anonymous. One driver works Monday through Friday assisting consumers who would otherwise have no way to get the help they need to support their recovery. The program assists consumers within a ten-mile radius of Westhampton and is a free service.

Both transportation programs remained open during COVID with fewer members due to community recovery groups going virtual and many area businesses closing their doors. The drivers were able to maintain employment by providing transportation to other programs within the agency that remained open. Since COVID has ended, RBT has rebounded well, but fewer individuals are using RTR. Some community recovery meetings continue to utilize zoom groups rather than in-person groups. Catholic Charities is currently working to increase numbers to pre-COVID capacity. Staff continues to market all of these programs at employment fairs and other community service events.

Children's System of Care (CSOC)

The goal of DCF's CSOC is to enable youth to remain at home, in school, and within their community. CSOC is committed to providing services that are:

a) Clinically appropriate and accessible
b) Individualized and delivered through a continuum of services and/or supports, both formal and informal, based on the unique strengths and needs of each youth and his or her family/ caregivers
c) Provided in the least restrictive, most natural setting appropriate to meet the needs of the youth and his or her family/caregivers
d) Family-guided, with families engaged as active participants at all levels of planning, organization, and service delivery
e) Community-based, coordinated, and integrated with the focus of having services, decision-making responsibility, and management operational at a community level
f) Culturally competent, with agencies, programs, services, and supports that are reflective of and responsive to the cultural, racial, and ethnic differences of the populations they serve
g) Protective of the rights of youth and their family/caregivers and
h) Collaborative across child-serving systems, including child protection, juvenile justice, and other system partners who are responsible for providing services and supports to the target populations.

CSOC served over 74,000 youth in CY 2022 through a complement of needs-driven supports and services within a system of care approach: family driven, youth-guided, strengths-based, individualized care. The primary goals of CSOC are to ensure youth receive quality care in the most appropriate, community-based setting whenever possible to maintain connections to family and communities for sustainable relationships and planning. CSOC also has a continuum of out-of-home treatment settings of varying degrees of intensity of service accessible based on youths' individual needs.

Family Support Organizations (FSOs)

FSOs are nonprofit organizations run by family members of youth with emotional, behavioral, developmental, and/or substance use challenges that have lived experience in supporting youth in addressing their needs. FSOs provide advocacy, education, and support through an array of supports and services including individual family-to-family peer support for youth with moderate and high needs, support groups and workshops, community outreach and education, telephonic support, and local level advocacy to help them navigate the System of Care, school system, CP&P, and the legal system, and to listen and provide moral support. In addition to caregiver supports, FSO Youth Partnerships (YPs), led by a young-adult Youth Coach, help youth to engage with other youth with mental, emotional, and behavioral health needs. Through support groups, social activities, and leadership development, youth and young adults ages 13-21 find their voice to affect change in their own lives and the lives of others. Each YP participates in monthly community activities to challenge stigma and strengthen other youth in their communities, and each year,

youth leaders across the state develop and facilitate an annual youth conference.

The In-Home Recovery Program

The In-Home Recovery Program, modeled after the Yale Child Study Center's Family Based Recovery Program in Connecticut, provides intensive in-home treatment for parents with substance use disorders, parenting support for children under the age of 36 months, and case management. The Nicholson Foundation provided funding for Preferred Behavioral Health to implement the first phase of the program and Yale Child Study Center to provide training, consultation, and technical assistance. The Department of Children and Families funded Rutgers University to evaluate the program and has continued to fund the program beyond the initial Nicholson funding period.

Peer Recovery Support Specialist Services

Peer Recovery Support Specialist (PRSS) Services are a component of the Division of Child Protection and Permanency's Child Protection Substance Abuse Initiative (CPSAI). The Peer Recovery Support Specialist establishes a one-on-one relationship with the parent/caregiver and encourages, motivates, and supports a peer who is seeking to establish or strengthen his or her recovery. They also assist the parent/caregiver to engage in treatment or reenter the community after residential treatment and to develop skills and access resources needed to initiate and maintain recovery by offering the benefit of shared life experiences and providing support. PRSS Services include Peer Mentoring/Coaching to assist the parent/caregiver access formal treatment services and other professional and non-professional services, resources in the community that can help meet his or her individual needs, set recovery goals, develop recovery action plans, and solve problems related to health, wellness, recovery, and recovery supports, including safe and sober housing, building or re-establishing supportive relationships, managing crises, and learning relapse prevention skills. PRSS Services also include Recovery Consultation, Education, and Advocacy including attending treatment team meetings, family team meetings, staying in communication with counselors and supervisors, facilitating discharge planning in collaboration with treatment team, educating family, community and other supportive individuals about recovery and recovery management, and documenting information as required by program policies and procedures.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state. i.e., RCOs, RCCs, peer-run organizations.

Division of Mental Health and Addiction Services (DMHAS)

Recovery Support and the Importance of a SUD Peer Workforce

Over the last several years, the DMHAS has made significant efforts to increase the SUD peer workforce. Recovery Specialists were hired for the Opioid Overdose Recovery Program (OORP), Support Team for Addiction Recovery (STAR), Telephone Recovery Support (TRS) and Intensive Recovery and Treatment Support (IRTS) programs, where they now play a vital role. They are employed in our two large Recovery Centers and all our smaller Community Peer Recovery

Centers. They provide recovery support for our various SUD housing programs. However, there is currently a gap in the provision of peer services in residential settings. One current goal for DMHAS is to expand the SUD workforce and the wealth of experience peers can bring to treatment settings.

The DMHAS has also worked to develop two peer credentials, the Certified Peer Recovery Specialist (CPRS) and National Peer Recovery Support Specialist (NPRSS) and has worked with Medicaid to reimburse OORP services in Emergency Rooms and SUD peer services in outpatient. However, there is currently a gap in the provision of peer services in residential settings that DMHAS is seeking to improve.

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

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

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

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

According to a report from the University of California San Francisco (UCSF), while peer providers have traditionally worked as volunteers, changes in mental health and SUD treatment and recognition of the importance of long-term recovery support, have led to a professionalization of this role with formalized training and certification, and the potential for paid employment. In recent years, the peer support services (PSS) workforce has evolved to become an essential part of mental health and addiction treatment, family support, and primary care services (Chapman, S., Blash, L., and Chan, K., *The Peer Provider Workforce in Behavioral Health: A Landscape Analysis*. San Francisco, CA, UCSF Health Workforce Research Center on Long-Term Care, 2015.)

Bassuk et al conducted a systematic review of the evidence on the effectiveness of peer support services for people in recovery from alcohol and drug addiction, which resulted in nine studies meeting the criteria for inclusion in the review. Despite methodological limitations found in the studies, the body of evidence suggested beneficial effects on participants (Bassuk, E., Hanson J., Greene, R., Richard, M., Laudet, A. Peer-delivered recovery support services for addictions in the United States: a systematic review. *Journal of Substance Abuse Treatment*. 2016; 63:1–9). In another systematic review, Reif et al evaluated peer support services for individuals with substance use disorders resulting in ten studies that met the review criteria. The studies demonstrated increased treatment retention, improved relationships with treatment providers and social supports, increased satisfaction, and reduced relapse rates (Reif, S., Braude, L., Lyman, D. R., Dougherty, R., Daniels, A., Ghose, S., Salim, O., & Delphin-Rittmon, M. (2014). Peer recovery support for individuals with substance use disorders: Assessing the evidence. *Psychiatric Services, 65*(7), 853–861).

A literature review by Tracy and Wallace found ten studies that met their minimum inclusion criteria, including randomized controlled trials or pre-/post-data studies, adult participants, inclusion of group format, substance use-related, and US-conducted studies published in 1999 or later. Studies demonstrated associated benefits in the following areas: 1) substance use, 2) treatment engagement, 3) human immunodeficiency virus/hepatitis C virus risk behaviors, and 4) secondary substance-related behaviors such as craving and self-efficacy. Peer support groups included in addiction treatment show much promise in potentially reducing substance use,

improving engagement, reducing HIV/HCV risk behaviors, and improving substance-related outcomes (Tracy K, Wallace SP. Benefits of peer support groups in the treatment of addiction. *Substance Abuse and Rehabilitation*, 2016 Sep 29;7:143-154).

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

SAMHSA defines peer support services (PSS) as specialized assistance that is delivered by a person in recovery from serious mental illnesses (SMI), substance use, or co-occurring mental and substance use conditions, before, during, and after treatment to facilitate a recipient's long-term recovery in the community (Chinman, G., Dougherty, D., Ghose, S., and Delphin-Rittmon, 2014). The goal of these services is to assist with the development of strategies to promote coping, problem-solving, and self-management of a person's behavioral health condition. This is accomplished by the peer support specialist drawing upon his/her own lived experiences and empathy to help others by promoting hope, developing skills and insights, fostering treatment engagement, accessing community supports, and building a satisfying life. Through the Recovery Community Services Program (RCSP), the Substance Abuse and Mental Health Services Administration/Center for Substance Abuse Treatment (SAMHSA/CSAT) funds grant projects across the country to develop and deliver these services. The peer recovery support services developed by the RCSP projects help people become and stay engaged in the recovery process and reduce the likelihood of relapse. Because they are designed and delivered by peers who have been successful in the recovery process, they embody a powerful message of hope, as well as a wealth of experiential knowledge. The services can effectively extend the reach of treatment beyond the clinical setting into the everyday environment of those seeking to achieve or sustain recovery.

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

Recovery support services encompass SAMHSA's guiding principles of recovery and include four major dimensions that support a life in recovery: health, home, purpose, and community. Peer workers assist individuals with developing a recovery plan that enables them to identify goals for

achieving wellness. Peer workers also help the clients they work with to facilitate resilience and manage setbacks or other stressful events that may precipitate a return to substance use. New Jersey's recovery support services are designed to span all stages of recovery – from initiation/stabilization through recovery maintenance and the enhancement of quality of life in long-term recovery.

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

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

- In collaboration with the individual, develop a recovery plan which should include culturally competent and relevant services that identifies goals with measurable objectives, assesses strengths, can be used to work towards those goals, identifies barriers that can inhibit goal attainment, and monitors the progress made attaining those goals;
- Educate the individuals on how to navigate treatment, social service and recovery support systems;
- Provide recovery support services based on the individual's preference and his/her assessed needs;
- Support the individuals as they move through the stages of change to encourage them in their recovery;
- Assist the individuals with accessing recovery support services in the community;
- Work collaboratively with the case manager to ensure the individual engages in services and transitions to the next level of care when indicated;
- Be a positive role model by sharing experiential knowledge, hope, and skills;

- Maintain relationships with the individual in order to assist him/her in the treatment engagement and retention process;
- Reinforce, guide, and reassure the individual that recovery is possible, and is built on multiple strengths, coping abilities, and the resources of each individual;
- Assist the individual with gaining skills and resources needed to initiate and maintain recovery and maintain compliance with MAT if it is part of their treatment;
- Assist in establishing and sustaining a social and physical environment supportive of recovery;
- Enhance identification and participation in the recovery community;
- Advocate for appropriate and effective community treatment and recovery;
- Empower individuals to make self-determined and self-directed choices about their recovery pathway;
- Provide support with face-to-face sessions and/or telephone support based on the individual's personal choice; and
- Help individuals maintain healthy community, family and social functioning.

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

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

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

Opioid Overdose Recovery Program (OORP)

The Division of Mental Health and Addiction Services (DMHAS) supports the role of peers through several recovery support initiatives. These programs assist individuals with opioid use disorders or those who are at risk of an opioid overdose through supportive services, case management, education, resources, and advocacy for families and individuals. The Opioid Overdose Recovery Program (OORP), which is in all 21 counties, provides support services to individuals reversed from opioid overdoes treated at hospital emergency departments. Peers working in OORP programs meet with individuals at bedside where they share their stories of hope and recovery. These peers continue to follow the patient for eight weeks after discharge and are instrumental in engaging individuals in the emergency department and beyond and letting them know that they are not alone and that recovery is possible by whatever pathway they choose.

OORPs operate in 56 of 75 (75%) hospital emergency departments throughout New Jersey. Fourteen OORPs are operating in all (100%) of the hospital emergency departments in their

respective counties.

Since its implementation on January 1, 2016, NJ's OORPs have cumulatively served 26,593 individuals who were reversed from an opioid overdose and were taken to a participating hospital emergency department. Eleven percent of individuals cumulatively served (3,032 of 26,593) were initially referred to withdrawal management and ten percent (2,641) of individuals cumulatively served were initially referred to substance use disorder treatment. An additional 11,421 (43%) individuals sought recovery support services. Common recovery supports included referrals to self-help, transportation supports, mental health and medical services and housing supports including sober living.

In 2018, the scope of core OORP activities was expanded by 16 of the 21 OORPs. The OORP expansion sites increased core services to include new sets of activities, including services beyond the emergency department in other areas within the hospital as well as services outside the hospital within the community for persons with an opioid or substance use disorder. OORP expansion within hospitals serves emergency department patients who suffered an opioid overdose but who were not administered naloxone as well as hospital in-patients with an identified primary or secondary OUD or SUD who are being treated for any condition in other hospital units. As with core OORP, OORP expansion provides eight weeks of patient follow-up. OORP expansion within the community includes funding additional peers to perform community outreach for persons with an OUD and/or SUD at shelters and neighborhood fairs. Through expansion, partnerships with prosecutors, sheriffs and other law enforcement personnel, diversion programs, healthcare providers, treatment providers and community programs were established.

Since its introduction, OORP expansion services have been provided to over 43,000 persons.

Support Teams for Addiction Recovery (STAR)

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

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

similar to those offered the original STAR teams, but with modifications to provide more effective services to this special population

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

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

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

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

Maternal Wraparound Program

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

follow-up with the women and their infants. Block Grant and State funding supports six M-WRAP regions statewide with each region serving 30 pregnant women. The overall goal with the M-WRAP is to alleviate barriers to services for pregnant opioid dependent women through comprehensive care coordination implemented within the five major timeframes when intervention in the life of the substance exposed infants (SEI) can reduce potential harm of prenatal substance exposure: pre-pregnancy, prenatal, birth, neonatal and early childhood. Required to develop Plans of Safe Care. The M-WRAP model is intended to promote maternal health, improve birth outcomes for women, their infants and families, and reduce the risks and adverse consequences of prenatal substance exposure.

The onset of the COVID-19 pandemic resulted in many significant safety precautions at the national and state level. The stay-at-home orders, such as closures of businesses, schools, restrictions in gatherings, had an impact on the social determinants of health (food, security, employment, income, access to medical care, etc.). Pregnant and parenting women with a history of substance use disorder could be at risk for increase in substance use or experience relapse due to feelings of isolation, lack of family supports, or social support systems. Their mental health could be adversely affected exhibiting depression during pregnancy and postpartum. July, 2021 the MWRAP statewide initiative eligibility criteria expanded to include pregnant women with substance use disorder, not exclusive to opioid dependency. The expansion increased the numbers of pregnant women eligible for the program from 30 to 50 per region.

Regional Recovery Centers

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

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

During CY 2022, there were 84,437 discharges from substance abuse treatment in New Jersey. Of these, 24,555 or 29%, quit or dropped out of treatment. While ALL clients can benefit from recovery support services, those clients who did not complete treatment may find recovery support beneficial and a gateway back into treatment and/or sustained recovery. It is clear that there are significant numbers of people who could benefit from ongoing recovery programs. While these

figures are drawn from those who enter the formal treatment system, there is a group of people of unknown size who have never accessed formal treatment who could also benefit from recovery services. This will also be an opportunity for those for whom access to treatment is not possible or delayed due to insufficient capacity within the system. The DMHAS Recovery Centers offer training, social, educational and recreational opportunities. There are classes focused on wellness, nutrition and illness management, including classes on self-care, stress management, financial management, literacy education, job, and parenting skills. Housing assistance (e.g., finding apartments and roommates) is provided, and telephone support is available to Recovery Center participants. It is expected that this peer-delivered service will result in improved social functioning, reduced substance abuse and an improved quality of life, including more social connectedness.

For SFY 2022, the two NJ State funded Regional Recovery Centers (Eva's Village and Living Proof Recovery Center of Voorhees) provided peer support services to 2,394 individuals.

Community Peer Recovery Centers (CPRC)

Funding was issued in 2019 to 2022 through multiple Request for Proposals (RFP) to expand and develop Community Peer Recovery Centers (CPRC) where individuals can access peer support, information about substance use disorder treatment, recovery support services, and information about other community resources in a supportive substance free environment. DMHAS initially awarded three providers in the amount of $100,000 each for start-up small-scale Recovery Centers to provide peer-to-peer recovery support services to prevent recurrent of substance use and promote sustained recovery, however DMHAS has now expanded CPRCs to all 21 counties.

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

In FY 22, nineteen SOR-funded CPRCs provided peer support services to 8,226 unduplicated individuals. The programs reported that 1,769 individuals received Recovery or Peer Coaching, 338 individuals received Recovery Housing and 398 individuals received Employment Support.

A small sampling of demographics of the participants who have visited a Community Peer Recovery Center through September 29, 2022 indicated there were 407 intake surveys reviewed.

The largest percentage (58.7%) of participants were White, non-Hispanic, 26.5% were Black, non-Hispanic, 16.8% were Hispanic/Latino, and 13.0% identified as other. The largest age group was 25-44, representing 50.6% of participants. There were more male (62.0%) than female (38.0%) participants. Of CPRC participants that completed the survey (n=400), 26.7% (n=107) utilized MAT. Forty-five percent (n=41) were utilizing Methadone, 44.0% (n=40) buprenorphine, and 11.0% (n=10) Vivitrol.

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

- Harm reduction
- Naloxone distribution
- Outreach
- Recovery support
- Treatment/care support/system navigation
- Case Management/Individual Services coordination
- Self-Help & Recovery Support Groups
- Community Resources
- Transportation
- Wellness activities
- Life Skills
- Special Interest (Parenting, Family, DV, angel, LG
- Spiritual and Faith-Based Support
- Cultural Historical & Gender Issues
- Family Support and Education
- Substance Abuse Education
- Relapse Prevention
- Child Care
- Parent Education and Child Development
- Spiritual and Faith-Based Support
- Basic Needs- Food, Clothing, Shelter

<u>Family Support Centers</u>

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

families in multiple areas of their lives, including self-care, pleasurable activities, problem solving, and goal setting. CRAFT addresses their loved one's resistance to change, in addition to teaching families behavioral and motivational strategies for interacting with their loved one.

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

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

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

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

In 2021, each regional FSC expanded due to the increased numbers of referrals coming from OORPs, STARs, ReachNJ, Connect4Recovery Call Center, Division of Children and Families, and Families, Drug Court, Probation, and Treatment Providers to assist family members of loved ones with an *OUD/stimulant use disorder, and some families without*. Each FSC Region now provides family support services for at least 150 families in their region.

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

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

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

fact that they are well attended and that families continue to provide positive feedback.

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

In FY 2022, the Regional Family Support Centers provided support to 300 families who had a family member with a verified opioid and/or stimulant use disorder. FSCs also provided family support to 165 additional family members who could not verify the substance their loved one was using. These additional family members still received family support from the FSC, however are counted separately and not included in the FSC Outcome Data which only focused on opioid and/or stimulant use families.

FY 2022 FSC Outcome Data was collected from the opioid/stimulant use families who received services from the three regional Family Support Centers (FSC). Some of these families completed an intake during the time frame while others began service prior to and continue to receive services. Outcome data for opioid/stimulant use families is collected through the FSC survey. The FSC enrollment survey is self-administered by family members within two weeks of their first contact with the program and a follow-up survey is completed approximately six months later. Data are from family members who received services from program inception through June 30, 2022.

Most (89.9%) family members were female and 59.9% were parents of their loved one with OUD. The highest percentage (58.9%) of loved ones of family members were aged 14-34 and the majority (73.5%) were male (n=296). Additional characteristics of family members and their loved ones are described below. Please note that not all families who were served completed an intake survey. Therefore, the characteristics shown below do not reflect the full population of families served by the program. The majority of family members and their loved ones were White, non-Hispanic and comprising 89.5% for family members (n=286), and 79.0% for loved ones (n=286). Updated outcome data are not available, so the most up-to-date data are included below. Family members’ areas of concern regarding their loved ones are also collected. The greatest percentage of family members expressed concern regarding their loved one’s mental health (94.4%), followed by interpersonal and family relationships (84.3%), and medical health (81.0%). The area of concern most frequently cited as the main concern was mental health, accounting for 55.6% (n=268).

The SOS assesses the impact of loved one’s substance use on family members across the eight domains shown below. Items asked how often family members experienced a total of 54

difficulties as a result of a loved one's abuse of alcohol or drugs. On a scale ranging from 1 (never) to 5 (almost always), mean values were highest on the emotional (M = 3.60) and relationship (M = 3.52) domains. Impacts on the legal (M = 2.00) and physical violence (M = 2.00) domains were lowest.

In addition, the Central FSC Region used the FSC Recovery Data Platform (RDP) Pilot to collect data. This pilot dramatically improved the monthly reporting process, supported the hybrid work model, eliminated paper files and offered opportunities to track outcomes for the Central Region FSC. The owner of the platform, Faces and Voices of Recovery, agreed with the recommendation to identify one specific CRAFT strategies for each family interaction. The Central Region FSC is very excited about this data collection because no one is tracking the individual CRAFT strategies. This is a recent upgrade and a small sample so more data needs to be collected. Practicing self-care was identified as the most commonly used strategy and this was addressed by the introduction of the self-care events. This is an example of the output that will help the FSC in planning future programming:

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

Collegiate Recovery Programs

Seven Higher Education institutions receive state or federal funds for Collegiate Recovery Programs. Rutgers University at New Brunswick and Newark, The College of New Jersey, Ramapo College, Ocean County Community College, Rowan University and Stockton University are funded under the State Opioid Response (SOR 2.0) SAMHSA discretionary grant. Collegiate Recovery Programs provide housing and support services to students in recovery, including: screening and intervention services; self-help, mentoring, peer and academic support; crisis management and relapse prevention; community education; and alcohol-free/alternative programming and community service opportunities.

In state fiscal years 2019-20, capital agreements were established with The College of New Jersey and Ramapo College to develop and designate recovery housing for students and to improve existing campus facilities to support the recovery community. Capital improvements included the re-purposing of a student recreation facility into a health and wellness center, creating a recovery lounge, and renovating a single-family dwelling into recovery housing.

- Process and outcome data for the current cycle of College Recovery Programs are reported as:

- 272 students receiving individual and/or group recovery support services
- 32 students reside in recovery housing
- 5,000 + students participated in campus-wide or large-scale substance-free activities/events
- 83% reported [past 30-day] abstinence from substance use
- 67% reported being employed
- 100% of students reported satisfactory academic standing
- 100% of students reported no criminal justice involvement
- 100% of students reported stable housing (on or off campus)
- 100% of students reported satisfaction with the services they receive through the collegiate recovery program

Telephone Recovery Support

In the Telephone Recovery Support (TRS) program, peers provide weekly telephone recovery support calls to people seeking and maintaining recovery from opioid addiction. Staff provide information about local recovery support services, including information about local resources such as self-help meetings, food pantries, and sober living, if needed. To date, 1,370 individuals have been served by TRS.

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

Intensive Recovery Treatment Support

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

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

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

Peers in Residential Treatment Programs

Over the last several years, DMHAS has made significant efforts to increase the SUD peer workforce. Peer support services have positively impacted and provided specialized assistance to persons in recovery from serious mental illness, substance use or co-occurring mental and substance use conditions before, during and after treatment. As a means to close the gap in the provision of peer services in residential settings, DMHAS issued an RFP in March 2023 to expand the peer workforce to include peer services in inpatient withdrawal management, short-term and long-term residential and halfway house settings. In June 2023, eight providers were awarded a contract for a total of 26 peers. The successful bidders will hire peers who will assist with issues that often occur concurrently with SUD, such as homelessness, legal issues, employment, child care, documentation, etc. In addition to linking individuals with the appropriate community resources, peers will also encourage individuals to remain in treatment as recommended in the treatment plan and modeling strategies on how to manage addiction successfully. The anticipated contract start date is July 2023.

Recovery Support Care Management (RSCM)

RSCM was established and effective on March 7, 2023 and is a behavioral health service intended to support consumers who have a SUD with complex physical and/or psychosocial needs. RSCM provides direct and comprehensive assistance to consumers to ensure access to the necessary treatment, rehabilitative and recovery services with the intent of reducing psychiatric and addiction symptoms, connect consumers with services, improve transitions between levels of care, implement strategies to address their unique needs, reduce opioid related deaths and sustain recovery in the community while supporting the consumers' continued stability and recovery throughout the continuum of care. This service is available as an enhancement in all levels of care. This service may be provided face-to-face or via a telehealth platform. Since Medicaid offers Care Management in outpatient, RSCM is excluded from reimbursement for consumers admitted into Ambulatory LOCs in Recovery Care Efficiency (RCE). As of August 16, 2023, there were 1,405 unduplicated clients who received this service.

Recovery Management Check-Up

Recovery Management Check-up (RMC) is service for discharged clients to support independent living and success with recovery and provide more methods of outreaching to clients. This will include virtual face-to-face visits, text messaging and chat features, and also the opportunity for actual in person contacts. This check-up service will help provide local recovery supports. RMC aims to identify and alleviate client problems before they derail recovery. Monthly contact forms the core of the proposed RMC. Problems will be addressed using motivational interviewing techniques or connecting clients to appropriate community resources or treatment if needed. The conceptual framework of RMC is to treat addiction as a chronic disease, with long-term management to minimize the number of acute episodes of substance abuse and with prompt treatment when episodes occur to prevent them from becoming more severe and consequential. Three regional awards (North, Central and South) were awarded in March 2023 to two agencies (one agency will cover two regions) to provide this service.

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

Peer Training

DMHAS supports the advancement of peers by offering training and professional development activities that increase and enhance the peer workforce. All peers working in DMHAS initiatives attend a 3-day Ethics training. The curriculum includes self-reflection, self-disclosure, racial and culturally responsive practices, MOUD, motivational interviewing, outreach, and engagement techniques. In addition, peers attend the 5-day Connecticut Community for Addiction Recovery (CCAR) which leads to peer certification. DMHAS supports two pathways to peer certification. The International Reciprocity and Credentialing Consortium (IC&RC) NJ affiliate, the Addiction Professionals Certification Board, issues the Certified Peer Recovery Specialist (CPRS) and NAADAC/NCC AP, the Association for Addiction Professionals, issues the National Certified Peer Recovery Support Specialist (NCPRS). To ensure DMHAS recovery programs have adequate staffing levels and that peers have equal opportunities to employment, DMHAS provides scholarships for training, certification, and testing fees. To date more than 1550 peers have been trained through the Division's Addiction Training and Workforce Development initiative; 553 or 36% of the peers trained have completed all training necessary to obtain certification which is substantial growth from the 200 last reported.

In addition to the basic core training, our training partner the New Jersey Prevention Network, has developed other training modules for peers. One currently being implemented is Basic Harm Reduction which utilizes the LeMire curriculum. NJPN is planning to develop a more advanced curriculum.

NJPN is also working on a series of trainings that will lead to certificate in specialized areas, such as, working in emergency rooms, criminal justice settings, treatment agencies, etc.

Peer Recovery Support Summit

DMHAS held a virtual Peer Recovery Support Summit in collaboration with NJPN on September 1, 2022 entitled, Advance-Connect-Transform, The Future of Peer Recovery Support. This event equipped 708 attendees with strategies in providing recovery support services across the continuum of care with 2 keynote speakers and 19 workshop sessions, featuring a total of 35 multidisciplinary expert speakers. All workshops were intentionally coordinated based on best practices that are relevant to the addiction/recovery field, cultural humility, current events, and opioid use disorders.

5. Does the state have any activities that it would like to highlight?

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

As part of the DMHAS Opioid Housing Subsidy Initiative, individuals in the program are also provided peer services through a Certified Recovery Peer Specialist (CPRS). The CPRS works with individuals with an OUD by connecting them to needed services and entitlements, and assisting them with apartment searching. Up to six (6) hours of peer services provided by a CPRS per month are reimbursed through Medicaid for individuals who are enrolled in FamilyCare (NJ's Medicaid program). For the services provided by peers who are not certified and for individuals who are not enrolled in FamilyCare, reimbursement is through State funds while the consumer seeks FamilyCare and the peer is in training to receive certification. Peer services may be billed to Medicaid once an individual is enrolled in FamilyCare and services are provided by a certified peer.

DMHAS has worked with the Division of Medical Assistance and Health Services (DMAHS) to develop a bundled reimbursement rate for the Opioid Overdose Recovery Program (OORP). The rate has been approved by CMS. It's important to note, that DMHAS grants reimbursement for

peers working in independent clinics which includes outpatient substance use agencies. DMAHS has developed a reimbursable rate for substance use disorder (SUD) case management services for its new supportive housing program. DMHAS is presently collaborating with Medicaid to provide reimbursement for Support Teams for Addiction Recovery case managers and OORP patient navigators.

A DMHAS peer recovery data collection system was implemented in 2020. The Recovery Data Platform (RDP) is a cloud-based software solution developed in part by Faces & Voices of Recovery and Recovery Trek. The platform aids Peer Service Providers with the tools and assessments needed to effectively implement peer recovery coaching programs. Through the use of robust reporting and scheduling tools, RDP provides an organization with outcomes data and service management tools. It is designed to capture peer services offered by organizations to individuals impacted by substance use disorders (SUDs). The Recovery Data Platform (RDP) is one of the largest collections of data for participants in SUD peer services for the state of NJ. RDP is being used by several initiatives to centralize information which allows a robust real-time analysis of recovery support services.

The data used to conduct outcome analyses is gathered in RDP using scientifically validated tools. The three outcome measures predominately used by the RDP pilot program are: Assessment of Recovery Capital, Cravings Rating Scale, and Outcome Rating Scale. These scores are based off of participant answers to questionnaires that are administered at regularly scheduled intervals. The outcome analysis focuses on establishing a baseline at the initiation of services and then re-evaluating.

The Recovery Data Platform (RDP) collects real-time data that helps track and organize participants' program interactions and progress. Programs can track individuals' growth and follow trends that assist in meeting recoveree's needs. The RDP allows recoverees to visually see the progress that are making which facilitates motivation to sustain recovery. Significant data collection includes assessment of recovery capital, a relationship scale, and an engagement scale that measures cravings. Output data additionally includes recovery coaching and telephone recovery support logs, referrals, education, employment, and resource information. Participating organizations entered data on peer recovery support services provided to over 12,000 participants which exceeded the earmarked 10,000 and is anticipating exceeding 15,000 during 2023. RDP now has one of the largest collections of Community Peer Recovery Center data for the state of NJ.

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

Environmental Factors and Plan

17. Community Living and the Implementation of Olmstead - Requested

Narrative Question

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in **Olmstead v. L.C., 527 U.S. 581 (1999)**, provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of M/SUD on America's communities. Being an active member of a community is an important part of recovery for persons with M/SUD conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated setting appropriate to the individual and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with M/SUD needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office for Civil Rights **(OCR)** cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other settings that have institutional characteristics to serve persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain evidenced-based supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

1. Does the state's Olmstead plan include:

Housing services provided	◉ Yes ○ No
Home and community-based services	◉ Yes ○ No
Peer support services	◉ Yes ○ No
Employment services.	◉ Yes ○ No

2. Does the state have a plan to transition individuals from hospital to community settings? ◉ Yes ○ No

3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?

The Division of Mental Health and Addiction Services (DMHAS) is in the process of revising Administrative Bulletin 5:11 in an effort to reduce hospital length of stay. Under this bulletin, consumers in state psychiatric hospitals are assigned to community service providers whom have the option of either accepting the consumer or requesting additional supports from DMHAS. In addition to community providers, state psychiatric hospitals have the option within their discharge planning process of requesting additional supports for the consumer in their potentially new living situations outside the institutions. Such requests and other efforts toward successful discharge are to be documented within the Individual Needs for Discharge Assessment (INDA). Assignments are based on hospital treatment team recommendations as well as consumer choice, and the assigned provider is expected to participate in treatment team meetings from the consumer’s first to his/her last while in the hospital. The early involvement of community providers in the treatment planning process fosters familiarity between the provider and the individual, allowing for immediate planning on the part of the provider to prepare to meet the individualized needs of each person upon discharge into their care. This preparation is critical to ensuring that each individual is provided with necessary community supports and thereby maximizing his/her chances of sustained integration within the community.

On June 21, 2018, Governor Murphy announced plans to return the DMHAS back to the Department of Human Services, reversing a decision made by Governor Christie in 2017. By restoring DMHAS at the Department of Human Services where Medicaid and social services are housed, Governor Murphy’s plan would ensure that mental health programs and substance use disorder services are delivered to New Jersey residents in the most effective and efficient manner possible. The four state psychiatric hospitals would remain in the Department of Health (DOH). DOH would create an integrated licensing system for mental health, substance abuse and primary care and continue to improve the quality of care in the state psychiatric hospitals. Governor

Murphy's plan took effect on August 20, 2018.

As part of its Home to Recovery II Plan, DMHAS is focusing its efforts on enhancing the community-based resources available to its consumers. One such enhancement is the implementation of Community Support Services (CSS). A rehabilitative service billable by Medicaid, CSS offers education to consumers in the community on navigating daily activities, rather than performing these activities on their behalf. The goal of these services is to nurture independence and self-reliance on the part of the consumer, empowering them to thrive as functional and competent members of a community outside of an institutional setting.

DMHAS has sharpened its focus on consumer employment as another key element to optimal community integration. To that effect, the Division has enhanced its Supported Employment services to include an in-reach pilot within the three regional state hospitals. Implemented in July 2015, this pilot program targets individuals who are ready for discharge and examines their interest in competitive employment outside the hospital. This in-reach is supplemental to the Division's existing Supported Employment services, which are available in each of New Jersey's 21 counties. Supported Employment services include assistance accessing benefits counseling; identification of occupational skills and interests; and the development and implementation of a job search plan based on the consumer's strengths, interests, needs, and abilities. The ultimate goal for consumers receiving Supported Employment services is to obtain meaningful and competitive employment as a means of further ensuring sustained integration within the community.

Another area of focus for DMHAS's Home to Recovery II Plan is the examination of outcomes geared toward monitoring sustainability of the Division's community integration efforts. These outcomes include the completion of Medicaid applications within 30 days of determining the necessary level of care for consumers in state psychiatric hospitals; utilization of DMHAS and other subsidies to facilitate sustained community in Community Support Services (CSS), and an increase in discharges to CSS as well as in the percentage of consumers served by CSS as compared to state psychiatric hospitals; and finally a decrease in hospitalizations in the form of lower census counts (for CEPP consumers and the total hospital population); fewer admissions to state hospitals; a reduction in length of stay on CEPP status and within the hospital overall; and a decrease in CEPP consumers as a proportion of the total hospital census. Here are some Highlights:

1. Partnership with Vital Statistics. In October 2014, DMHAS issued Administrative Bulletin 4:27 in response to delays in hospital discharges resulting from missing patient identification documents. With the collaborative efforts between DMHAS and Vital Statistics, and subsequent development of the AB 4:27, a new process was implemented whereby DMHAS staff routinely retrieve birth certificates prepared by Vital Statistics for New Jersey born consumers that were previously unable to produce them for discharge planning. This process has greatly improved the discharge process by helping to remove a significant barrier to discharge. In SFY2017, 471 birth certificates were obtained by way of this collaboration. The number of birth certificates obtained in SFY 2018 and SFY 2019 were 438 and 401 respectively. In 2020, this process was endorsed over to DOH for continuance.

2. Validation of Vacancy Tracking Systems. The Bed Enrollment Data System (BEDS) was developed to help DMHAS manage and track vacancies. Utilization of a web-based system provides real-time access to vacancy information and helps facilitate assignments and avoid outdated spreadsheets. The BEDS system currently tracks CSS, residential and short-term care facility (STCF) placements. Beginning in 2023, DMHAS will procure a web-based data system that will ultimately serve to provide enhanced tracking of referrals and vacancies for beds and services, including status of the referrals, disposition, and communication regarding the referrals. The data system will maintain information and communications on community and hospital referrals and provide the information needed to monitor referrals and intervene to facilitate placement and linkages to services. The ability to manage behavioral health bed vacancies and ongoing referral communications in one system allows for timely response in efficiently managing diversionary efforts. The data system will foster a continuum of community-based care that meets the needs of the individual where they live. The system will contain a public facing portal for individuals to be able to request an appointment with a service provider. The initial implementation phase will focus on the acute care continuum of services including a real-time connection between the crisis call center professionals, mobile crisis teams, crisis receiving stabilization centers and other acute care providers.

3. Enhancements to Community Capacity: DMHAS created 1808 new Supportive Housing placements from 2010 to 2016 under the Olmstead Settlement Agreement. DMHAS created 1808 new Supportive Housing placements from 2010 to 2016 under the Olmstead Settlement Agreement. In 2017, DMHAS transitioned to Community Support Services (CSS). CSS is mental health rehabilitation service and supports necessary to assist the persons receiving services in achieving mental health rehabilitative and recovery goals as identified in an individualized rehabilitation plan (IRP); including achieving and maintaining valued life roles in the social, employment, educational and housing domains; and assisting persons receiving services in restoring or developing his/her level of functioning to that which allows them to achieve community integration and to remain in an independent living setting of his/her choosing. There were 900 number of new placements created from SFY2017 to SFY2023. This would also include recycled subsidies and multiple re issuance of subsidies. DMHAS will be funding 150 new subsidies in 2024.

4. Continued utilization of the Intensive Case Review Committee (ICRC). All consumers in the state hospital are reviewed by ICRC once approximately every four weeks to ensure that consumer assignments have been made in preparation for discharge in a timely manner, barriers to discharge are addressed, systemic issues are addressed, and compliance with length of stay targets are maintained. The purpose of these meeting is to develop strategies for resolution of barriers and systems issues.

5. Continued Utilization of Hospital Project Teams. Project Team meetings are higher-level meetings that occur immediately after

ICRC and are typically chaired by the hospital CEO/DCEO or Medical Director. Policy and systems issues as well as any issue that may involve collaboration with another Division or state Department, are discussed at these meetings and elevated to Olmstead leadership to address. In addition to policy and systems reviews, Project Team meetings also discuss newly-designated CEPP consumers to ensure that a discharge plan is in place. Finally, Olmstead staff will also use these meetings to update the hospital leadership on any new administrative bulletins, requests for proposals, updates or changes to the vacancy tracking system, and/or trends identified in the data.

6. Hospital Diversion Initiative. The Olmstead Office has worked collaboratively with Centralized Admissions within the state psychiatric hospitals on a process for providing diversionary activities for individuals that do not meet criteria for commitment to the state hospital and are in need of less restrictive community settings. This diversionary initiative has increased to include persons serviced in county hospitals, STCFs, and/or other entities in which state hospitalization may have otherwise been explored as the next step. Regional Olmstead staff assist in securing additional supports needed for persons receiving services as a means of addressing their individualized circumstances and needs in the most integrated setting possible within their required level of care. This collaboration allows for reduced hospital census as well as enhanced community re-integration of persons receiving services.

7. Olmstead office expansion. The Olmstead office has increased its scope from primary implementation, monitoring and oversight of the Olmstead deliverables at the state psychiatric hospitals to also overseeing diversion to the state psychiatric hospitals and managing two novel community-based programs (Crisis and Receiving Stabilization Centers and Crisis Diversion Homes). The office has grown from four FTEs to eleven FTEs. In addition to the staffing increases, the Olmstead Unit has additional job duties due to the development and implementation of several new programs. Crisis Diversion, is anticipated to include 5 Crisis Receiving and Stabilization facilities as well as 4 Crisis Diversion Homes will fall under the purview of the Olmstead Unit. Key Olmstead Unit staff will be available on call to provide programmatic technical assistance. The Olmstead Unit will be responsible for the following up of referrals, analysis of data, and providing a needs assessment for gaps in services and housing for each county. The Olmstead Unit will continue monitoring of the Olmstead deliverables at the state psychiatric hospitals and facilitate community placement referrals for AKFC.

8. The Olmstead office partners other offices to meet the needs of individuals who also are served by the Division of Developmental Disabilities (DDD) or the Office of Managed Care. The Olmstead staff continue to collaborate with DOH and DDD staff regarding discharge planning of dually diagnosed consumers with both intellectual developmental disabilities and mental illness (IDD/MI) in the state psychiatric hospitals. DDD Transitional Case Managers (TCMs) are stationed at each respective state hospital and have their sole or primary responsibilities at the state hospitals focusing on the state hospital DDD population, the DDD referrals and working with hospital staff to address any discharge barriers that may be present. Joint DDD and State Hospital meetings occur at each hospital on a monthly basis to discuss discharge planning and address any systems issues. On a bi-weekly basis, higher level meetings are scheduled between DDD and DMHAS to discuss issues that require a higher-level review. Olmstead staff partner with DOH and the Office of Managed Care to facilitate state hospital discharges of individuals who need Medicaid state plan services or who utilized MLTSS. A training will be provided by the Olmstead Office to the Managed Care Organizations (MCOs) on assessment of level of care so that their members who have an SMI and are in need of housing can be placed in the least restrictive setting.

9. Trainings with county hospitals and hospitals with diversion beds. The Olmstead Office initiated a pilot program in 2016 to provide diversionary activities for individuals that do not meet criteria for commitment to the state hospital and are in need of less restrictive community settings. The diversionary initiative has grown over the years to include persons served in county hospitals, Short Term Care Facilities (STCFs), and/or other entities in which state hospitalization may have otherwise been explored as the next step. Regional Olmstead staff has developed a training which will be provided for each of the county hospitals, STCFs, and diversion entities. The training will enhance community re-integration of persons receiving service and ensure that all entities are able to obtain assistance with securing additional supports needed for applicable person receiving services as a means of addressing their individualized circumstances and needs in the most integrated setting possible within their required level of care.

10. Technical Assistance to providers. The Olmstead Unit currently provides ongoing technical assistance and training to providers on the utilization of the web-based electronic referral tracking system, Division polices and administrative bulletins that govern the discharge process from the state psychiatric hospitals, utilization of DMHAS and community resources to develop wraparound supports for individuals being transitioned to a less restrictive level of care.

DMHAS has requested TA support from SAMHSA to provide training on additional Evidenced Based Practices such as the MISSION model, Critical Time Intervention (CTI) and Individual Placement and Support—Supported Employment (IPCS-SE) model. TA support will also include training on improving communication and collaboration with partners and stakeholders, seamless integration of existing housing services into new crisis services programs, overcoming systemic barriers to housing and workforce development and retention strategies. As DMHAS focuses on diverting state hospital admissions to maintain a decreased census and reduce unnecessary hospitalizations, training will also include use of crisis diversion homes and effective transitioning of consumers through the crisis continuum, including CRSCs and STCFs, to community linkages and supports and training on Evidenced Based Practices in diversion strategies. Training for housing service providers, case managers and supported employment in crisis risk assessment and planning, client engagement, and coordination with treatment and other service providers should include a component on accessing any new local crisis programs that have been developed with an emphasis on integration with existing services. Staff working in crisis services, including call centers, mobile crisis teams, and crisis stabilization programs, need working

knowledge of the housing and employment programs and resources available within their community and how to access them.

Please indicate areas of technical assistance needed related to this section.

Technical Assistance: Olmstead/Diversion Management Team and Staff

• Review of existing Olmstead plan and data metrics with the goal of revising or establishing additional meaningful performance indicators and data metrics that focus on diversion of state hospital and nursing facility admissions, reduction of rapid re-hospitalizations, an increase in community housing opportunities, and maintenance of consumer community tenure.
• Guidance for state Olmstead staff on updating the Olmstead Plan to include a focus on diverting state hospital, nursing facility, and ED admissions in addition to maintaining the timely reintegration of individuals to the community.
• Use of crisis diversion homes and effective transitioning of consumers through the crisis continuum, including CRSCs and STCFs, to community linkages and supports.
• Training on Evidenced Based Practices in diversion strategies.

Technical assistance is needed to provide training on additional Evidenced Based Practices, improving communication and collaboration with partners and stakeholders, seamless integration of existing housing services into new crisis services programs, overcoming systemic barriers to housing and workforce development and retention strategies.

Training on the following EBPs will build upon current practice and support provider efforts in assisting consumers with maintaining community tenure, decreasing repeat hospitalizations and effectively intervening to deescalate a crisis.

• The MISSION model has been shown when combined with supportive housing to help improve housing retention, mental health outcomes, and access to care. The Academy of Psychiatric Rehabilitation and Recovery can be explored to provide this training.
• Critical Time Intervention (CTI), which provides continuity of care to individuals with SMI during transitions from homelessness, psychiatric hospitals, or other institutions into community housing, has been associated with reductions in negative psychiatric symptoms, length of psychiatric hospital stays, and emergency department visits. The Center for the Advancement of Critical Time Intervention offers CTI trainings.
• Individual Placement and Support – Supported Employment (IPCS-SE) model, which has been adapted for working with people who are experiencing homelessness and those who have been involved in the criminal justice system. IPS Employment Center can be explored to provide this training.
• TA to help explore strategies to enhance community tenure for individuals in the following SMI populations: older adult (55 and older); individuals with medical comorbidities, individuals with a significant legal history, co-occurring SUD, and/or co-occurring I/DD.
• TA to help with exploring strategies for discharging individuals from inpatient state hospitals and nursing facilities to least restrictive community settings and also exploring continued strategies to enhance community tenure and further diversionary activities.

Additional training topics include:

• Training for housing service providers, case managers and supported employment in crisis risk assessment and planning, client engagement, and coordination with treatment and other service providers. The training should also include a component on accessing any new local crisis programs that have been developed with an emphasis on integration with existing services. Staff working in crisis services, including call centers, mobile crisis teams, and crisis stabilization programs, need working knowledge of the service system and resources available within their community and how to access them.
• Identifying and utilizing shared data systems to allow for rapid and coordinated communication between behavioral health clinical staff and other service providers.
• Building partnerships and enhancing services by using memorandums of understanding and operationalizing integration of services.
• Strategies on addressing workplace shortages, retention and addressing staff trauma.
• Enhancing relationships with landlords by developing effective outreach, recruitment and retention strategies in order to continue efforts to secure permanent housing for individuals in need, particularly those with significant legal histories and/or credit issues.
• Managing landlord tenant relationships and eviction prevention.
• Development of practices that allow for no wrong door, streamlined access to housing in the community.
• Strategies for navigating housing and community integration of forensically involved consumers and diverting readmissions to the state psychiatric hospitals and emergency departments.
• Training for providers on identifying, accessing and linking to state and county resources and underutilized entitlements.
• Technical assistance around developing a model for community-based outpatient competency restoration.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Environmental Factors and Plan

18. Children and Adolescents M/SUD Services –Required for MHBG, Requested for SUPTRS BG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SUPTRS BG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community.[1]. Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.[2]. For youth between the ages of 10 and 14 and young adults between the ages of 25 and 34, suicide is the second leading cause of death and for youth and young adults between 15 and 24, the third leading cause of death.[3].

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21.[4].

Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on financing, workforce development and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs.[5].

According to data from the 2017 Report to Congress[6] on systems of care, services:

1. reach many children and youth typically underserved by the mental health system.
2. improve emotional and behavioral outcomes for children and youth.
3. enhance family outcomes, such as decreased caregiver stress.
4. decrease suicidal ideation and gestures.
5. expand the availability of effective supports and services; and
6. save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious M/SUD needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

- non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and

employment); and

- residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

---

[1]Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2).

[2]Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

[3]Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

[4]The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

[5]Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from **https://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings-Executive-Summary/PEP12-CMHI0608SUM**

[6] **http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf**

Please respond to the following items:

1. Does the state utilize a system of care approach to support:

a) The recovery of children and youth with SED? (●) Yes ( ) No

b) The resilience of children and youth with SED? (●) Yes ( ) No

c) The recovery of children and youth with SUD? (●) Yes ( ) No

d) The resilience of children and youth with SUD? (●) Yes ( ) No

2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address M/SUD needs:

a) Child welfare? (●) Yes ( ) No

b) Health care? (●) Yes ( ) No

c) Juvenile justice? (●) Yes ( ) No

d) Education? (●) Yes ( ) No

3. Does the state monitor its progress and effectiveness, around:

a) Service utilization? (●) Yes ( ) No

b) Costs? (●) Yes ( ) No

c) Outcomes for children and youth services? (●) Yes ( ) No

4. Does the state provide training in evidence-based:

a) Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families? (●) Yes ( ) No

b) Mental health treatment and recovery services for children/adolescents and their families? (●) Yes ( ) No

5. Does the state have plans for transitioning children and youth receiving services:

a) to the adult M/SUD system? (●) Yes ( ) No

b) for youth in foster care? (●) Yes ( ) No

c) Is the child serving system connected with the FEP and Clinical High Risk for Psychosis (CHRP) systems? (●) Yes ( ) No

d) Does the state have an established FEP program? (●) Yes ( ) No

Does the state have an established CHRP program? (●) Yes ( ) No

e) Is the state providing trauma informed care? (●) Yes ( ) No

6. Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

The Division of Mental Health and Addiction Services (DMHAS) funds FEP programs ages 15-35.
The DCF provides DCF-CP&P staff with training on substance use prevention, treatment, and recovery, including the Substance Use Disorder Fellowship: A NJ Child Welfare Certification Program, as well as training for system partners who work with children and families. CSOC is presently working with NASHP to improve transition planning.

The goal of DCF's CSOC is to enable youth to remain at home, in school, and within their community. CSOC is committed to providing services that are:

1. Clinically appropriate and accessible
2. Individualized and delivered through a continuum of services and/or supports, both formal and informal, based on the unique strengths and needs of each youth and his or her family/ caregivers
3. Provided in the least restrictive, most natural setting appropriate to meet the needs of the youth and his or her family/caregivers
4. Family-guided, with families engaged as active participants at all levels of planning, organization, and service delivery
5. Community-based, coordinated, and integrated with the focus of having services, decision-making responsibility, and management operational at a community level
6. Culturally competent, with agencies, programs, services, and supports that are reflective of and responsive to the cultural, racial, and ethnic differences of the populations they serve
7. Protective of the rights of youth and their family/caregivers and
8. Collaborative across child-serving systems, including child protection, juvenile justice, and other system partners who are responsible for providing services and supports to the target populations.

CSOC served over 74,000 youth in CY 2022 through a complement of needs-driven supports and services within a system of care approach: family driven, youth-guided, strengths-based, individualized care. The primary goals of CSOC are to ensure youth receive quality care in the most appropriate, community-based setting whenever possible to maintain connections to family and communities for sustainable relationships and planning. CSOC also has a continuum of out-of-home treatment settings of varying degrees of intensity of service accessible based on youths' individual needs.
Description of the current Children's System of Care and Program Summaries

The primary goals of CSOC are to ensure youth receive quality care in the most appropriate, community-based setting whenever possible to maintain connections to family and communities for sustainable relationships and planning. CSOC also has a continuum of out-of-home treatment settings of varying degrees of intensity of service accessible based on youths' individual needs.

1. CSOC employs the use of the system of care approach and collaborates with many system partners throughout the State to leverage expertise of the local communities. There are state administrative and management staff, and services are provided by private agencies – primarily not-for-profit agencies.

2. CSOC staff members are assigned to manage the key services available through CSOC (i.e. CMO, MRSS, IIC/BA, FSO) in a collaborative, regional model.

3. Services are primarily funded through Medicaid state plan amendments (Title XIX and Title XXI).

4. CSOC also receives funding through the NJ FamilyCare Comprehensive Demonstration (1115 Waiver). The most recent Waiver renewal was approved by the Centers for Medicare and Medicaid Services (CMS) on April 1, 2023. More information about the Children's Support Services Program is available at Department of Human Services | 1115 NJ FamilyCare Demonstration Renewal Request.

5. Services are provided based on medical necessity.

6. Medical necessity is authorized by PerformCare, the Contracted System Administrator (CSA)/Administrative Services Organization (ASO), which provides the administrative services to the system of care.

Care Management Organization (CMO)

CMOs are nonprofit organizations responsible for care management, assessment, and comprehensive service planning for youth and their families with intense and/or complex needs related to behavioral health, substance use, and/or intellectual or developmental disability. Youth are enrolled with a CMO when independent CSOC CSA review of clinical and need-based information about the youth meets the threshold of clinical criteria, and the youth and family can benefit from services. CMOs engage families and youth, coordinate Child/Family Team (CFT) meetings, and implement Individual Service Plans (ISP) for each youth and their family. The CMO provides a single point of accountability for the organization, coordination, and delivery of services and supports needed to maintain stability for each youth.
Child Family Team (CFT)-Wraparound Approach
The Wraparound approach depends on collaboration among a team of family members, professionals, and significant community residents identified by the family and organized by the care manager to design and oversee implementation of the Individual Service Plan (ISP). The ISP connects the assessed strengths and needs of the youth with plan elements including family vision,

goals, strategies, supports, and services. The CFT is an ongoing coordinated process that includes participation from the youth, the youth's family, the CMO care manager, and any other individual identified by the youth and family to help support the family towards a sustainable plan of care. The CFT meets, at minimum, every 90 days or as needed. Through the CFT process strengths and needs, progress and barriers to care, and services to be implemented are identified. Once identified, a request is added to the youth's treatment (care) plan, which is reviewed by CSA's licensed clinical staff (Care Coordinators) against established clinical criteria and in the context of the youth's assessment and comprehensive plan. Clinical criteria for services are located at: http://www.performcarenj.org/provider/clinical-criteria.aspx. The Care Coordination staff requests additional information from the CMO when there is a question about the youth meeting the clinical criteria. Clinically appropriate services are authorized by the CSA.
Behavioral Health Homes

In five counties, CMOs serve as the designated Behavioral Health Home (BHH) entities for youth in New Jersey, serving as a "bridge" that connects prevention, primary care, and specialty care. Each Behavioral Health Home (BHH) is a designated Care Management Organization (CMO) with enhanced care management teams that include medical expertise and health/wellness education for purposes of providing fully integrated and coordinated care for youth remaining in their home and who have chronic medical conditions. Medical and wellness staff are integrated into the existing CMO CFT structure responsible for care coordination and comprehensive treatment planning for youth and their families, which includes planning for the holistic needs of the youth.

Family Support Organizations (FSOs)

FSOs are nonprofit organizations run by family members of youth with emotional, behavioral, developmental, and/or substance use challenges that have lived experience in supporting youth in addressing their needs. FSOs provide advocacy, education, and support through an array of supports and services including individual family-to-family peer support for youth with moderate and high needs, support groups and workshops, community outreach and education, telephonic support, and local level advocacy to help them navigate the System of Care, school system, CP&P, and the legal system, and to listen and provide moral support. In addition to caregiver supports, FSO Youth Partnerships (YPs), led by a young-adult Youth Coach, help youth to engage with other youth with mental, emotional, and behavioral health needs. Through support groups, social activities, and leadership development, youth and young adults ages 13-21 find their voice to affect change in their own lives and the lives of others. Each YP participates in monthly community activities to challenge stigma and strengthen other youth in their communities, and each year, youth leaders across the state develop and facilitate an annual youth conference.

Mobile Response and Stabilization Services (MRSS)

MRSS is the CSOC's urgent response service designed to help families stabilize youth in home and community settings. MRSS are available 24 hours per day, 7 days a week, year-round. MRSS provides immediate (within one hour) intervention designed to minimize risk, maintain the youth in his/her current living arrangement, prevent repeated hospitalizations, stabilize behavioral health needs, and improve functioning in life domains such as school and home routines. Mobile Response and Stabilization Services (MRSS) deliver services to youth vulnerable to or experiencing stressors, coping challenges, emotional or behavioral symptoms, difficulties with substance use as a coping strategy, or traumatic circumstances that may compromise the youth's ability to function optimally and thrive within their family/living situation, school, and/or community environments. MRSS is designed as an upstream intervention available to support families and youth when they first identify they need assistance based on their definition of need. Care is individualized, strengths-based, youth-centered, family-driven, community-based, trauma-informed, and culturally and linguistically mindful. MRSS provides engagement, crisis intervention, assessment, and planning designed to stabilize presenting stressors, behaviors and/or emotional challenges, maintain youth in their home environment and community, build formal and informal supports, and prevent unnecessary psychiatric hospitalization, out of home care, and legal involvement.
Intensive In-Community/Behavioral Assistance (IIC/BA) services

Intensive In-Community/Behavioral Assistance (IIC/BA) services are short term, intensive, community-based therapeutic interventions, rather than clinic or office-based, that are needs-driven, youth and family guided, and accessible. IIC/BA are aimed at engaging youth and families in a therapeutic process to reduce and stabilize challenging behavioral and emotional patterns and symptoms, introducing "replacement" skills, and developing parent skills for sustaining positive change and connecting to continued therapeutic supports when the need presents.

IIC services have two components:
• IIC Bio-Psychosocial and Strengths and Needs Assessments are conducted and submitted to the CSA for review by licensed behavioral health clinicians within 10 days of request. The assessment describes present challenges, strengths, identified goals, youth and family perspective and recommended intervention strategies. Assessments are provided in a youth's current living situation, including resource homes and detention centers. Assessments provide necessary information for a level of care determination.
• IIC Treatment Services are clinical interventions provided by licensed or licensed-supervised master's level clinicians working within the scope of their licensing board in the youth and families' natural environment. Time limited and goal-oriented, these services aim to reduce acute symptomatology, enhance strengths, and transition youth and families to more traditional, i.e. clinic/office-based services, as soon as possible.

BA services are adjunctive to IIC services. They are never stand-alone. BA services are delivered by a license-supervised individual who holds a bachelor's degree at minimum and has at least one-year experience working with the population served. The BA is

the agent of the IIC plan of care. The BA service provides direct youth and parent training, support, and intervention to maximize the potential of positive and sustainable change.

Evidence-Based Practices

The Children's System of Care has a focused strategic priority to ensure capacity to provide behavioral health services that are based on the best evidence available with a goal of improving outcomes and the quality of life for children, youth, and young adults receiving services through the Division. The following are examples of EBPs available through CSOC: Multisystemic Therapy (MST), Functional Family Therapy (FFT), Wraparound approach, Trauma Focused Cognitive Behavioral Therapy (TF CBT), Six Core Strategies and Nurtured Heart Approach, and the ARC framework and ARC Grow Model. Additional information on EBPs available through CSOC is located in another document (C12 – Trauma).

Youth Outpatient Services

Outpatient mental health treatment services offer community based behavioral health care to youth and families. These services frequently exist within a licensed community mental healthcare agency. Outpatient services are designed to support, enhance, and encourage the emotional development of life skills to preserve or improve individuals' functioning, strengths, and resources. Interventions may include individual, group, and family therapy, as well as medication evaluation and monitoring, and referral. Interventions are provided based on the need of the youth and family. CSOC does not manage outpatient services but does coordinate and collaborate with these providers at the local system and individual planning levels to support meeting youth and family needs.

Partial Care/Partial Hospitalization

Partial Care/Partial Hospitalization programs are highly structured, intensive (minimum 2 hours, 3 to 6 times per week) behavioral health services for youth with serious behavioral health needs. Multi-disciplinary behavioral health interventions include rehabilitation programming such as activities to support daily living, recreation, socialization, and community reintegration. Programs are typically located in a community-based mental health or hospital setting (N.J.A.C. 10:37-12). These services assist in stabilizing youth with acute needs, either following, or for prevention of, hospitalization or other out-of-home treatment.

Children's InterAgency Coordinating Council (CIACC)

The CIACC serves as the county mechanism to advise DCF/CSOC on the development and maintenance of a responsive, accessible, and integrated system of care for youth with behavioral and emotional health needs, substance use, and/or intellectual or developmental disabilities and their families. Through enhanced coordination of systems partners, the CIACC also identifies service and resource gaps and priorities for resource development. Functions of the CIACCs include:

• Evaluating the local county policies to understand and minimize the impact of local barriers to serving youth with behavioral and emotional health needs, substance use, and/or intellectual and developmental disabilities in their community.
• Identifying local strategies and mechanisms to promote the integration and coordination of county, State, or other resources serving youth with behavioral and emotional health needs, substance use, and/or intellectual or development disabilities.
• Assessing local systems needs using information received from DCF, the Contracted System Administrator (CSA), any child-serving agency identified by DCF, and other bodies to make recommendations regarding service and resource development priorities.
• Identifying and informing DCF/CSOC regarding gaps and barriers to local service effectiveness.
• Providing input to State, regional, and county entities regarding system performance and service need.

In collaboration with the Department of Education, DCF recommended the creation of an "Educational Partnership" in every county in NJ. These partnerships use the County Inter-Agency Coordinating Councils to build a better working partnership between the DCF system of care and the local education system. This initiative has many goals, but one simple goal is to have at least one person in every school in NJ formally trained on the DCF service delivery system. This will help to facilitate a more preventative response to behavioral health challenges. Efforts to achieve this goal continue. DCF believes bringing systems together through the Educational Partnership will improve coordination in the service delivery process.

Out-of-Home (OOH) Treatment Services

Funding for CSOC OOH care encompasses a full continuum of services for behavioral health, intellectual or developmental disabilities, substance use, and co-occurring treatment needs. OOH treatment intervention must be directly related to the goals and objectives established by the Child/Family Team (CFT) process in coordination with the multidisciplinary Joint Care Review (JCR)/treatment plan. The OOH provider submits the JCR to the CSA for utilization review and for clinical determination of continued stay in out-of-home treatment. Family/guardian/caregiver involvement is essential, and, unless contraindicated, should occur consistently and on a regular basis (or as determined in the JCR/treatment plan). The recommended length of stay for OOH intervention is typically nine to twelve months. One single episode of OOH care is optimal. Clinical criteria for the OOH continuum of services are available at http://www.performcarenj.org/provider/clinical-criteria.aspx.

CSOC data have demonstrated a gradual decline in OOH utilization over the past several years, which is attributed to the success of maintaining more youth at home with community supports. Based on the analysis of utilization data, while most youth are served in the community, some with high needs require OOH intervention.

Behavioral Health Out of Home Treatment Services

• IRTS (Intensive Residential Treatment Services) - Non-hospital treatment services provided to youth with a wide range of serious emotional and behavioral needs who require 24 hours per day care in a safe, structured environment with constant line-of-sight supervision.
• PCH (Psychiatric Community Home) - 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.
• SPEC (Specialty Bed Program) - Programs that provide intensive residential services for children who are presenting with 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.
• RTC (Residential Treatment Center) - Programs that provide 24 hours 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.
• GH (Group Home) - Group home services provide up to 24 hours per day care and treatment to youth whose needs cannot be met appropriately in their own homes or in resource care, but who do not need the structure and intensiveness of a more restrictive setting.
• TH (Treatment Homes) - 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.
• STAS (Stabilization and Assessment Services for Child Welfare) - Short-term, highly structured, and nurturing environments with professional competencies to stabilize children engaged with, or at risk of, involvement with child welfare, who are homeless, and/or present with complex behavioral health challenges on an emergent basis, and who do not meet the need for an acute hospital setting. The intent is to stabilize crises in a soothing and trauma aware milieu while diagnostic assessments, services, and supports that meet the children's needs are conducted. The goal of this intervention is to identify and secure an appropriate living situation for youth (in home/out-of-home). In 2019, CSOC issued an RFP for up to two five-bed STAS programs for females and males, ages 13 – 18, but ultimately awarded three STAS programs due to the recent unexpected closure of a residential program serving human trafficking involved youth in need of stabilization and assessment services. These additional 15 beds complement the STAS beds developed in 2017-2018 to serve young children, ages 5-12.

Intellectual/Developmental Disability Out-of-Home Treatment Services

• SSH IDD (Special Skills Home) - Designed for youth who present with challenges in adjusting within their primary home setting or in a less intensive treatment setting. These homes are in private single-family homes. Youth are under the supervision of an agency trained mentor parent. There is no awake, overnight staff monitoring or supervision.
• GH-1 IDD (Group Home-Level 1) - Designed for youth who present with periodic behavioral difficulties that cannot be consistently managed in their primary home environment or in a less intensive treatment setting.
• GH-2 IDD (Group Home-Level 2) - Designed for youth who present with persistent challenging behaviors that cannot be safely and consistently managed in their primary home environment or in a less intensive treatment setting.
• RTC BH/DD (Residential Treatment Center for Intellectual/Developmental Disabilities) - Provides all-inclusive integrated programming with comprehensive therapeutic and clinical services in a 24-hour staff supervised, community-based setting for youth who present severe and persistent challenges in social, emotional, behavioral, and/or psychiatric functioning with a co-occurring intellectual/developmental disability.
• SPEC-IDD (Specialty IDD) - Designed for youth who present with challenges related to sexually reactive behavior. These specialty homes are in private single-family homes. Youth are under the supervision of an agency trained mentor parent. There is no awake, overnight staff monitoring or supervision.
• PCH-IDD (Psychiatric Community Home-IDD) - Provides supervised 24-hour care within an intensive treatment program for youth with intellectual/developmental disabilities who present with severe behavioral health challenges. PCH-IDD programs are designed for youth who have received inpatient services for behavioral health needs and who cannot be supported in their current living arrangement with a reasonable degree of safety.
• Intensive-IDD (Intensive Psychiatric Community Home -IDD) - Youth who are considered for admission present with complex, challenging behavior(s) of such intensity, frequency, and duration that it prevents the youth's personal development and inclusion in family life and community. Challenging behaviors may be unusual responses to sensory experiences and recurring trauma, thus manifesting challenging behaviors that include, but are not limited to, inappropriate/rule violations, noncompliance, self-injurious behaviors, and destructive, aggressive, and/or assaultive behaviors that require medical attention.
• RESP IDD (Respite for Intellectual/Developmental Disabilities) - Short term out-of-home respite services for youth and young adults with limited behavioral challenges.
• Crisis Stabilization and Assessment Program - CSAP IDD provides 24-hour care in a highly structured, community-based treatment setting with professional competencies and capabilities to stabilize youth with I/DD ages 6 to 20 years old (males/females) that are in crisis and unable to be safely supported in their current living situation. The primary goal upon stabilization is transitioning the youth to the community with wraparound services and supports, whenever possible. CSAP provides comprehensive diagnostic assessments that result in the identification of proper in-home services and supports that can meet the youth's habilitative and behavioral health needs upon transition.

Substance Use (SU) Treatment

The Children's System of Care offers an array of substance use treatment services for youth and young adults, including four withdrawal management beds, contracted outpatient/intensive outpatient services through 9 providers statewide, partial care services through one provider, and short term out-of-home treatment through one provider with 19 beds. In addition, residential treatment services for youth with co-occurring substance use needs and significant behavioral health needs can be accessed

through the CMO from five providers with a total of 54 beds.

The South Jersey Initiative provides fee for service funding to 10 providers for outpatient and intensive outpatient substance use services for the eight southern counties. One agency, with a capacity of three beds, provides short term out-of-home treatment.

Outpatient and Intensive Outpatient services are authorized based on individual clinical need and are not monitored on a slot-based method. This allows the providers to serve more youth and avoid waiting lists. The contracted providers manage their annual funding for these services.

A parent/legal guardian may contact the CSA to access CSOC contracted services. If the parent/legal guardian is requesting substance use treatment services, the CSA licensed clinicians complete the CSOC standardized substance use assessment via phone, determine appropriate levels of care, provide referrals, and authorize services. If a youth meets clinical criteria for out of home co-occurring services, he/she will be opened with a CMO from their service area. The CMO Care Manager will assist in coordinating treatment services for youth and families, including meet and greets with treatment providers, educating families about services for their youth during and after treatment process, as well as providing support and encouraging family involvement throughout this process.

Families may also access services directly through one of the CSOC contracted substance use treatment providers. The provider will complete a substance use assessment and submit it to the CSA for review by licensed clinicians for intensity of service determination and authorization for treatment.

The ASAM Criteria (developed by the American Society of Addiction Medicine (ASAM)) are used to determine admission to level of care and readiness for discharge/transfer to another level of care. These decisions are made by Licensed Clinical Alcohol and Drug Counselors (LCADCs) with appropriate specialized training employed by the CSA.

Substance use treatment services are authorized without regard to income, private health insurance, or eligibility for FamilyCare.

Types of substance use treatment services offered through CSOC

• Outpatient (Level I) – consists of less than 6 hours of service per week for adolescents including individual, family, and group therapy/counseling, including co-occurring services.
• Intensive Outpatient (Level 2.1) – consists of more than 6 hours per week of day treatment for adolescents including individual, family, and group therapy/counseling, including co-occurring services.
• Partial Care (Level 2.5) – consists of 20 hours per week for adolescents including educational programming, individual, family, and group therapy/counseling, including co-occurring services.
• Co-Occurring OOH Treatment (Level 3.5 and Level 3.7) – consists of residential services for adolescents/young adults providing 24 -hour care with dually licensed clinicians including individual, family, and group therapy/counseling, including co-occurring services. Level 3.7 also provides 24-hour nursing care and a more intense clinical program, offering more hours of clinical services including individual, family, and group therapies by a dually licensed clinician, as well as an increased ratio of direct care staff to youth.
• Medically Monitored High Intensity Inpatient-Withdrawal Management (Level 3.7WM) - Medically monitored withdrawal management, providing medical and nursing 24-hour care, evaluation, and withdrawal management in an agency with inpatient beds.
• Co-Occurring Behavioral Health/Substance Use Treatment Program – provides 24 hours supervised, all inclusive, co-occurring clinical services in a community-based setting for adolescents ages 13-18 who present with challenges in social, emotional, behavioral and/or psychiatric functioning as well as co-occurring substance use treatment needs.
• South Jersey Initiative (SJI) - The South Jersey Initiative is a historical funding stream that was designated as a result of advocacy to increase substance use treatment resources for youth and young adults in Southern NJ. To receive SJI funding, the youth must meet ASAM criteria for services and must be from one of the following eight counties: Atlantic, Burlington, Camden, Cumberland, Gloucester, Cape May, Ocean, and Salem. SJI funding is the payer of last resort. Authorization for outpatient/intensive outpatient substance use treatment services, under the SJI funding, is the same process for accessing contracted funding. Intensity of service determination is based on ASAM criteria.

Supports and Services for Youth with Developmental Disabilities

DD Eligibility

CSOC is responsibility for determining eligibility for developmental disability services for children under age 18. Families apply for DD eligibility through the CSOC established process. The CMOs and MRSS work with family members enrolled with them to make application for eligibility determinations. The Division of Developmental Disabilities (DDD) continues to determine eligibility for individuals aged 18 and over, and the Children's System of Care provides services to those youth. DDD and CSOC collaborate through an established protocol to provide a seamless transition to adult services.

Intensive In-Home: IIH Supports

While traditional therapies are typically provided at the health care provider's office location, Intensive In-Home (IIH) services are provided in the youth's home or at another location in the community, which makes sense to both the family needs and the goals

of the service. IIH covers a variety of services geared to assist youth with challenging behaviors that may impact their ability to remain at home.

• Clinical and therapeutic interventions- These services are rehabilitative, focused on the restoration of a youth's functional level after an acute episode or decline in functioning related to mental illness or a significant life stressor.

• Applied Behavior Analysis (ABA)- ABA is a set of habilitation services, designed for decreasing dangerous behaviors while assisting youth in acquiring and retaining self-help, communication, and adaptive skills. Services focus on helping youth learn these skills while working with and training the youth's parent or caregiver to implement a behavior plan.

• Individual Support Services (ISS)- ISS is skill development for activities of daily living. Including self-care tasks and the enabling of an individual to live independently in the community.

Family Support Services for Children with Intellectual/Developmental Disabilities

Family Support Services (FSS) are available for youth who are determined eligible for developmental disability services and meet the criteria for FSS. The services described below may be provided based on availability and appropriateness to the needs of the youth and their family.

• Respite means "break" or "relief." Respite services are intended to provide temporary relief for the primary caregiver from the demands of caring for an individual with disabilities during the times when the caregiver would normally be available to provide care. The service relieves family members from care on a temporary basis for short periods of time. There are several different settings for respite, including home-based, agency after-school, overnight stays, and weekend recreation. Please note that respite services are dependent upon funding availability.

• Assistive Technology is designed to increase the functional skills of a youth with a developmental disability and enhance their ability to live successfully in the community. An assistive device is an item to increase, maintain, or improve functional capabilities of the youth, and is not solely therapeutic. Vehicle and home (environmental) modifications are also included in this category. It must be an item not covered by medical insurance and cannot be used to restrain the youth.

• Educational Advocacy is a service provided to youth and their families when the youth needs in-depth help with education-related needs.

• Summer Camp offers limited financial support for eligible youth to attend summer camp. Youth can attend either a specialized camp or a mainstream camp, as long as the camp becomes qualified as a camp provider through CSOC. One-to-One Aide services may also be available for youth deemed eligible.

Juvenile Justice

Reducing the Number of Juvenile Justice Commitments

The Children's System of Care (CSOC) is fully accessible to youth involved with the juvenile justice system and the services coordinated by care managers help to keep youth out of detention centers. There has been a significant decrease in the number of detention center admissions resulting in the reduction of the number of county detention centers from seventeen to six in the past few years (Burlington County Detention Center closed in 2020).

Detention Alternative Program/Youth Advocate Program (DAP/YAP)

CSOC funds Community Re-Integration Services through YAP (Youth Advocate Program) to maintain youth in their community who, without this program, would enter out-of-home treatment due to juvenile justice involvement. The program provides services both individually and in groups, along with a mentor, life skills groups, and employment skills. The program is located in the three counties (Middlesex, Camden, and Essex) with the highest rate of court ordered out-of-home referrals. Additionally, this program has enabled the Division of Child Protection and Permanency to successfully maintain youth in resource homes after their arrest.

Medicaid

Currently, youth in juvenile detention facilities are eligible for Medicaid or New Jersey FamilyCare (S-CHIP) only after adjudication and referral to a non-secure setting.

CSOC Representation on the New Jersey Council for Juvenile Justice Improvement

Diversion and the reentry processes are discussed by the Access to Treatment and Racial Disparities sub-committees of the Council. Formal recommendations are presented to the full Council by the individual sub-committees.

DCF Cooperative Relationships with the Juvenile Justice Commission (JJC)

Since December 2004, the Department has maintained a Memorandum of Understanding with the JJC that outlines a distinct process by which youth in the JJC can be referred directly to what is now known as the Children's System of Care for services that will be implemented upon the youth's release from a JJC facility. Representation from both CP&P and CSOC participate in the JJC and Annie E. Casey Foundation driven Juvenile Detention Alternative Initiative (JDAI) in order to collaborate on developing alternatives to detention and to reduce the number of youth going into detention. Both systems participate in each other's planning and case review processes.

The Juvenile Justice Commission is responsible for operating state services and sanctions for juveniles and for developing a statewide plan for the effective provision of juvenile justice services and sanctions at the state, county, and local levels. To emphasize New Jersey's commitment to provide coordinated quality services and appropriate sanctions for youthful offenders while ensuring the public's safety, the JJC established the State/Community Partnership Grant Program. These Partnership Grants provide funding to each county for services to reduce detention overcrowding, to provide treatment for sex offenders, to increase disposition options, and to provide aftercare to youth and their families.

Special Case Review Committee

The Special Case Review Committee (SCRC) reviews those youth, both male and female, who present multi-system needs/issues and the need for special attention or advocacy. Included are those who appear to have developmental disabilities, those who need placement by DCF/CP&P due to court orders for diversion or aftercare, and/or those who have special presenting problems, including homelessness, and those who are being referred, or are accepted by, DCF/CSOC.

The Office of Special Needs oversees the SCRC in terms of intra- and inter-agency planning. It is chaired by the Special Needs Assistant. Members include representatives from CP&P, Office of Adolescent Services, Children's System of Care, the JJC Juvenile Parole and Transitional Services (JP&TS), Pre-Release Teams, Regional Court Liaisons/designees, the JJC Child Study Teams, JJC community residential homes, and representatives from the New Jersey Training School at Jamesburg (NJTS), Juvenile Medium Security Facility (JMSF), and the Juvenile Female Secure Care and Intake Facility (Hayes Unit) Social Services Departments.

Meetings are held twice a month, for northern and southern regional cases, respectively. Referrals are primarily made from the Reception and Program Review committees, the Reception and Assessment Center (RAC), the New Jersey Training School (NJTS), and Juvenile Female Secure Care and Intake Facility. However, youth may be referred by any source identifying a special need for advocacy and planning, including the Institutional Classification Committees, JP&TS staff, court liaisons, supervisors, and program staff.

When youth in a JJC facility have permanency and treatment needs that require the intervention of DCF, the JJC Special Needs Review Committee will work with CSOC and CP&P to make appropriate referrals prior to time of discharge. In circumstances where CSOC is unable to access a timely treatment plan in accordance with mandatory release dates, CP&P will be expected to effectuate the most appropriate contingency plan until such time that a more feasible plan is developed. Care Management Organization (CMO) involvement is inclusive in this agreement, when appropriate.

CSOC maintains a "Protocol for Supervision of Juvenile Probationers Court-ordered to Attend and Complete a DCSOC Specialty Services Program." This protocol was approved in 2012 by NJ Juvenile Probation Managers, NJ Conference of Chief Probation Officers, CSOC Representative for Specialty Programs, NJ Juvenile Committee of Family Presiding Judges, and the NJ Conference of Family Presiding Judges. Subsequent protocols were developed that address communication and collaboration for youth in either a residential treatment program or a substance use treatment program.

CSOC Training and Technical Assistance

CSOC offers a broad array of training and technical assistance to system partners through contracts with several entities including Rutgers University Behavioral HealthCare, the Boggs Center, and Autism New Jersey.
DCF/CSOC funds the Technical Assistance Center through University Behavioral Health Care - Rutgers, the State University, to provide training statewide. CSOC, through the UMDNJ Training contract, offers training to all children's system of care providers free of charge.

In addition, CSOC staff provides training on working with individuals with behavioral health challenges to staff of the Juvenile Justice Commission.

The Contracted System Administrator (CSA)

The Contracted System Administrator (CSA) was designed to provide the State with overall healthcare system management to assure 24-hour access to appropriate and coordinated services and provide child-specific and systemic data analysis on all children under the jurisdiction of CSOC.

The CSA creates a common single point of entry for youth and families. The CSA functions as, and is inclusive of the activities of, a non-risk Administrative Services Organization (ASO). The CSA registers all youth requesting services, authorizes services in a single electronic record, and tracks and coordinates care for all New Jersey youth enrolled in CSOC.

CSOC retains all regulatory and policy-making authority. As such, there are key functions that remain the responsibility of CSOC, including, but not limited to, network development, provider contracting, and provider outcome standards. As a partner to CSOC, the CSA provides administrative support and is encouraged to offer recommendations for improvements to the delivery of services which may be implemented with the approval of CSOC.

The CSA performs a broad range of administrative service functions including, but not limited to, the following:

• Providing a Call Center with 24-hour/7-day intake and customer service capability.

• Providing a web-based application/interface with the CSA's Management Information System (MIS).
• Managing care, including utilization management, outlier management (including authorization of services), and care coordination; if youth are involved with a Care Management Organization, the CSA reviews service requests based on the youth's comprehensive plan of care which is developed by the Child/Family Team (CFT).
• Coordinating access to services for all youth, including facilitating access to specialized services for youth involved with the Division of Child Protection and Permanency (CP&P).
• Coordinating Third Party Liability and medical coverages.
• Intellectual/Developmental Disability (IDD) eligibility determinations for youth up to age 18.
• Coordinating a transition to adult services for youth.
• Providing quality and outcomes management, and system measurement that supports CSOC's goal to promote best practices and aiding the State in assuring compliance with State and federal guidelines.
• Providing training and training materials.
• Providing support for provider network development.
• Completing annual audit reviews.

To support these administrative services, the CSA created and routinely maintains an MIS called CYBER (Child and Youth Behavioral Electronic Record) that is backed by strong, clinical guidance and fosters flexibility, system integration, comprehensive information management, and production of management reports that support business decisions.

Youth Suicide Prevention Resources

Every life lost to suicide is a tragedy and the New Jersey Department of Children and Families is committed to decreasing youth suicide and supporting youth who have attempted suicide. Suicide is the third leading cause of death for New Jersey youth between 10 and 24 years of age.

Traumatic Loss Coalitions for Youth (TLC) – UBHC Suicide Prevention

The Traumatic Loss Coalitions for Youth Program (TLC) at Rutgers-University Behavioral HealthCare is an interactive, statewide network that seeks to reduce suicide attempts, deaths by suicide, and to promote recovery of persons affected by suicide by offering collaboration and support to professionals working with school-age youth and direct crisis response services to staff and youth at youth-serving organizations following a traumatic event. The TLC offers county, regional, and statewide conferences, training, consultation, on-site traumatic loss response, and technical assistance. Since its inception, the TLC has trained thousands of individuals throughout the state with the purpose of saving lives and promoting post trauma healing and resiliency for the youth of New Jersey. The TLC website can be accessed at http://ubhc.rutgers.edu/tlc/

Project Connect
In November 2020, the Garrett Lee Smith Youth Suicide Prevention Grant was awarded to the New Jersey Department of Health (NJDOH) from the Substance Abuse and Mental Health Services Administration (SAMHSA). This federal grant was awarded to implement NJDOH's Readiness to Stand United Against Youth Suicide (R2S Challenge). The Department of Children and Families (DCF) is collaborating with the DOH on a portion of the grant. This collaboration is to assist New Jersey hospitals to effectively connect youth to services following suicide attempts. DCF is developing Project Connect to increase engagement in community mental health services after hospital discharge, reduce unnecessary Emergency Department utilization through connection to appropriate community services, and improve safety and well-being for youth and families. Through the innovative role of the Regional Care Coordinator (RCC), Project Connect works in partnership with identified hospitals to enhance discharge planning for youth with suicide ideation and/or attempts. After youth are medically stabilized, screened, and determined to be safe for discharge, hospital staff will engage in a warm transfer process to connect families to PerformCare and community resources. Hospital staff will also be coached on how to obtain consent to connect the family to the RCC who will make contact with the caregiver post-discharge to provide the youth and family with follow up support and ensure linkage and engagement with community behavioral health services.
Zero Suicide
The Children's System of Care was granted the opportunity to work with the Educational Development Center (EDC) on Zero Suicide. Zero Suicide is a Transformational Framework for Health and Behavioral Health Care Systems. The foundational belief of Zero Suicide is that suicide deaths for individuals under the care of health and behavioral health systems are preventable. For systems dedicated to improving patient safety, Zero Suicide presents an aspirational challenge and practical framework for system-wide transformation toward safer suicide care. The Zero Suicide Institute at EDC (ZSI) provides expertise, customized consultation, and training for health and behavioral health care systems and providers, state agencies, tribal governments, health plans, and others as they launch evidence-based practices for suicide prevention, adopt continuous quality improvement efforts, and implement the Zero Suicide framework for safer suicide care. The Zero Suicide EDC website is zerosuicide.edc.org
Our partnership with EDC is a two-year investment, that started with the implementation of Zero Suicide within our Care Management and Family Support Organizations as well as some of our out of home treatment programs. Year 2 looks to include teams from additional OOH organizations as well as the organizations that oversee our Mobile Response Stabilization Services.
As a result of working with the EDC to implement the Zero Suicide Framework, our partners have created and updated policies regarding suicide prevention, attempts, and protocols and some have engaged in agency-wide staff training, policy consultation, workforce readiness surveys, and piloted screening projects that regularly assess a youth's potential for suicidal thoughts or ideations, and, if identified, guide the youth onto a pathway that will build their resilience and coping skills, reducing risk and helping them to thrive. Some of our partners have also included individuals with living experience on their Zero Suicide teams.

2NDFLOOR Youth Helpline

Accredited by the American Association of Suicidology, 2NDFLOOR is a confidential call/text helpline and message board platform serving youth and young adults. Youth who contact the 2NDFLOOR are assisted with their daily life challenges by professional staff and trained volunteers. The 2nd Floor website can be accessed at http://www.2ndfloor.org/

Crisis Text Line

The Children's System of Care has partnered with Crisis Text Line in New Jersey to provide another tool for constituents. Crisis Text Line is a free 24/7 support that connects anyone experiencing a self-defined crisis with a trained counselor. It can be accessed from anywhere in the United States. When texts are received, they are screened by an algorithm for severity, and texts that indicate imminent risk are placed at the top of the queue for faster response. Crisis counselors are trained to bring texters from "a hot moment to a cool calm," using empathic listening techniques. They collaboratively problem-solve to help the texter come up with a plan to stay safe. Calls are anonymous and confidential, unless referral to emergency services is necessary. For cell phone plans with AT&T, T-Mobile, Sprint, or Verizon, texts are completely free and will not show up on the phone bill. For plans with another carrier, normal text rates will apply and will appear on the phone bill as 741741. Additional information about Crisis Text Line can be found at http://www.crisistextline.org

Additional Suicide Prevention/Crisis Resources

Staffed by mental health professionals and peer support specialists 24 hours a day, seven days a week, the New Jersey Suicide Prevention Hopeline is available to all ages for confidential telephone support (except when a suicide attempt is in progress), assessment, and referral. The NJ Hopeline offers call, text, chat, and email options. General information is available at: www.njhopeline.com

New Jersey Youth Suicide Prevention Advisory Council

Established in, but not of, the Department of Children and Families, the New Jersey Youth Suicide Prevention Advisory Council is comprised of appointed New Jersey citizens and state government representatives. The New Jersey Youth Suicide Prevention Advisory Council examines existing needs and services and makes recommendations for youth suicide reporting, prevention, and intervention. It advises the development of regulations pursuant to N.J.S.A. § 30:9A-25 et seq.

7. Does the state have any activities related to this section that you would like to highlight?

see answers in question number 6

Please indicate areas of technical assistance needed related to this section.

None

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Environmental Factors and Plan

19. Suicide Prevention - Required for MHBG

Narrative Question

Suicide is a major public health concern, it is a leading cause of death overall, with over 47,000 people dying by suicide in 2021 in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance abuse, painful losses, exposure to violence, and social isolation. Mental illness and substance abuse are possible factors in 90 percent of the deaths from suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, SAMHSA urges M/SUD agencies to lead in ways that are suitable to this growing area of concern. SAMHSA is committed to supporting states and territories in providing services to individuals with SMI/SED who are at risk for suicide using MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the M/SUD agencies play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

Please respond to the following:

1. Have you updated your state's suicide prevention plan in the last 2 years? ○ Yes ● No

2. Describe activities intended to reduce incidents of suicide in your state.

In spring 2019, DMHAS created a position for a Suicide Prevention Coordinator within the Medical Director's Office at DMHAS. One full-time employee (Suicide Prevention Program Specialist), who started work on April 1, 2019 is principally involved with general suicide-related matters and specifically tasked with the organization and implementation of a statewide Zero Suicide approach and other statewide activities. Funding in the amount of $500,000 for this purpose has been included in the DHS budget, and this funding has been authorized in every year since 2019. In addition to supporting the statewide Zero Suicide Academy training, the funding also supports initiatives by the Rutgers Gun Violence Research Center to address lethal means, an annual suicide prevention conference, and related activities.

Mental Health and Substance Use Disorder providers contracted and/or licensed by the Department of Human Services are required to report Unusual Incidents regarding individuals they serve. State Psychiatric Hospitals are also required to report Unusual Incident Reporting Management System (UIRMS) data regarding individuals they serve, but the facilities report to the Department of Health's Division of Behavioral Health Services (DBHS), not to DHS/DMHAS. Both reporting systems require reporting of serious suicide attempts and deaths. DMHAS requires providers to intensely analyze each of these events to assess opportunities for improvement in their systems and processes.

DOH/DBHS revised Administrative Bulletin # 3:41: Screening, Assessment, Management, and Treatment of Suicidal and Non-Suicidal Self-Directed Violence that requires all NJ Psychiatric Hospitals to screen and/or assess all patients admitted to and discharged from state psychiatric hospitals. In addition, the Bulletin delineates the administration of evidence-based screening and assessment tools at various points of care to keep all patients safe during their hospital stay and mandates suicide specific treatments for patients identified with moderate or high suicide risk. Treatment modalities include Safety Planning and Cognitive-Behavioral Therapy for Suicide Prevention (CBT-SP). DMHAS assisted with the aforementioned training, which was held on August 14, 2019.

The Suicide Prevention Coordinator works with a Suicide Prevention Advisory Committee within DMHAS. The coordinator also monitors and analyzes data from the NJ Violence Death Reporting System (VDRS), Department of Health –New Jersey's detailed and timely surveillance system of all violent fatalities—as well as existing NJ data from other systems that capture non-fatal suicide attempts of individuals who received treatment through Emergency Department visits and inpatient hospitalizations. Data shows that New Jersey has the lowest suicide death rate of any state in the nation, although efforts must continue to address the need, including concerns about rising attempts in female adolescents and older adults.

With this information, the New Jersey Department of Human Services (DHS) continues to offer an annual Suicide Prevention Conference to reflect new data, resources, and information available for the public. The conferences have attracted over 1,000 attendees from all walks of life in recent year. A variety of topics including 988, Veterans, and Gun Violence were addressed. Several break-out sessions based on practice gaps and major issues in the public mental health system, as well as being tailored to specific interests and areas of concern. This year's Suicide Prevention Conference is planned for October 19, 2023 and will be virtual.

Additionally, DMHAS was accepted in early 2021 to participate in the VA/SAMHSA Governor's Challenge to Prevent Suicide Among Service Members, Veterans, and Their Families (SMVF). Our military service members are faced with many challenges, including depression and suicidality and veterans die by suicide at a rate 15 times higher than other adults, while also being more likely to own a firearm. This challenge expands into core areas consisting of screening, identifying, connecting, and assessing for lethal means for SMVF. Initially, the DMHAS Suicide Prevention Coordinator had co-chaired the Governor's Challenge, but has stepped down with the appointment of a new lead. DMHAS continues to be an active participant, however, and has related sponsored training and offered the services of the Rutgers GVRC to assist with the initiative.

Youth Suicide Prevention Resources

Every life lost to suicide is a tragedy and the New Jersey Department of Children and Families is committed to decreasing youth suicide and supporting youth who have attempted suicide. Suicide is the third leading cause of death for New Jersey youth between 10 and 24 years of age.

Traumatic Loss Coalitions for Youth (TLC) – UBHC Suicide Prevention

The Traumatic Loss Coalitions for Youth Program (TLC) at Rutgers-University Behavioral HealthCare is an interactive, statewide network that seeks to reduce suicide attempts, deaths by suicide, and to promote recovery of persons affected by suicide by offering collaboration and support to professionals working with school-age youth and direct crisis response services to staff and youth at youth-serving organizations following a traumatic event. The TLC offers county, regional, and statewide conferences, training, consultation, on-site traumatic loss response, and technical assistance. Since its inception, the TLC has trained thousands of individuals throughout the state with the purpose of saving lives and promoting post trauma healing and resiliency for the youth of New Jersey. The TLC website can be accessed at http://ubhc.rutgers.edu/tlc/

Project Connect
In November 2020, the Garrett Lee Smith Youth Suicide Prevention Grant was awarded to the New Jersey Department of Health (NJDOH) from the Substance Abuse and Mental Health Services Administration (SAMHSA). This federal grant was awarded to implement NJDOH's Readiness to Stand United Against Youth Suicide (R2S Challenge). The Department of Children and Families (DCF) is collaborating with the DOH on a portion of the grant. This collaboration is to assist New Jersey hospitals to effectively connect youth to services following suicide attempts. DCF is developing Project Connect to increase engagement in community mental health services after hospital discharge, reduce unnecessary Emergency Department utilization through connection to appropriate community services, and improve safety and well-being for youth and families. Through the innovative role of the Regional Care Coordinator (RCC), Project Connect works in partnership with identified hospitals to enhance discharge planning for youth with suicide ideation and/or attempts. After youth are medically stabilized, screened, and determined to be safe for discharge, hospital staff will engage in a warm transfer process to connect families to PerformCare and community resources. Hospital staff will also be coached on how to obtain consent to connect the family to the RCC who will make contact with the caregiver post-discharge to provide the youth and family with follow up support and ensure linkage and engagement with community behavioral health services.

2NDFLOOR Youth Helpline

Accredited by the American Association of Suicidology, 2NDFLOOR is a confidential call/text helpline and message board platform serving youth and young adults. Youth who contact the 2NDFLOOR are assisted with their daily life challenges by professional staff and trained volunteers. The 2nd Floor website can be accessed at http://www.2ndfloor.org/

Crisis Text Line

The Children's System of Care has partnered with Crisis Text Line in New Jersey to provide another tool for constituents. Crisis Text Line is a free 24/7 support that connects anyone experiencing a self-defined crisis with a trained counselor. It can be accessed from anywhere in the United States. When texts are received, they are screened by an algorithm for severity, and texts that indicate imminent risk are placed at the top of the queue for faster response. Crisis counselors are trained to bring texters from "a hot moment to a cool calm," using empathic listening techniques. They collaboratively problem-solve to help the texter come up with a plan to stay safe. Calls are anonymous and confidential, unless referral to emergency services is necessary. For cell phone plans with AT&T, T-Mobile, Sprint, or Verizon, texts are completely free and will not show up on the phone bill. For plans with another carrier, normal text rates will apply and will appear on the phone bill as 741741. Additional information about Crisis Text Line can be found at http://www.crisistextline.org

Additional Suicide Prevention/Crisis Resources

Staffed by mental health professionals and peer support specialists 24 hours a day, seven days a week, the New Jersey Suicide Prevention Hopeline is available to all ages for confidential telephone support (except when a suicide attempt is in progress), assessment, and referral. The NJ Hopeline offers call, text, chat, and email options. General information is available at: www.njhopeline.com

New Jersey Youth Suicide Prevention Advisory Council

Established in, but not of, the Department of Children and Families, the New Jersey Youth Suicide Prevention Advisory Council is comprised of appointed New Jersey citizens and state government representatives. The New Jersey Youth Suicide Prevention Advisory Council examines existing needs and services and makes recommendations for youth suicide reporting, prevention, and intervention. It advises the development of regulations pursuant to N.J.S.A. § 30:9A-25 et seq.

3. Have you incorporated any strategies supportive of Zero Suicide? ◉ Yes ○ No

4. Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments? ◉ Yes ○ No

If yes, please describe how barriers are eliminated.

In November 2020, the Garrett Lee Smith Youth Suicide Prevention Grant was awarded to the New Jersey Department of Health (NJDOH) from the Substance Abuse and Mental Health Services Administration (SAMHSA). This federal grant was awarded to implement NJDOH's Readiness to Stand United Against Youth Suicide (R2S Challenge). The Department of Children and Families (DCF) is collaborating with the DOH on a portion of the grant. This collaboration is to assist New Jersey hospitals to effectively connect youth to services following suicide attempts. DCF is developing Project Connect to increase engagement in community mental health services after hospital discharge, reduce unnecessary Emergency Department utilization through connection to appropriate community services, and improve safety and well-being for youth and families. Through the innovative role of the Regional Care Coordinator (RCC), Project Connect works in partnership with identified hospitals to enhance discharge planning for youth with suicide ideation and/or attempts. After youth are medically stabilized, screened, and determined to be safe for discharge, hospital staff will engage in a warm transfer process to connect families to PerformCare and community resources. Hospital staff will also be coached on how to obtain consent to connect the family to the RCC who will make contact with the caregiver post-discharge to provide the youth and family with follow up support and ensure linkage and engagement with community behavioral health services.

5. Have you begun any prioritized or statewide initiatives since the FFY 2022 - 2023 plan was submitted? (●) Yes ( ) No

If so, please describe the population of focus?

Screening and Screening Outreach Programs are located within each of New Jersey's 21 counties. These programs are available to individuals in emotional crisis who require immediate attention and cannot wait for a regular appointment. Screening and screening services are typically located in a general hospital and available 24-hours a day, seven-days a week. An individual may walk in without an appointment, or be brought to the screening center by a parent, friend, spouse, law enforcement officials, mental health worker, or any other concerned individual. If the person in crisis is unable or unwilling to come to the Center, a screening outreach team may be sent to the person.

For information about adult mental health services, visit the Division of Mental Health and Addiction Services' website at http://www.state.nj.us/humanservices/divisions/dmhas/.

The National Suicide Prevention Lifeline transitioned to 988 in July 2022 and is now the 988 Suicide and Crisis Lifeline. The 988 Lifeline continues to provide free and confidential emotional support to people in suicidal crisis, mental health and/or substance use crisis, or emotional distress. The 988 Lifeline is available to individuals who are seeking information or assistance for themselves, friends or relatives and can be reached 24 hours a day, every day of the year via call, text and chat.

Calls are received from anyone of any age and are answered by a peer, a trained volunteer, or a clinical staff member. If a caller is assessed as being at serious risk of suicide, the caller can be "warm-transferred" to the appropriate local Psychiatric Emergency Service, 911 or other entity (including DCF-sponsored 2nd Floor Youth Crisis Line) that can provide emergency or other necessary services for that individual.

The SMHA now funds all five 988 Lifeline contact centers that operate in New Jersey. The NJ Suicide Prevention Hopeline, operated by Rutgers University Behavioral Health Care since 2013, is transitioning calls, chats and texts to the 988 Lifeline system. In SFY23 (July 1, 2022 – June 30, 2023) the 988 Lifeline centers in NJ received approximately 54,500 incoming calls. In addition, the NJ Hopeline received approximately 30,000 calls totaling 84,500 calls for the year. This is an average of 7,042 calls per month.

In response to firearms in a home increasing the risk for suicide among all household members by 300%, DMHAS has partnered with the Rutgers University School of Public Health's Gun Violence Research Center (GVRC) to address suicide by firearms and safe storage. The GVRC has developed 2 webinars for DMHAS to be posted publically: one on firearms and suicide for the community, and the second for healthcare providers. Most recently, The GVRC has developed a freely available online map of locations across New Jersey willing to consider temporary and legal storage of personal firearms, and plan to disseminate the map broadly and to examine the experiences of participating sites in the months following the development and dissemination of the map.

A statewide Zero Suicide approach in collaboration with the Zero Suicide Institute launched in fall of 2019 with 3 academies taking place in Fall 2020. Behavioral Health agencies applied and 30 were accepted into the academies. Each agency sent 4 people to train over 3 virtual half-days due to the pandemic. In January 2022, these agencies began their Community of Practice sessions with the Zero Suicide Institute to aid in the implementation of the approach within their agency. In 2022, in partnership with the Zero Suicide Institute, future academies scheduled for some time in 2023 were agreed upon and currently have a tentative schedule date.

The Children's System of Care was granted the opportunity to work with the Educational Development Center (EDC) on Zero Suicide.

Zero Suicide is a Transformational Framework for Health and Behavioral Health Care Systems. The foundational belief of Zero Suicide is that suicide deaths for individuals under the care of health and behavioral health systems are preventable. For systems dedicated to improving patient safety, Zero Suicide presents an aspirational challenge and practical framework for system-wide transformation toward safer suicide care. The Zero Suicide Institute at EDC (ZSI) provides expertise, customized consultation, and training for health and behavioral health care systems and providers, state agencies, tribal governments, health plans, and others as they launch evidence-based practices for suicide prevention, adopt continuous quality improvement efforts, and implement the Zero Suicide framework for safer suicide care. The Zero Suicide EDC website is zerosuicide.edc.org

Our partnership with EDC is a two-year investment, that started with the implementation of Zero Suicide within our Care Management and Family Support Organizations as well as some of our out of home treatment programs. Year 2 looks to include teams from additional OOH organizations as well as the organizations that oversee our Mobile Response Stabilization Services.

As a result of working with the EDC to implement the Zero Suicide Framework, our partners have created and updated policies regarding suicide prevention, attempts, and protocols and some have engaged in agency-wide staff training, policy consultation, workforce readiness surveys, and piloted screening projects that regularly assess a youth's potential for suicidal thoughts or ideations, and, if identified, guide the youth onto a pathway that will build their resilience and coping skills, reducing risk and helping them to thrive. Some of our partners have also included individuals with living experience on their Zero Suicide teams.

In November 2020, the Garrett Lee Smith Youth Suicide Prevention Grant was awarded to the New Jersey Department of Health (NJDOH) from the Substance Abuse and Mental Health Services Administration (SAMHSA). This federal grant was awarded to implement NJDOH's Readiness to Stand United Against Youth Suicide (R2S Challenge). The Department of Children and Families (DCF) is collaborating with the DOH on a portion of the grant. This collaboration is to assist New Jersey hospitals to effectively connect youth to services following suicide attempts. DCF is developing Project Connect to increase engagement in community mental health services after hospital discharge, reduce unnecessary Emergency Department utilization through connection to appropriate community services, and improve safety and well-being for youth and families. Through the innovative role of the Regional Care Coordinator (RCC), Project Connect works in partnership with identified hospitals to enhance discharge planning for youth with suicide ideation and/or attempts. After youth are medically stabilized, screened, and determined to be safe for discharge, hospital staff will engage in a warm transfer process to connect families to PerformCare and community resources. Hospital staff will also be coached on how to obtain consent to connect the family to the RCC who will make contact with the caregiver post-discharge to provide the youth and family with follow up support and ensure linkage and engagement with community behavioral health services.

Please indicate areas of technical assistance needed related to this section.

DMHAS would like to receive technical assistance in relation to website development and the use of social media.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Environmental Factors and Plan

20. Support of State Partners - Required for MHBG

Narrative Question

The success of a state's MHBG and SUPTRS BG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The State Medicaid Authority agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations.
- The state's agency on aging which provides chronic disease self-management and social services critical for supporting recovery of older adults.
- The state's intellectual and developmental disabilities agency to ensure critical coordination for individuals with ID/DD and M/SUD conditions.
- Strong partnerships between SMHAs and SSAs and their counterparts in physical health, public health, and Medicaid, Medicare, state and area agencies on aging and educational authorities are essential for successful coordinated care initiatives. While the State Medicaid Authority (SMA) is often the lead on a variety of care coordination initiatives, SMHAs and SSAs are essential partners in designing, implementing, monitoring, and evaluating these efforts. SMHAs and SSAs are in the best position to offer state partners information regarding the most effective care coordination models, connect current providers that have effective models, and assist with training or retraining staff to provide care coordination across prevention, treatment, and recovery activities.
- SMHAs and SSAs can also assist the state partner agencies in messaging the importance of the various coordinated care initiatives and the system changes that may be needed for success with their integration efforts. The collaborations will be critical among M/SUD entities and comprehensive primary care provider organizations, such as maternal and child health clinics, community health centers, Ryan White HIV/AIDS CARE Act providers, and rural health organizations. SMHAs and SSAs can assist SMAs with identifying principles, safeguards, and enhancements that will ensure that this integration supports key recovery principles and activities such as person-centered planning and self-direction. Specialty, emergency and rehabilitative care services, and systems addressing chronic health conditions such as diabetes or heart disease, long-term or post-acute care, and hospital emergency department care will see numerous M/SUD issues among the persons served. SMHAs and SSAs should be collaborating to educate, consult, and serve patients, practitioners, and families seen in these systems. The full integration of community prevention activities is equally important. Other public health issues are impacted by M/SUD issues and vice versa. States should assure that the M/SUD system is actively engaged in these public health efforts.
- SAMHSA seeks to enhance the abilities of SMHAs and SSAs to be full partners in implementing and enforcing MHPAEA and delivery of health system improvement in their states. In many respects, successful implementation is dependent on leadership and collaboration among multiple stakeholders. The relationships among the SMHAs, SSAs, and the state Medicaid directors, state housing authorities, insurance commissioners, prevention agencies, child-serving agencies, education authorities, justice authorities, public health authorities, and HIT authorities are integral to the effective and efficient delivery of services. These collaborations will be particularly important in the areas of Medicaid, data and information management and technology, professional licensing and credentialing, consumer protection, and workforce development.

Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period? (●) Yes ( ) No

2. Has your state identified the need to develop new partnerships that you did not have in place? (●) Yes ( ) No

If yes, with whom?

Please see attached.

3. Describe the manner in which your state and local entities will coordinate services to maximize the efficiency, effectiveness, quality and cost-effectiveness of services and programs to produce the best possible outcomes with other agencies to enable consumers to function outside of inpatient or residential institutions, including services to be provided by local school systems under the Individuals with Disabilities Education Act.

Please see attached.

Please indicate areas of technical assistance needed related to this section.

Footnotes:

Support of State Partners - Required for MHBG

2. Has your state identified the need to develop new partnerships that you did not have in place? If yes, with whom?

Division of Mental Health and Addiction Services (DMHAS)

Tribal Communities and Department of State (DOS)

Though they are not federally recognized, three American Indian tribes are active in New Jersey: the Nanticoke Lenni-Lenape, and Powhatan Renape in Southern New Jersey and the Ramapough Lenape in the northern part of the state. In the mid-1990s, NJ state government created the Commission on American Indian Affairs, which is situated in the NJ Department of State. The commission is made up of members from the three main tribes. Part of the Commission's purpose is:

> To ensure that the American Indian Tribal members and communities within the State of New Jersey have full opportunities for their own cultural, educational, social, economic, physical, mental health, and welfare development, as well as continue to contribute to and participate in the on-going life and development of the State's extended family.

The most recent version of the New Jersey Middle School Survey of Risk and Protective Factors (2021). Some findings highlighted with regards to NJ Native American middle school students were:

- Past year alcohol use was above the state average (10.4%) for Native American or Alaskan Native (16.7%)
- Past year binge drinking was above the state average (2.8%) for students identifying as Native American or Alaskan Native (13.3%)
- Past year marijuana use was above the state average (2.5%) for students identifying as Native American or Alaskan Native (6.7%)
- Past year use of inhalants was above the state average (0.8%) for students identifying as Native American or Alaskan Native (3.3%)

DMHAS has not previously collaborated with the Commission on Indian Affairs. However, to help address the inequities such as those listed above, DMHAS, will support the Commission's work in serving tribal members by providing funds to enable the tribes to offer substance abuse prevention services, or, alternatively to engage an established DMHAS-funded prevention agency to provide the services. Programs will be adapted to honor tribal customs and traditions. DMHAS will provide guidance to the tribes on the Strategic Prevention Framework and other principles of evidence-based prevention.

In-Depth Technical Assistance (IDTA) 2023

New Jersey was recently awarded another round of In-Depth Technical Assistance (IDTA) through the National Center on Substance Abuse and Child Welfare's (NCSACW) 2023: "Advancing Collaborative Practice and Policy: Promoting Healthy Development and Family Recovery for

Infants, Children, Parents, and Caregivers Affected by Prenatal Substance Exposure". The Department of Health is the lead State Department and NJ state representatives include the Departments of Children and Families, Human Services, and the Governor's Office. The state team will include an individual with lived experience. The DMHAS Women's Treatment Coordinator represents the Department of Human Services. The overall goal is to increase awareness of pregnant women and SUD, through increased education and maximizing messaging through the perinatal work force; increase awareness and access to treatment, Plans of Safe Care, and improving screenings in hospitals and healthcare providers.

Maternal and Child Health Policy Innovation Program Alumni Policy Academy 2023-2024

New Jersey will be participating in the Maternal and Child Health Policy Innovation Program (MCH PIP) Alumni Policy Academy, which will run from August 2023 to April 2024. The National Academy for State Health Policy (NASHP) is convening this Alumni Policy Academy with support from the Health Resources and Services Administration, Maternal and Child Health Bureau. This Policy Academy will build upon previous and current work to advance MCH policy innovations with a particular focus in perinatal systems of care. The Policy Academy will convene State to State webinars, online collaborative workspaces and targeted technical assistance for participating states to share with and learn from each other. The New Jersey team is comprised of the Departments of Human Services with Medicaid as the lead, DMHAS, DFD and the Departments of Children and Families and Health.

Strategic Prevention Technical Assistance Center

Beginning in the fall of 2023, DMHAS will collaborate with the Strategic Prevention Technical Assistance Center (SPTAC) to develop a new Prevention Strategic Plan. The plan will be organized according to the five steps of the Strategic Prevention Framework. Stakeholders from the community (including youth and young adults), representatives from the prevention community in New Jersey, and staff from other departments and divisions of state government will contribute to the development of the plan.

Children's System of Care (CSOC)

Project Connect

In November 2020, the Garrett Lee Smith Youth Suicide Prevention Grant was awarded to the New Jersey Department of Health (NJDOH) from the Substance Abuse and Mental Health Services Administration (SAMHSA). This federal grant was awarded to implement NJDOH's Readiness to Stand United Against Youth Suicide (R2S Challenge). The Department of Children and Families (DCF) is collaborating with the DOH on a portion of the grant. This collaboration is to assist New Jersey hospitals to effectively connect youth to services following suicide attempts. DCF is developing Project Connect to increase engagement in community mental health services after hospital discharge, reduce unnecessary Emergency Department utilization through connection to appropriate community services, and improve safety and well-being for youth and families. Through the innovative role of the Regional Care Coordinator (RCC), Project Connect

works in partnership with identified hospitals to enhance discharge planning for youth with suicide ideation and/or attempts. After youth are medically stabilized, screened, and determined to be safe for discharge, hospital staff will engage in a warm transfer process to connect families to PerformCare and community resources. Hospital staff will also be coached on how to obtain consent to connect the family to the RCC who will make contact with the caregiver post-discharge to provide the youth and family with follow up support and ensure linkage and engagement with community behavioral health services.

Zero Suicide

The Children's System of Care was granted the opportunity to work with the Educational Development Center (EDC) on Zero Suicide. Zero Suicide is a Transformational Framework for Health and Behavioral Health Care Systems. The foundational belief of Zero Suicide is that suicide deaths for individuals under the care of health and behavioral health systems are preventable. For systems dedicated to improving patient safety, Zero Suicide presents an aspirational challenge and practical framework for system-wide transformation toward safer suicide care. The Zero Suicide Institute at EDC (ZSI) provides expertise, customized consultation, and training for health and behavioral health care systems and providers, state agencies, tribal governments, health plans, and others as they launch evidence-based practices for suicide prevention, adopt continuous quality improvement efforts, and implement the Zero Suicide framework for safer suicide care. The Zero Suicide EDC website is zerosuicide.edc.org.

Our partnership with EDC is a two-year investment, that started with the implementation of Zero Suicide within our Care Management and Family Support Organizations as well as some of our out of home treatment programs. Year 2 looks to include teams from additional OOH organizations as well as the organizations that oversee our Mobile Response Stabilization Services.
As a result of working with the EDC to implement the Zero Suicide Framework, our partners have created and updated policies regarding suicide prevention, attempts, and protocols and some have engaged in agency-wide staff training, policy consultation, workforce readiness surveys, and piloted screening projects that regularly assess a youth's potential for suicidal thoughts or ideations, and, if identified, guide the youth onto a pathway that will build their resilience and coping skills, reducing risk and helping them to thrive. Some of our partners have also included individuals with living experience on their Zero Suicide teams.

Children's Crisis Intervention Services (CCIS) Initiative

Although the Children's System of Care (CSOC) has a comprehensive, statewide service array, the current behavioral health crisis has taxed our inpatient providers, which are, for many youth in the system, a service of last resort. While CSOC has no direct authority over the Children's Crisis Intervention Services (CCIS) units, we do redesignate the units annually, so we meet with CCIS medical directors regularly to troubleshoot youth-level issues on a day-to-day basis. We have seen how youth with co-occurring mental health, substance use disorder, and/or intellectual/developmental disabilities cannot always be sufficiently served at CCIS units, which can lack the capacity to address or understand the issues these youth and their families face.
But now, thanks to Block Grant funds provided by DMHAS, a regular forum will be established to give each CCIS, and the state agencies involved with the maintenance of the CCIS network, a

voice in the monitoring of the CCIS units. This three-year initiative will provide a structured forum, inclusive of CCIS medical directors, to promote collaboration and enhance the capacity of the CCIS units across the state to serve youth in need of inpatient services.

Rutgers University Behavioral Health Care (UBHC) has been contracted to run the project, by first conducting a needs assessment process that will include interviews of staff at each CCIS to identify their training and consultation needs, which will then be distilled into a statewide report on trends. Rutgers UBHC will then develop a training and technical assistance plan that will connect CCIS staff at all levels with national experts. An additional needs assessment will be conducted at the half-way point of the initiative. We anticipate holding the first quarterly meeting in the first quarter of 2023.

We hope that CCIS staff will share our perception of the problem, but training needs will be identified through the needs assessment process, so we will see if the issues around youth with co-occurring conditions rise to the top. Ultimately, the goal of this initiative is to enhance the flow of youth in and out of the CCIS units, limit the backlog, and make accessing CCIS units' services a more graceful process.

The Society for the Prevention of Teen Suicide

In partnership with the Society for the Prevention of Teen Suicide (SPTS) and funded via the American Rescue Plan Act, 185,000 Behavioral Health Toolkits were distributed to: 125,000 to 6th grade parents statewide and inventory for school counselors; 40,000 to Children's Mobile Response; 15,000 to Care Management Organizations; and 5,000 to Family Support Organizations. Additionally, 45,000 Mental Health Crisis Toolkits were distributed to: Inventory to every emergency room statewide; 10,000 to Children's Mobile Response; and 5,000 to Care Management Organization. SPTS is dedicated to increasing awareness, saving lives and reducing the stigma of suicide through specialized training programs and mental health resources that empower teens, parents, school staff and community members with the skills needed to help youth build a life of resiliency.

Child Trauma Response Initiative

The Children's System of Care has partnered with the NJ Office of the Attorney General to participate in the Child Trauma Response Initiative, which seeks to bring a trauma-informed lens to how local providers and law enforcement work together to support youth who are impacted by caregiver substance use disorder. The goal of the initiative is to ensure that children impacted by caregiver substance use disorders and their families are effectively connected to resources and supports for treatment and resilience. This initiative is being piloted in three New Jersey municipalities: Millville, Asbury Park, and Plainfield.

3. Describe the manner in which your state and local entities will coordinate services to maximize the efficiency, effectiveness, quality and cost-effectiveness of services and programs to produce the best possible outcomes with other agencies to enable consumers to function outside of inpatient or residential institutions, including services to be provided by

local school systems under the Individuals with Disabilities Education Act.

Division of Mental Health and Addiction Services (DMHAS)

State Epidemiological Outcomes Workgroup

DMHAS was awarded a Strategic Prevention Framework State Incentive Grant (SPF-SIG) by SAMHSA in October 2006 to implement environmental strategies to prevent the onset and reduce the progression of substance abuse, including childhood and underage drinking. In addition, the award was used to build prevention capacity and infrastructure at the state and community levels. A key component of this grant is the use of a data-driven strategic approach and use of the SPF to conduct a statewide needs assessment through collection and analysis of epidemiological and community readiness data.

As one requirement of the SPF-SIG, the SSA convened the New Jersey State Epidemiological Outcomes Workgroup (SEOW), comprised of individuals from various state departments including Health, Transportation, Education, Human Services, Juvenile Justice, county offices, universities, community provider agencies and statewide organizations. The SEOW continues to meet monthly to review data and discuss ways to use those data to develop or support programs that prevent the onset and reduce the progression of substance use disorder and mental illness in New Jersey.

The SSA continues to actively recruit for new members of the SEOW. Currently representatives from the NY/NJ High Intensity Drug Trafficking Area (HIDTA), the Department of Health's (DOH) Division of Family Health, DOH Division of HIV, STD, and TB Services (DHSTS), Department of Military and Veterans Affairs (DMAVA), the NJ Poison Information and Education System (NJPIES), the New Jersey Hospital Association Behavioral Health Group, NJ Housing and Mortgage Finance Agency (NJHMFA), Office of Managed Health Care Behavioral Health Unit, Office of the Secretary of Higher Education (OSHE), as well as representatives from the NJ State Police's Regional Operations Intelligence Center (ROIC), and New Jersey's Prescription Drug Monitoring Program (which became operational in September 2011) participate, along with many others.

Strategic Prevention Framework-Partnerships for Success

The Division of Mental Health and Addiction Services (DMHAS) was awarded a second Strategic Prevention Framework-Partnerships for Success (SPF-PFS) grant in 2018 from SAMHSA (its first SPF-PFS grant was awarded in 2013). In this project, DMHAS partners with the Department of Children and Families' (DHS) Children's System of Care (CSOC). DMHAS prevention coalitions provide training on the basics of substance abuse prevention, and use of the SPF, for CSOC's Children's Inter-Agency Coordinating Councils (CIACC) in each county. The CIACCs provide a forum where the system of services for children with special social and emotional needs can be developed, reviewed, revised and/or redirected through a collaborative decision-making process with the New Jersey Department of Children and Families (DCF) to promote optimal services provided in the least restrictive, but most appropriate setting possible. DMHAS is also utilizing SPF-PFS funds for various prevention infrastructure developments and enhancements.

Certified Community Behavioral Health Clinic

The state continues to work in partnership with our sister division, the Division of Medical Assistance and Health Services (DMAHS) on a number of initiatives that will promote services and enhance the Medicaid behavioral health benefit. Recent examples, with assistance from DMHAS, DMAHS has included, Substance Use Disorder Case Management and Peer Services in the Medicaid benefit package.

The Division of Mental Health and Addiction Services (DMHAS) was selected to be one of the eight Certified Community Behavioral Health Clinic (CCBHC) demonstration states. This project is a collaboration between the Department of Human Services' Division of Medical Assistance and Health Services (DMAHS) and DMHAS and the Department of Children and Families (DCF). There are seven behavioral health providers dually licensed in mental health and substance abuse participating as CCBHCs. The Federal Demonstration was extended to September 30, 2025 and the state partners are currently DMHAS, DMAHS and DCF are working collaboratively to develop a Medicaid State Plan Amendment which would include the CCBHC service in the Medicaid State Plan.

Behavioral Health Homes

DMHAS has explored several models of integration, with the most prominent being the behavioral health home (BHH) initiative. Health Homes is a Medicaid State Plan option that provides an opportunity to build a person-centered system of care that achieves improved outcomes and better services and value for the NJ Medicaid program. DMHAS has partnered with N.J. Medicaid to expand upon the existing behavioral health case management infrastructure to provide coordinated primary and behavioral health integration.

In a partnership with the Division of Medical Assistance and Health Services (Medicaid) and the Department of Children and Families, DMHAS launched health homes in select counties in July of 2014. Currently, there are nine BHHs in New Jersey: two each in Atlantic, Bergen and Mercer Counties and three in Monmouth County. The BHH is a high intensity service targeting those with the most need. It is continuing standard of care that allows individuals to have all of their health care needs identified, addressed, and treated in a coordinated way. The same team of clinicians and practitioners either deliver, or coordinate the delivery of, all the necessary medical, behavioral, and social supports required for the individual, acknowledging the impact each area has on the others. It is not a residential program. It is a whole-person care delivery model.

In accordance with guidance from the Centers for Medicare and Medicaid Services (CMS), a Health Home must have the capability to provide all of the following services, as warranted based on members' needs:

- Comprehensive care management;
- Care coordination;
- Health promotion;
- Comprehensive transitional care (including appropriate follow-up from inpatient to other settings)'

- Individual and family support;
- Referral to community and social support services;
- Use of health information to link services as feasible and appropriate.

It is expected that the use of a behavioral health home model will result in improved health outcomes for the consumer base, better quality of treatment, and improved cost effectiveness; improved consumer experience with care; and declines in the use of hospitals, emergency departments, and other costly inpatient care.

Integrated Care Learning Community

DMHAS and DMAHS have explored several models of integration, and continues to evaluate the needs of all populations. In 2020-2021 staff from DMHAS, NJ, DMAHS, and the Department of Health (DOH) participated in an Integrated Care Learning Community led by NASADAD and Center for Excellence in Integrated Health Solutions. One outcome from the learning community was the DOH added reimbursement for behavioral health services delivered by the FQHCs through the uncompensated care fund.

Promoting Integration of Primary Behavioral Health Care (PIPBHC)

Building on the relationships we have developed with our partners and the knowledge we have gained through our learning activities, NJ applied for, and in March 2020 was awarded a SAMHSA PIPBHC grant. The five-year grant program will end in March 2025. This grant provides integrated care to individuals who have a substance use disorder. The program provides the enrolled individuals with screening, testing, treatment and/or referral and care coordination for co-occurring medical diseases with a focus on infectious disease. Outcomes to date have been very positive.

In Depth Technical Assistance (IDTA) Neonatal Abstinence Syndrome and Substance Exposed Infants (NAS SEI)

As a SAMHSA Prescription Drug Abuse Policy Academy State, in 2014, NJ applied for a unique technical assistance opportunity through the SAMHSA supported NCSACW to address the multi-faceted problems of NAS and SEI. NJ DHS/DMHAS as the lead State agency, partnered with the Department of Children and Families (DCF) and Department of Health (DOH), and submitted a successful application (no funding attached). The IDTA goal was to develop uniform policies/guidelines that address the entire spectrum of NAS and SEI from pre-pregnancy, prevention, early intervention, assessment and treatment, postpartum and early childhood. The IDTA provided technical assistance to NJ to strengthen collaboration and linkages across multiple systems such as addictions treatment, child welfare, and medical communities to improve services for pregnant women with opioid and other substance use disorders and outcomes for their babies. The Core Team included over 60 individuals representing multiple State Departments and Divisions, community stakeholders, treatment providers, and the medical community. Three goals were established: (1) Increase perinatal SEI screening at multiple intervention points; (2) Leverage existing programs and policy mechanisms to collaboratively increase the rate at which women

screening positive on the 4P's Plus get connected for a comprehensive assessment by establishing formal warm-handoffs and other safety net measures; and (3) Leverage existing programs and policy mechanisms to collaboratively increase the rate at which women delivering SEIs and their babies and any other eligible children, receive early support services for which they are eligible. Workgroups were formed. New Jersey was recently awarded technical assistance through the National Center on Substance Abuse and Child Welfare's (NCSACW) 2023 Policy Academy: Advancing Collaborative Practice and Policy: Promoting Healthy Development and Family Recovery for Infants, Children, Parents, and Caregivers Affected by Prenatal Substance Exposure. The Department of Health is the lead State Department and NJ Policy Academy State representatives include the Departments of Children and Families, Human Services, and the Governor's Office. The DMHAS Women's Treatment Coordinator represents the Department of Human Services. The overall goal is to increase awareness of pregnant women and SUD, through increased education and maximizing messaging through the perinatal work force, increase awareness and access to treatment, Plans of Safe Care, and improving screenings in hospitals and healthcare providers.

Opioid Overdose Recovery Program

The Opioid Overdose Recovery Program (OORP) responds to individuals reversed from opioid overdoses and treated at hospital emergency departments as a result of the reversal. OORP utilizes Recovery Specialists and Patient Navigators to engage individuals reversed from an opioid overdose to provide non-clinical assistance, recovery supports and appropriate referrals for assessment and substance use disorder treatment. The Recovery Specialists and Patient Navigators maintain follow-up with these individuals for a minimum of 8 weeks after the initial contact. OORP includes linking individuals to appropriate and culturally-specific services and provides support and resources throughout the process. OORP providers are required to have protocols and procedures in place for priority populations that include pregnant women and parents who have custody of their children and are at risk of child welfare involvement. For pregnant women, OORP provider policies must indicate how they will collaborate with the hospital social worker and/or hospital staff to ensure coordination and access of MAT services. This program was initially implemented in five counties as of January 2015 and is now currently operational in all 21 counties in New Jersey, utilizing state, SABG, and SOR funds. A key goal of OORP is to prevent relapse and future overdose.

DMHAS was able to provide Governor's Initiative funding to 17 OORPs to expand services. The funds enable them to serve individuals who did not experience an overdose, but who present in the emergency department with issues attributable to opioid use disorder. These individuals are also able to receive OORP services as described above. Effective July 2021, expansion services are funded by the SABG.

Prison Intensive Recovery Treatment Support

Since 2017, DMHAS has worked with the Department of Corrections to provide Intensive Recovery Treatment Supports (IRTS) post-release services to a cohort of eligible offenders (n=200) with Opioid Use Disorder that receive MAT prior to release from prison, and to another cohort of non-MAT eligible offenders (n=400) both pre- and post-release into the community.

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

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

Recovery Court

Recovery Court is a cooperative initiative between the Administrative Office of the Courts (AOC) and the SSA which commenced in 2002. This agreement allows the AOC to transfer treatment funding to the SSA who then secures and makes available, based upon clinical need, a complete continuum of care for Recovery Court offenders sentenced in New Jersey Superior Court. Fifteen vicinages serving all 21 counties. Recovery Courts function within the existing Superior Court structure to provide treatment along the full continuum of care and diversion opportunities for non-violent offenders who otherwise may be incarcerated in state prisons for drug related offenses. Recovery Court participation had been voluntary. In July 2012 legislation was signed into law that stipulated a two-phase Recovery Court expansion: broaden the legal eligibility to include second degree burglary and robbery and require mandatory sentencing to Recovery Court. These were both accomplished by the court by July 2017.

Mutual Agreement Program

The SSA oversees the Mutual Agreement Program (MAP), a Parolee Substance Use Treatment Project implemented through Memoranda of Agreements between the SSA and the New Jersey State Parole Board (NJSPB). This funding is a combination of direct appropriations from DMHAS and funds transferred from NJSPB. For the NJSPB, these funds support an FFS network which offers the full continuum of care including long term and short-term residential care, halfway house, partial care, detoxification, outpatient and intensive outpatient treatment, co-occurring services, psychotropic medication reimbursement, and medication assisted treatment.

Jail Inmates

The New Jersey Department of Human Services' Division of Mental Health and Addiction Services (DMHAS), in collaboration with the Department of Corrections (DOC), Department of Health (DOH) and our community partners to coordinate and deliver medication-assisted treatment (MAT) for opioid addiction to individuals serving within county based correctional facilities. This partnership will help facilitate the connections individuals will need in order to sustain treatment services upon release.

This funding is being made available as part of Governor Murphy's initiative to combat the opioid

epidemic in New Jersey and designed to encourage the use of or increase use of MAT in county correctional facilities for individuals with an opioid use disorder (OUD). Nationally, 75 percent of inmates with opioid use disorder are reported to have relapsed within three months of release and only 8 percent enter treatment after incarceration. (Fox et al., 2015) Few inmates receive MAT during incarceration despite MAT being the clinical standard for OUD treatment.

In New Jersey, a recent survey conducted by the DMHAS in collaboration with the County Jail Wardens' Association indicate that an average of 17 percent of jail detainees screen positive for a substance use disorder with a range of 10 percent - 69 percent among the jails reporting. (DMHAS/CJWA, 2018). Of particular concern are the rates of opioid overdose immediately following release from incarceration. In response to overdose deaths among its prison/jail population, the Rhode Island Department of Corrections initiated a model to screen and treat with MAT and sustain MAT post release through a community provider network. Results published in JAMA Psychiatry, researchers compared the pre- and post-intervention periods and found that "In the 2016 period, 26 of 179 individuals (14.5%) who died of an overdose were recently incarcerated compared with 9 of 157 individuals (5.7%) in the 2017 period, representing a 60.5% reduction in mortality."(Green et al, JAMA Psychiatry, April 2018)

With the arrival of criminal justice reform in New Jersey, jail/prison wardens are seeing more rapid return of individuals to their communities, often within 24 - 48 hours. Therefore, individuals are more likely to be released prior to or while experiencing the onset of opioid withdrawal symptoms. This can put individuals at an increased risk for overdose. Nevertheless, MAT being introduced pre-release has been shown to improve the likelihood of recovery sustainability post-release and can mitigate the risk associated with shorter jail stays. This initiative seeks to support wardens in building the capacity to deliver and sustain MAT for the impacted population.

Housing

On January 1, 2019, the Supportive Housing Connection (SHC) was transferred to the Department of Community Affairs (DCA), Division of Housing and Community Services (DHCS). All direct care staff of the SHC were transferred to DCA, DHCS as hourly employees as they were for NJHMFA. DCA, DHCS employed an SHC supervisor and began recruitment for vacant positions within the SHC. The role and function of the SHC remains intact, the changes are in the physical location of SHC and its employees, now housed at the DCA’s Trenton, NJ location. The Memorandum of Agreement (MOA) between the NJHMFA and the Department of Human Services (DHS) / Division of Mental Health and Addiction Services (DMHAS), expired December 31, 2018; the new MOA between DCA and DHS/DMHAS, has an effective date of January 1, 2019.

In January 2019, the Department of Human Services/ DMHAS launched a partnership with the Department of Community Affairs (DCA) to administer housing subsidies to consumers receiving services from DMHAS. DCA/SHC is responsible for the following tasks on behalf of the Division: Housing Search Assistance, Landlord Recruitment, Housing Inspections, Subsidy Processing, Rental Subsidy Administration, and Tenant/Landlord Inquiry Resolutions. The goal of this partnership is to increase community-based living, and enhance community tenure for consumers recently recovering from and/or at-risk for homelessness and/or placement in inpatient psychiatric

settings.

Division of Developmental Disabilities

DMHAS' Office of Planning, Research, Evaluation, Prevention, and Olmstead (OPREPO) partners with DMHAS' Division of Developmental Disabilities (DDD). and the Department of Health's (DOH) State Psychiatric Hospitals on the discharge planning of individuals diagnosed with a serious mental illness and a co-occurring developmental disability (DD/MI). DDD Transitional Case Managers (TCMs) are stationed at each respective state hospital and focus on the referrals of DD/MI patients to community placements and collaborate with the OPREPO and state psychiatric hospital staff to address and ameliorate any discharge barriers that may be present. Joint DMHAS, DDD and State Hospital meetings occur at each hospital on a monthly basis to discuss discharge planning of DD/MI individuals and address systems issues. On a bi-weekly basis, administrative level meetings are scheduled between DDD and DMHAS to discuss issues that require a higher-level review.

Division of Medical Assistance and Health Services

DMHAS's Office of Planning, Research, Evaluation, Prevention, and Olmstead (OPREPO) staff partners with Department of Health's (DOH) State Psychiatric Hospitals and the DMAHS Office of Managed Care to facilitate state hospital discharges of individuals who are in need of Managed Long Term Support Services (MLTSS) or Medicaid state plan services such as nursing supports or personal care assistance. Coordinating these services allows for an alternative to nursing home placement; with additional supports individuals can be placed in the community residential settings or age in place in their own homes. OPREPO is facilitating a training which will be provided to the Managed Care Organizations (MCOs) on assessment of level of care so that their members who have an SPMI and are in need of housing in the community can be placed in the least restrictive setting.

Partnerships with other State Agencies for Olmstead Implementation (Department of Health)

State Psychiatric Hospital – DMHAS's Office of Planning, Research, Evaluation, Prevention, and Olmstead (OPREPO), continues to focus its efforts on improving community integration for its state psychiatric hospital individual receiving services. The Department of Health operates three regionally-based, adult psychiatric hospitals and one adult forensic hospital that serve people with persistent and severe mental illness who are in need of intensive, inpatient care and treatment. OPREPO continues the implementation and oversight of the Home to Recovery Plan II. OPREPO continues to monitor the Olmstead deliverables at the state psychiatric hospitals and facilitates community placement referrals for Ann Klein Forensic Center (AKFC).

Centralized Admission – OPREPO has increased its scope from primary implementation, monitoring and oversight of the Olmstead deliverables at the state psychiatric hospitals to also overseeing diversion to the state psychiatric hospitals. OPREPO has worked collaboratively with the Department of Health's Centralized Admissions within the state psychiatric hospitals on a process for providing diversionary activities for individuals that do not meet criteria for commitment to the state hospital and are in need of less restrictive community settings. Regional Olmstead staff assist in securing additional supports needed for applicable person receiving

services as a means of addressing their individualized circumstances and needs in the most integrated setting possible within their required level of care. This collaboration allows for reduced hospital census as well as enhanced community re-integration of persons receiving services.

Partnership with other State and County Agencies in Mental Health Justice Involved Services

New Jersey accomplished a sea change in criminal justice with the New Jersey Criminal Justice Reform Act which took effect January 1, 2017. It essentially eliminated monetary bail in the state. The new system brought with it, the assumption that innocent people should not be in jail. People can be held only if, a judge reviews the flight risks and any other factors and can typically release the inmate their unless release poses an unacceptable flight risk or poses a danger to their community. A risk assessment was developed and all jail inmates are administered the assessment. As a result of this act, the number of detainees in county jails fell sharply the majority of offenders released from jail in 24 hours. Also, more summonses are issued by law enforcement keeping more consumers in the community.

Justice Involved Services (JIS)

The SMHA has been funding JIS since 2000. The services work to divert from incarceration individuals whose legal involvement may have resulted from untreated mental illness or co-occurring mental health and substance abuse disorders. It is a short-term case management program designed to help consumers to successfully link to mental health or co-occurring and other services in order to stabilize and enter valued community roles reducing their incidence and length of incarceration. The program provides access to community-based mental health and substance abuse treatment services as well as critical social services. Through case management linkage, clients receive treatment and psychiatric rehabilitation services, housing, employment, medications and health services. The SMHA is involved in very active collaborations with the Judiciary, Office of the Attorney General, local law enforcement and State Parole Board, and funds 15 JIS services and several other criminal justice initiatives. JIS is provided to a diverse mix of consumers, male and female as well as individuals of Caucasian, African American, Hispanic, Asian and Asian Indian backgrounds and from many different countries.

Pre-booking Diversion

Pre-booking diversion typically involves a police-based intervention to avoid arrest for non-criminal, non-violent offenses. The SMHA's acute care screening services are a form of pre-booking diversion in that police are able to bring consumers to screening for mental health crisis services. Also, Crisis Intervention Teams (CIT) are local initiatives designed to improve the way law enforcement and the community respond to people experiencing mental health crises; police are trained to identify and de-escalate situations involving consumers. CIT is built upon strong partnerships between law enforcement, mental health provider agencies and individuals and families affected by mental illness.

Crisis Intervention Team (CIT)

DMHAS funds a Crisis Intervention Team (CIT) Center of Excellence through the Mental Health Association of Southwest New Jersey. The Center facilitated the development of new county CIT efforts. Presently 19 of 21 counties, with one in process, as well as the NJ State Police (NJSP) provide training to law enforcement, dispatcher and mental health staff in CIT. These counties offer the training to other counties and municipalities as well as their own. As of May 2021, 276 of 565 municipalities have at least one certified CIT officer. As of May, 2021, 5,696 law enforcement and mental health provider staffs have been trained, the majority law enforcement.

Post-booking Diversion

Post booking diversion involves an intervention by a mental health staff person so that consumers are released from detention earlier than they otherwise would be; released on their own recognizance or released from jail with mental health intervention and treatment conditions or helping to avoid detention altogether.

Criminal Diversions

One form of post booking diversion that has been formally accomplished in NJ is through Prosecutor Diversion Programs. Prosecutor Offices identify a defendant who has a serious mental illness which is confirmed by the Mental Health JIS professional associated with the program. The JIS program arranges for mental health and related services. These become a condition of a plea bargain or dismissal of the indictment if the defendant successfully completes treatment and any conditions set by the Prosecutor.

The Union County Prosecutor's Office created and piloted this program, with DMHAS funds; however, the funds do not include treatment dollars. In 2014, the Office of the Attorney General (OAG) expanded the program by awarding two-year grants to Essex and Ocean counties for a prosecutor-led mental health diversion program on indictable offenses The grants had limited treatment dollars. In FY 2016, the OAG awarded three additional Prosecutor-Led Diversion programs: Warren, Hunterdon and Gloucester. The funding was only for two years, with the Prosecutor's Offices continuing as they were able after the funding expired. The SMHA continues to assist with services through local community mental health providers. There were no new grants awarded since 2016.

Atlantic County was awarded funds from the Office of the Attorney for a special Veterans Prosecutor Diversion Program. In conjunction with division funds, this program targeted Veterans whose charges are related to their behavioral health issues. The program coordinates with the VA Healthcare Systems and the New Jersey Department of Military and Veterans Affairs (DMAVA) to obtain needed services. With the Atlantic Veterans initiative, there are now seven funded prosecutor-led diversion programs or one third of the state. Necessary treatment and support services will continue to be a challenge. In 2017, legislation was signed that made the Prosecutor-Led Diversion Program for Veterans statewide, although no appropriation was made. There have been few referrals to this program as reported by the OAG as of January 1, 2019.

Municipal Court Liaison (MCL)

DMHAS funds a Municipal Court Liaison (MCL) Program which works directly with a number of local Municipal Courts; a case manager/municipal court liaison is stationed at the Municipal Court or available for referrals and provides individual consultations to the judges and attorneys, upon request. This often results in diversion to treatment which the liaison facilitates. DMHAS also funds a similar program in Atlantic City. The city of Newark a plea court which arranges for needed services post plea. Asbury Park has been funding a social worker who provides similar liaison services for many years.

The DMHAS, working with the Administrative Office of the Courts (AOC) has and continues to expand the availability of the MCL to include two to three municipalities within Passaic, Essex, Ocean, Monmouth, Mercer, Camden, Gloucester and Cumberland counties. The JIS programs will be providing the case management. The effort is ongoing with additional municipalities expected to be included as DMHAS resources are identified.

The PROMISE Parole Program & Parole Collaboration

This is a collaborative program of the State Parole Board, DMHAS and Housing and New Jersey Mortgage Finance Agency to assist parolees with serious mental illness to transition and integrate into their community and provide mental health and other wrap around services including employment and housing to reduce VOP. DMHAS funds a case manager to provide linkage and coordination.

Department of Corrections Max-out Pre-release Planning and Collaboration

This is a tri-monthly meeting with representative of DOC, Ann Klein Forensic Center (AKFC) and regional DMHAS representatives who review prisoners with serious mental illness coming up for max out who may need continued commitment at AKFC or community mental health services as an alternative.

The Veterans Assistance Initiative (VAI)

This is a combined effort of the Judiciary, the NJ Department of Military and Veterans Affairs (DMAVA) and the Department of Human Services, DMHAS. It uses existing resources of the participating state agencies to provide services to veterans/service members who get arrested and needs linkage and coordination with services through the local Veterans Service Offices (VSO) of DMAVA. All vicinages in New Jersey have the VAI.

The project was initially piloted in the municipal courts and in the criminal division of Superior Court and Municipal divisions in Atlantic. It formally provides a referral for behavioral health and generic services through DMAVA to those present and former military service men and women who become entangled with the criminal justice system. These individuals may come to the attention of the courts by police arrest documents, identification in jail or during the court process.

This program aims to connect service members with services that address physical, mental and personal issues through the local Veterans Service Offices of DMAVA. Local DMHAS funded mental health and justice involved services may compliment behavioral health available through

the Veterans Health Administration. The program is geared toward providing services to veterans through referral, not diverting veterans from the courts, although this can happen when appropriate. Veterans who are charged with indictable and non-indictable offenses other than minor traffic matters, as well as veterans who are on probation, are eligible to participate in the program. The nature of the offense will not matter in the decision as to whether or not a veteran should be referred for services.

As of May 1, 2019, there have been 4,182 statewide referrals made to DMAVA Veteran Service Officers through the local courts since inception. The program is voluntary and although referrals are made, present and former service members may not take advantage of the opportunity.

The Chief Justice's Mental Health Advisory Committee

In 2019, the Chief Justice and Acting Administrative Director of the courts, continued the work of earlier efforts to increase awareness of mental health and promote access by establishing a Mental Health Advisor Committee on which the SMHA was invited to actively participate. The Department of Human Services Commissioner was named as co-chair of the overall committee. Through the committee process, members are identifying the points of intersection with the Judiciary and in fact much of the criminal justice system, determining if and when mental health services should be available to defendants and how to accomplish it.

In 2022, DHS with collaboration with the AOC Mental Health Advisory Committee developed an RFP for the awarding of 3-4 grants to providers to work with jails to identify individuals with 3rd or 4th degree charges, non-violent, who would be referred to providers for a MH screening to determine if they have an SPMI which would assist in possible discharge and enrollment to treatment services (CJR Pilot).

Suicide Prevention

DMHAS partners with a number of other governmental, professional, provider and consumer entities in addressing suicide. The Adult Suicide Prevention Committee is the primary medium for this. The Committee was formed in December 2011 consisting of NJ DHS staff, NJ DOH staff, Rutgers University, and the NJ Governor's Council on Alcoholism and Drug Abuse. In addition to state agencies, individuals with lived experience are also a part of the Committee. The Committee meets monthly and more frequently when required to prioritize goals around suicide prevention initiatives in the state. A major focus of the Committee is to plan and host an annual Suicide Prevention Conference. This conference expands each year consisting of attendees from professional organizations, behavioral health agencies, support and advocacy groups, consumer organizations, individuals with lived experience, community stakeholders, primary care physicians, emergency departments and more.

NJ DHS DMHAS started a Suicide Prevention Unit in April 2019 to spearhead multiple suicide prevention initiatives in the State. DMHAS first partnered with the Education Development Center (EDC) to host three Zero Suicide Academies in the Fall of 2020. Zero Suicide is a commitment to suicide prevention in health and behavioral health care systems and is also a specific set of strategies and tools. The foundational belief of Zero Suicide is that suicide deaths for individuals

under care within health and behavioral health systems are preventable. Following the three Academies, DMHAS partnered with EDC further to offer nine months of Community of Practice sessions to the participants of the academy for technical assistance and follow-up during their first year of implementation. DMHAS is currently working with EDC to host a second set of academies in the 2023 year.

DMHAS has also partnered with the Rutgers University School of Public Health's Gun Violence Research Center (GVRC) to develop webinars covering a range of suicide prevention topics (e.g., firearm suicide prevention across settings). The intent was to target diverse audiences from health care providers, parents, gun owners, law enforcement, service members and veterans, and adolescents. Webinars represent a quick and scalable intervention that could reach stakeholders both within and beyond New Jersey. Two webinars in total were created, one for healthcare practitioners, and one for the general public which have been put on the DMHAS public website. Additionally, the GVRC has developed a freely available online map of locations across New Jersey willing to consider temporary and legal storage of personal firearms to disseminate the map broadly and to examine the experiences of participating sites in the months following the development and dissemination of the map.

Focusing on attracting the Primary Care community to suicide prevention training because of the statistic that 45% of those who died by suicide saw their primary care provider within a month of their death, DMHAS partnered with the NJ Academy of Family Physicians in 2020. As the professional association specifically for family physicians in New Jersey, NJAFP represents nearly all family physicians in New Jersey and can directly communicate with 6,500 primary care physicians and residents. This project created 6 accredited podcasts to discuss suicide prevention training and resources, support, and electronic health records.

In early 2021, DMHAS was offered to join the SAMHSA/VA Governor's Challenge to Prevent Suicide for Service Members, Veterans, and their Families (SMVF). DMHAS is co-leading the challenge along with the NJ Department of Military and Veterans Affairs. A team composition was created consisting of members from the National Guard, VA, Department of Labor, NJ Hospital Association, NJ Gun Violence Research Center, Rutgers University, NY State representatives, and other community agencies. This team will meet to combat three priority areas set forth by SAMHSA and the VA to prevent suicide for SMVF which include: Identify Service Members, Veterans and Their Families and Screen for Suicide Risk, Connectedness and Improve Care Transitions, and Increase Lethal Means Safety and Safety Planning for Service Members, Veterans and Their Families.

As The National Suicide Prevention Lifeline transitioned to 988 Nationwide in July 2022, DMHAS created a 988 Key Stakeholder group consisting of various members of the State to convene strategies and implement programs to further prevent suicide in NJ.

New Jersey Behavioral Health Planning Council

State agency representation and participation on the New Jersey Behavioral Health Planning Council / Citizens Advisory Board includes representatives from the following governmental entities: DMHAS, DMAHS (Medicaid), the NJ Department of Children & Families, NJ

Department of Corrections, the NJ Juvenile Justice Commission, the NJ State Housing Authority (New Jersey Housing and Mortgage Finance Agency-NJHMFA), the NJ Department of Health, the NJ Division of Aging, the NJ Division of Vocational Rehabilitation, the NJ Division of Family Development (Social Services), the NJ Division of Aging Services, the NJ Division of Developmental Disabilities, the NJ Department of Education, the NJ Board of Chosen Freeholders, the NJ League of Municipalities, the Gloucester County Mental Health Board, the Warren County Department of Human Services, and the Burlington County Office of Human Services.

Consumer advocacy groups on the Council, include: the National Alliance on Mental Illness in New Jersey (NAMI-NJ), County Family Support Organizations, Self Help Centers, Youth Development Council, and Statewide Consumer Advisory Committees (SCAC). Professional entities represented on the council include: the NJ Supportive Housing Association, NJ Hospital Association, the Consumer/Provider Association of New Jersey, the NJ County Drug and Alcohol Directors Association, the NJ Association of Mental Health & Addictions Agencies (NJAMHAA)

The Council's membership and associates also include leadership from well-respected community-based behavioral health organizations such as: RWJ/Barnabas Health - Institute for Prevention, Collaborative Support Programs of NJ, NewPoint Behavioral Health, Attitudes in Reverse, Psych Odyssey, and various other New Jersey partners.

Disaster and Terrorism Branch

DMHAS is home to a specialized behavioral health Disaster and Terrorism Branch (DTB) located within the Office of the Assistant Commissioner for Mental Health and Addiction Services. The DMHAS Director of the Disaster and Terrorism Branch is responsible for activating the state's behavioral health disaster response plan in coordination with the NJDHS Emergency Social Services Coordinator and the New Jersey Office of Emergency Management, during a declared disaster. Each New Jersey County also maintains a county-specific all hazards mental health disaster plan. During times of disaster, the county's plan can also be activated by the County Mental Health Administrator in coordination with the County Office of Emergency Management and in collaboration with the state partners.

DMHAS has over 120 contracted community mental health provider agencies. Over the past several years and especially since September 11, training for these mental health providers as well as private practitioners, has been consistently provided through federal grant programs. In fiscal year 2007 more than 3,500 people received training through DMHAS sponsored training programs. The Disaster and Terrorism Branch is home to a multi-disciplinary Training and Technical Assistance Group (TTAG) which has the capacity to provide on-demand training for mental health professionals in the wake of disaster to further increase the state's capacity to address the psychosocial needs of the community. The services available through the Disaster and Terrorism Branch include: Individual crisis counseling, Psychological first aid, Disaster-specific psycho-educational information, Group crisis counseling, Consultation and training, Information and referral services, and Toll-free warm line services.

The Disaster and Terrorism Branch maintains this website to share relevant information with the public and with mental health professionals. The Branch works in close collaboration with public health, law enforcement, emergency management, and other professionals at the local, state and federal levels to coordinate mitigation, planning, response and recovery efforts. DTB also actively promotes the participation of mental health professionals in drills, exercises, and ongoing professional development activities.

Children's System of Care (CSOC)

Juvenile Justice

Reducing the Number of Juvenile Justice Commitments

The Children's System of Care (CSOC) is fully accessible to youth involved with the juvenile justice system and the services coordinated by care managers help to keep youth out of detention centers. There has been a significant decrease in the number of detention center admissions resulting in the reduction of the number of county detention centers from seventeen to six in the past few years (Burlington County Detention Center closed in 2020).

Detention Alternative Program/Youth Advocate Program (DAP/YAP)

CSOC funds Community Re-Integration Services through YAP (Youth Advocate Program) to maintain youth in their community who, without this program, would enter out-of-home treatment due to juvenile justice involvement. The program provides services both individually and in groups, along with a mentor, life skills groups, and employment skills. The program is located in the three counties (Middlesex, Camden, and Essex) with the highest rate of court ordered out-of-home referrals. Additionally, this program has enabled the Division of Child Protection and Permanency to successfully maintain youth in resource homes after their arrest.

Medicaid

Currently, youth in juvenile detention facilities are eligible for Medicaid or New Jersey FamilyCare (S-CHIP) only after adjudication and referral to a non-secure setting.

CSOC Representation on the New Jersey Council for Juvenile Justice Improvement

Diversion and the reentry processes are discussed by the Access to Treatment and Racial Disparities sub-committees of the Council. Formal recommendations are presented to the full Council by the individual sub-committees.

DCF Cooperative Relationships with the Juvenile Justice Commission (JJC)

Since December 2004, the Department has maintained a Memorandum of Understanding with the JJC that outlines a distinct process by which youth in the JJC can be referred directly to what is now known as the Children's System of Care for services that will be implemented upon the

youth's release from a JJC facility. Representation from both CP&P and CSOC participate in the JJC and Annie E. Casey Foundation driven Juvenile Detention Alternative Initiative (JDAI) in order to collaborate on developing alternatives to detention and to reduce the number of youth going into detention. Both systems participate in each other's planning and case review processes.

The Juvenile Justice Commission is responsible for operating state services and sanctions for juveniles and for developing a statewide plan for the effective provision of juvenile justice services and sanctions at the state, county, and local levels. To emphasize New Jersey's commitment to provide coordinated quality services and appropriate sanctions for youthful offenders while ensuring the public's safety, the JJC established the State/Community Partnership Grant Program. These Partnership Grants provide funding to each county for services to reduce detention overcrowding, to provide treatment for sex offenders, to increase disposition options, and to provide aftercare to youth and their families.

Special Case Review Committee

The Special Case Review Committee (SCRC) reviews those youth, both male and female, who present multi-system needs/issues and the need for special attention or advocacy. Included are those who appear to have developmental disabilities, those who need placement by DCF/CP&P due to court orders for diversion or aftercare, and/or those who have special presenting problems, including homelessness, and those who are being referred, or are accepted by, DCF/CSOC.

The Office of Special Needs oversees the SCRC in terms of intra- and inter-agency planning. It is chaired by the Special Needs Assistant. Members include representatives from CP&P, Office of Adolescent Services, Children's System of Care, the JJC Juvenile Parole and Transitional Services (JP&TS), Pre-Release Teams, Regional Court Liaisons/designees, the JJC Child Study Teams, JJC community residential homes, and representatives from the New Jersey Training School at Jamesburg (NJTS), Juvenile Medium Security Facility (JMSF), and the Juvenile Female Secure Care and Intake Facility (Hayes Unit) Social Services Departments.

Meetings are held twice a month, for northern and southern regional cases, respectively. Referrals are primarily made from the Reception and Program Review committees, the Reception and Assessment Center (RAC), the New Jersey Training School (NJTS), and Juvenile Female Secure Care and Intake Facility. However, youth may be referred by any source identifying a special need for advocacy and planning, including the Institutional Classification Committees, JP&TS staff, court liaisons, supervisors, and program staff.

When youth in a JJC facility have permanency and treatment needs that require the intervention of DCF, the JJC Special Needs Review Committee will work with CSOC and CP&P to make appropriate referrals prior to time of discharge. In circumstances where CSOC is unable to access a timely treatment plan in accordance with mandatory release dates, CP&P will be expected to effectuate the most appropriate contingency plan until such time that a more feasible plan is developed. Care Management Organization (CMO) involvement is inclusive in this agreement, when appropriate.

CSOC maintains a "Protocol for Supervision of Juvenile Probationers Court-ordered to Attend and

Complete a DCSOC Specialty Services Program." This protocol was approved in 2012 by NJ Juvenile Probation Managers, NJ Conference of Chief Probation Officers, CSOC Representative for Specialty Programs, NJ Juvenile Committee of Family Presiding Judges, and the NJ Conference of Family Presiding Judges. Subsequent protocols were developed that address communication and collaboration for youth in either a residential treatment program or a substance use treatment program.

CSOC Training and Technical Assistance

CSOC offers a broad array of training and technical assistance to system partners through contracts with several entities including Rutgers University Behavioral HealthCare, the Boggs Center, and Autism New Jersey.

DCF/CSOC funds the Technical Assistance Center through University Behavioral Health Care - Rutgers, the State University, to provide training statewide. CSOC, through the UMDNJ Training contract, offers training to all children's system of care providers free of charge.

In addition, CSOC staff provides training on working with individuals with behavioral health challenges to staff of the Juvenile Justice Commission.

Children's InterAgency Coordinating Council (CIACC)

The CIACC serves as the county mechanism to advise DCF/CSOC on the development and maintenance of a responsive, accessible, and integrated system of care for youth with behavioral and emotional health needs, substance use, and/or intellectual or developmental disabilities and their families. Through enhanced coordination of systems partners, the CIACC also identifies service and resource gaps and priorities for resource development. Functions of the CIACCs include:

- Evaluating the local county policies to understand and minimize the impact of local barriers to serving youth with behavioral and emotional health needs, substance use, and/or intellectual and developmental disabilities in their community.

- Identifying local strategies and mechanisms to promote the integration and coordination of county, State, or other resources serving youth with behavioral and emotional health needs, substance use, and/or intellectual or development disabilities.

- Assessing local systems needs using information received from DCF, the Contracted System Administrator (CSA), any child-serving agency identified by DCF, and other bodies to make recommendations regarding service and resource development priorities.

- Identifying and informing DCF/CSOC regarding gaps and barriers to local service effectiveness.

- Providing input to State, regional, and county entities regarding system performance and service need.

In collaboration with the Department of Education, DCF recommended the creation of an "Educational Partnership" in every county in NJ. These partnerships use the County Inter-Agency Coordinating Councils to build a better working partnership between the DCF system of care and the local education system. This initiative has many goals, but one simple goal is to have at least one person in every school in NJ formally trained on the DCF service delivery system. This will help to facilitate a more preventative response to behavioral health challenges. Efforts to achieve this goal continue. DCF believes bringing systems together through the Educational Partnership will improve coordination in the service delivery process.

Educational Services

Educational Stability for Homeless Youth

The McKinney-Vento Act defines homeless children as "individuals who lack a fixed, regular, and adequate nighttime residence." This includes youth residing in out of home (OOH)/State facilities. The Department of Corrections, the DCF, the DHS, and the JJC are required to provide educational programs to students in State facilities ages five through 20 and for students with disabilities ages three through 21 who do not hold a high school diploma. Students must be able to receive high school credit.

In general State agencies are required to: provide a program comparable to the special education student's current individualized education program (IEP), and implement the current IEP or develop a new IEP; develop an individualized program plan (IPP), within 30 calendar days, for each general education student, in consultation with the student's parent, school district of residence, and a team of professionals with knowledge of the student's educational, behavioral, emotional, social, and health needs to identify appropriate instructional and support services; discuss the IPP with the student and make a reasonable effort to obtain parental consent for an initial IPP, including written notice; and, review and revise the IPP at any time during the student's enrollment, as needed, or on an annual basis if the student remains enrolled in the State facility educational program, in consultation with the school district of residence.

Attendance in educational programs is compulsory for all students, except for a student age 16 or above who may explicitly waive this right. For a student between the ages 16 and 18, a waiver is not effective unless accompanied by consent from a student's parent or guardian. A waiver may be revoked at any time by the former student. The actual number of days a student with a disability must attend the educational program shall be determined by the student's IEP.

Each State agency shall ensure all students with a disability in the agency's State facilities are provided a free and appropriate public education as set forth under the Individuals with Disabilities Education Act, 20 U.S.C. §§1400 et seq., and shall provide special education and related services as stipulated in the individualized education program (IEP) in accordance with the rules governing special education.

The State of New Jersey Department of Education Homeless Education link at https://www.state.nj.us/education/homeless/ provides additional links for information/resources.

Educational Stability for Youth in Out-of-Home Placement

In October 7, 2008, the federal government signed into law the Fostering Connections to Success and Increasing Adoptions Act (P.L. 110-351). This act required all states to arrange for children and youth in foster care to remain in their "school of origin" to ensure educational stability unless it is determined to be in a child's best interest to go to the new district where the Resource Family Home is located. New Jersey responded to this charge by passing the Education Stability Law on September 9, 2010, which established a system that supports the act. The DCF, Department of Education (DOE) and Office of the Child Advocate (OCA) worked together to implement this law. For children, changing schools can affect their ability to thrive academically, socially, behaviorally and psychologically. This is especially true for children in resource family homes. For these children – who often suffer the lingering effects of abuse or neglect and the trauma of being removed from their homes and families – school can often be the most stable part of their lives.

Work continues to fully implement the requirements of coordination between the DCF and the local school districts. To support the continued progress "Improving the Educational Outcomes of Children in Out-of-Home Placements: An Interagency Guidance Manual" is available on the DCF website at
https://www.nj.gov/dcf/families/educational/stability/GuidanceManual.pdf
The guidance manual includes a model memorandum of agreement (MOA) and provides specific actions to reach the indicator and goals in the MOA.

Suicide Prevention

Youth Suicide Prevention Resources

Every life lost to suicide is a tragedy and the New Jersey Department of Children and Families is committed to decreasing youth suicide and supporting youth who have attempted suicide. Suicide is the third leading cause of death for New Jersey youth between 10 and 24 years of age.

Traumatic Loss Coalitions for Youth (TLC) – UBHC Suicide Prevention

The Traumatic Loss Coalitions for Youth Program (TLC) at Rutgers-University Behavioral HealthCare is an interactive, statewide network that seeks to reduce suicide attempts, deaths by suicide, and to promote recovery of persons affected by suicide by offering collaboration and support to professionals working with school-age youth and direct crisis response services to staff and youth at youth-serving organizations following a traumatic event. The TLC offers county, regional, and statewide conferences, training, consultation, on-site traumatic loss response, and technical assistance. Since its inception, the TLC has trained thousands of individuals throughout the state with the purpose of saving lives and promoting post trauma healing and resiliency for the youth of New Jersey. The TLC website can be accessed at http://ubhc.rutgers.edu/tlc/

Zero Suicide

The Children's System of Care was granted the opportunity to work with the Educational

Development Center (EDC) on Zero Suicide. Zero Suicide is a Transformational Framework for Health and Behavioral Health Care Systems. The foundational belief of Zero Suicide is that suicide deaths for individuals under the care of health and behavioral health systems are preventable. For systems dedicated to improving patient safety, Zero Suicide presents an aspirational challenge and practical framework for system-wide transformation toward safer suicide care. The Zero Suicide Institute at EDC (ZSI) provides expertise, customized consultation, and training for health and behavioral health care systems and providers, state agencies, tribal governments, health plans, and others as they launch evidence-based practices for suicide prevention, adopt continuous quality improvement efforts, and implement the Zero Suicide framework for safer suicide care. The Zero Suicide EDC website is zerosuicide.edc.org

Our partnership with EDC is a two-year investment, that started with the implementation of Zero Suicide within our Care Management and Family Support Organizations as well as some of our out of home treatment programs. Year 2 looks to include teams from additional OOH organizations as well as the organizations that oversee our Mobile Response Stabilization Services.

As a result of working with the EDC to implement the Zero Suicide Framework, our partners have created and updated policies regarding suicide prevention, attempts, and protocols and some have engaged in agency-wide staff training, policy consultation, workforce readiness surveys, and piloted screening projects that regularly assess a youth's potential for suicidal thoughts or ideations, and, if identified, guide the youth onto a pathway that will build their resilience and coping skills, reducing risk and helping them to thrive. Some of our partners have also included individuals with living experience on their Zero Suicide teams.

Project Connect

In November 2020, the Garrett Lee Smith Youth Suicide Prevention Grant was awarded to the New Jersey Department of Health (NJDOH) from the Substance Abuse and Mental Health Services Administration (SAMHSA). This federal grant was awarded to implement NJDOH's Readiness to Stand United Against Youth Suicide (R2S Challenge). The Department of Children and Families (DCF) is collaborating with the DOH on a portion of the grant. This collaboration is to assist New Jersey hospitals to effectively connect youth to services following suicide attempts. DCF is developing Project Connect to increase engagement in community mental health services after hospital discharge, reduce unnecessary Emergency Department utilization through connection to appropriate community services, and improve safety and well-being for youth and families. Through the innovative role of the Regional Care Coordinator (RCC), Project Connect works in partnership with identified hospitals to enhance discharge planning for youth with suicide ideation and/or attempts. After youth are medically stabilized, screened, and determined to be safe for discharge, hospital staff will engage in a warm transfer process to connect families to PerformCare and community resources. Hospital staff will also be coached on how to obtain consent to connect the family to the RCC who will make contact with the caregiver post-discharge to provide the youth and family with follow up support and ensure linkage and engagement with community behavioral health services.

2NDFLOOR Youth Helpline

Accredited by the American Association of Suicidology, 2NDFLOOR is a confidential call/text

helpline and message board platform serving youth and young adults. Youth who contact the 2NDFLOOR are assisted with their daily life challenges by professional staff and trained volunteers. The 2nd Floor website can be accessed at http://www.2ndfloor.org/

Crisis Text Line

The Children's System of Care has partnered with Crisis Text Line in New Jersey to provide another tool for constituents. Crisis Text Line is a free 24/7 support that connects anyone experiencing a self-defined crisis with a trained counselor. It can be accessed from anywhere in the United States. When texts are received, they are screened by an algorithm for severity, and texts that indicate imminent risk are placed at the top of the queue for faster response. Crisis counselors are trained to bring texters from "a hot moment to a cool calm," using empathic listening techniques. They collaboratively problem-solve to help the texter come up with a plan to stay safe. Calls are anonymous and confidential, unless referral to emergency services is necessary. For cell phone plans with AT&T, T-Mobile, Sprint, or Verizon, texts are completely free and will not show up on the phone bill. For plans with another carrier, normal text rates will apply and will appear on the phone bill as 741741. Additional information about Crisis Text Line can be found at http://www.crisistextline.org

Additional Suicide Prevention/Crisis Resources

Staffed by mental health professionals and peer support specialists 24 hours a day, seven days a week, the New Jersey Suicide Prevention Hopeline is available to all ages for confidential telephone support (except when a suicide attempt is in progress), assessment, and referral. The NJ Hopeline offers call, text, chat, and email options. General information is available at: www.njhopeline.com

New Jersey Youth Suicide Prevention Advisory Council

Established in, but not of, the Department of Children and Families, the New Jersey Youth Suicide Prevention Advisory Council is comprised of appointed New Jersey citizens and state government representatives. The New Jersey Youth Suicide Prevention Advisory Council examines existing needs and services and makes recommendations for youth suicide reporting, prevention, and intervention. It advises the development of regulations pursuant to N.J.S.A. § 30:9A-25 et seq.

Community Programs for Outreach and Intervention with Youth and Young Adults at Clinical High Risk for Psychosis (CHR-P) – A SAMHSA Grant Program

On September 30, 2018, SAMHSA awarded a 4-year grant to the Children's System of Care to address youth and young adults at clinical high risk for psychosis. CSOC worked in partnership with DMHAS to develop the program, which provides outreach and intervention for youth and young adults up to age 25, who may be experiencing prodromal symptoms of psychosis.

The program utilizes established behavioral health agencies who are currently providing treatment services for persons experiencing first episode psychosis (FEP). NJ PROMISE provides intervention to approximately 60 youth and young adults across three regions annually. Through

extensive outreach, coordinated care, the use of evidence-based, evidence-informed, best, and promising practices, as well as the expertise of a team of professionals, participants and their families will have the tools necessary to lead productive lives in their homes and communities.

The project's measurable goals are to:

- Reduce the percentage of youth/young adults at clinical high risk for psychosis who become hospitalized.
- Reduce the prevalence of psychiatric symptoms that youth/young adults at clinical high risk for psychosis experience.
- Increase the percentage of youth and young adults at clinical high risk for psychosis who adopt their collaboratively developed treatment plan, including all recommended medication.
- Increase the overall functioning of youth and young adults at clinical high risk for psychosis, as evidenced by increased participation at school, employment, and in their communities.

Division of Child Protection and Permanency

The Division of Child Protection and Permanency (CP&P) is New Jersey's child protection and child welfare agency within the New Jersey Department of Children and Families (DCF). Its mission is to ensure the safety, permanency, and well-being of children and support families. CP&P is responsible for investigating allegations of child abuse and neglect and, if necessary, arranging for the child's protection and the family's treatment. The Child Abuse Hotline (State Central Registry) receives reports of child abuse and neglect 24-hours a day, 7-days a week. Reports requiring a field response are forwarded to the CP&P Local Office who investigates.

Clinical Consultants report to CP&P Area Offices and serve as liaisons, joined from the wraparound perspective, that translate system of care principles and values into case practice and planning and assist in the coordination of behavioral health services for youth involved in the child welfare system. The Care Management Organization (CMO) Clinical Consultant is a jointly owned and administered position between the CMO and CP&P. Clinical Consultants translate clinical information into user-friendly language to identify mental health concerns regarding youth involved in the child welfare system and propose interventions to address underlying issues. Clinical Consultants serve as an advocate for youth in permanency and discharge planning, speaking on a clinical level with the Contracted Systems Administrator (CSA), PerformCare, and provider agencies and facilitating communication between care management entities. Clinical Consultants are required to be master's level clinician's licensed by the New Jersey Board of Marriage and Family Therapists or Board of Social Work Examiners.

Office of Adolescent Services (OAS)

The New Jersey Department of Children and Families' (DCF) Office of Adolescent Services (OAS) supports adolescents' transition to adulthood, achieve economic self-sufficiency and interdependence, and engage in healthy lifestyles by:

- Ensuring services provided through DCF are coordinated, effective, meet best practice

standards, are youth-driven, and adapt to the needs of families and communities,
- Developing linkages with other service providers to create a more equitable and seamless service system, and
- Providing leadership and policy development in the adolescent services field.

OAS work is guided by the principles that adolescent services should:
- Treat all youth with respect,
- Empower youth to engage in planning regarding their own lives, as well as service planning within their communities to the extent it is developmentally appropriate,
- Use a strengths-based and culturally competent approach,
- Assist youth to develop protective and positive attributes and reduce risky behavior,
- Be flexibly structured to meet the individual needs of youth,
- Promote healthy connections to family and other caring adults,
- Affirm the ability of all youth to succeed, but at their own pace and with support,
- Be coordinated and accessible and endeavor to meet established and emerging best practice standards, and
- Use data and focus on outcomes.

Youth Resources Spot (www.njyrs.org)

DCF supports various programs and services for adolescents and young adults including housing, life skills, mentoring, employment/training, educational support, youth advocacy, and healthcare.

The New Jersey Youth Resource Spot provides information on local resources for youth. Users can search Child Protection and Permanency's (CP&P) policies, learn how to contact a CP&P worker, and email questions to the Office of Adolescent Services. Youth can also learn how to determine if they're eligible for Wraparound Funds, the Independent Living Stipend, and more.

This guide provides youth with valuable resources that will help their transition into adulthood: Helping You Transition to Adulthood: Resources for New Jersey's Youth at https://nj.gov/dcf/adolescent/YOUTHRESOURCEGUIDE2013.pdf.

Task Force on Helping Youth Thrive in Placement

DCF is committed to ensuring that children and youth, including those in out-of-home placement, remain connected to people important in their lives and fully participate in their schools, neighborhoods and communities. In essence, DCF wants children and youth to enjoy a normal childhood and adolescence regardless of their involvement in the child welfare system. DCF formed the Task Force on Helping Youth Thrive in Placement (HYTIP) to study and recommend ways these children can remain connected to their friends, schools, neighborhoods, and communities. Its interim report offered recommendation for change in several areas, and DCF responded by updating its regulations so children and youth can enjoy contact with family and friends and recreation, education, and employment opportunities within their home community. DCF continues to review and strengthen its practice culture, regulations, and contracting process to help children and youth enjoy a normal and fulfilling childhood and adolescence.

The Task Force on Helping Youth Thrive in Placement recommendations are available here: https://nj.gov/dcf/adolescent/TaskForceHYTIP.pdf

The Youth Thrive Overview is available here:
https://nj.gov/dcf/providers/notices/nonprofit/YT.pdf

Youth Thrive Protective and Promotive Factors are available here:
https://nj.gov/dcf/providers/notices/nonprofit/YTdef.pdf

LGBTQ resources are available here: https://nj.gov/dcf/adolescent/lgbtqi/

DCF Division of Family and Community Partnerships (FCP)

DCF's Family and Community Partnerships' (FCP) promotes the health, well-being and personal safety of New Jersey's children and families. It works with parents, caregivers, organizations, and communities to ensure an effective network of proven support services, public education, and community advocacy to prevent maltreatment.

The Office of Early Childhood Services is responsible for the planning, development, implementation and evaluation of prevention services for families and caregivers of children from pregnancy/birth to kindergarten. OECS provides oversight and technical support to ensure evidence-based practice, ongoing quality improvement, and positive impacts for participants of funded programs. OECS works in close collaboration with local, state and national partners to ensure integration of maternal, parent, infant and early childhood services to promote family health and well-being, and prevent child neglect and abuse.

Family and Community Partnerships' Office of Early Childhood Services (OECS) works across state government and with state and local advocates to ensure child abuse and neglect prevention services and supports reach families before a child is born. Early childhood services are available up to a child's sixth birthday.
Programs include:

Connecting NJ

New Jersey's network of service hubs dedicated to providing essential services that help families, and care for children, primarily from pregnancy to age five. Connecting NJ agencies, partners and support systems offer access to information and referrals to local wellness services, including healthcare for mothers and children, early education programs, domestic violence support, addiction treatment, financial assistance, home visiting programs, behavioral health services, and more. For more information: https://nj.gov/connectingnj/

County Councils for Young Children

County Councils for Young Children (CCYC) is a social service planning community organization. It strengthens collaboration between parents, families, and local community providers. These community members come together to promote parent leadership and support on

the local level.

Help Me Grow

Help Me Grow (HMG) promotes infant and child health, development, and social-emotional well-being; early learning and school readiness; and helps to prevent child neglect and abuse. HMG works with partners to improve the quality and availability of services at the state and local level, and eliminate disparities through early childhood systems integration.

Home Visitation

The Home Visitation Initiative seeks to improve the physical and emotional well-being of infants, children, and their families by providing community-based education and in-home support to parents.

Project LAUNCH (Linking Actions for Unmet Needs in Children's Health)

With the support of the Substance Abuse and Mental Health Services Administration and the New Jersey Department of Children and Families, Project LAUNCH links and enhances efforts to improve the overall wellness of young children in Essex County.

Strengthening Families

Strengthening Families (SF) is an evidence-based approach to reduce child abuse and neglect through training and guidance to child care and family child care providers.
The Office of Family Support Services provides leadership, support, and development to communities and family serving organizations in order to identify community strengths, needs, and community-based promising strategies that will improve the accessibility of support programs and improve the community context in which families live.

Family and Community Partnerships' (FCP) Office of Family Support Services (OFSS) promotes the social well-being and strengthening of children, families, and communities. By partnering with community entities, OFSS provides funding, leadership, and technical assistance to its programs. Responsible for the long-term development of New Jersey's Family Success Centers and Kinship Navigator Program, OFSS leads these programs to deliver appropriate and beneficial services that strengthen and support families.

Family Success Centers

Family Success Centers are "one-stop" shops that provide wrap-around resources and supports for families before they find themselves in crisis. Family Success Centers offer primary child abuse prevention services to families and bring together concerned community residents, leaders, and community agencies to address the problems that threaten the safety and stability of families and the community. There is no cost to access services provided by Family Success Centers (FSCs).

Program Goals: Family Success Centers seek to provide a warm and welcoming home-like

environment that provides family friendly activities and resources within communities to strengthen families.

Population Focus: Family Success Centers offers services to any children, youth, families, individuals, and communities. Program Services: Core services include:

- Access to information on child, maternal and family health services, economic self-sufficiency and job readiness
- Information and referral services (connection to off-site public and private resources)
- Life skills training
- Housing services
- Parent education
- Parent-child activities
- Advocacy

Kinship Navigator Program

Kinship Navigator supports caregivers who have taken on the responsibility of caring for their relatives' children. These children can include the caregiver's siblings, nieces, nephews, or grandchildren. Local Kinship agencies help caregivers navigate other forms of government assistance, determine their eligibility for Kinship Navigator Program benefits, and provide technical support with legal commitments to the child.

Program Goals: The local kinship agencies serve three functions. First, staff from the agencies helps caregivers "navigate" other forms of government assistance. Secondly, kinship agencies determine if the caregiver's family is eligible for Kinship Navigator Program benefits such as help with short-term expenses for the relative child, such as furniture, moving expenses and clothing. Finally, kinship agencies provide technical support and guide the family through the process of Kinship Legal Guardianship if the caregiver wishes to make a legal commitment to the child.

Population Focus: Kinship caregivers are special people who have taken on the responsibility of caring for their relatives' children. These children might be the caregiver's siblings, nieces, nephews, or, most often, grandchildren.

The children may be eligible for monthly payments through the federal Temporary Assistance for Needy Families (TANF) program as well as Medicaid health insurance.
Services include: Wraparound case management which includes a small subsidy for goods such as furniture, clothing, or funding for extra-curricular activities, and assistance with obtaining Kinship Legal Guardianship. Services are provided in all 21 counties.

School-Linked Services

The Office of School-Linked Services (OSLS) contracts with private non-profit organizations and school districts to provide prevention and support services for youth in New Jersey's elementary, middle, and high schools. OSLS's programs aim to implement prevention and intervention programs that are comprehensive and multifaceted and build on the strengths of young people so they can achieve their educational and life goals.

School Based Youth Services Program

The School Based Youth Services Program (SBYSP) is located in host schools and coordinate with existing resources in the community. All youth are eligible to participate and services are provided before, during, and after school. SBYSP services include: mental health counseling; employment counseling; substance abuse education/prevention; preventive health awareness including pregnancy prevention; primary medical linkages; learning support; healthy youth development; recreation; and information/referral.

Prevention of Juvenile Delinquency

Prevention of Juvenile Delinquency (PJD) is located in host schools to enhance services and collaborate with SBYSP. All youth enrolled in the host school where they display behaviors that can or have caused them to become involved in the juvenile justice system are eligible to participate. PJD services complement the SBYSP and focus specifically juvenile delinquency prevention strategies and self-regulation skills to prevent juvenile delinquent behaviors that can impede the student's achievement of their education and life goals. PJD services include case management and counseling services; collaboration with local law enforcement, state and school and community-based agencies, dropout prevention, life and coping skills.

Adolescent Pregnancy Prevention Initiative

Adolescent Pregnancy Prevention Initiative (APPI) is located in host schools to enhance services and collaborate with SBYSP where available. All youth enrolled in the host school where they display behaviors that could lead to an unplanned pregnancy are eligible to participate. Youth involved in the program will gain increased pregnancy prevention skills to support the achievement of their education and life goals. APPI services complement the SBYSP program, where available, and focus specifically on pregnancy prevention skills and knowledge to support the student's ability to achieve their education and life goals. APPI services include: case management and counseling services; education and awareness groups; linkages to available services and resources; and collaboration with school personnel.

Family Friendly Centers

Family Friendly Centers (FFC) is located in host schools to enhance afterschool programming in elementary and middle schools. FFCs provide constructive academic, recreational, and social enrichment activities to students and their families. All FFC programs emphasize positive youth development, encourage parental participation, and seek to establish partnerships with school and community stakeholders to meet the unique needs of youth and their families.

Parent Linking Program

Parent Linking Program (PLP) is located in host high schools to enhance services and to collaborate with SBYSP. For expecting and parenting teen mothers and fathers, PLP works to minimize and eliminate barriers to earning a high school diploma. This is accomplished through

the development and implementation of programs that strengthen pregnant and parenting teen's ability and access to complete their education (secondary and postsecondary); improve child and maternal health outcomes; improve pregnancy spacing and reduce the likelihood of repeat teen pregnancies; increase parenting skills for mothers, fathers, and families; strengthen positive young father involvement and co-parenting relationships, as appropriate, decrease intimate partner violence; and raise awareness of available resources.

New Jersey Child Assault Prevention

New Jersey Child Assault Prevention programs operate in every county, providing educational awareness training and implementing strategies to handle and/or prevent child assault/neglect to children in grades pre-school through twelve, their parents/guardians as well as educators.

Newark School Based Health Center

Newark School Based Health Center provides primary medical, dental, and behavioral health care services to students and families (up to age 21). Centers are located in several Newark schools and services are available to members of the school's surrounding community.

Additional State and Local Partnerships

Children's System of Care Planning

The Children's System of Care (CSOC) has previously reported on the collaboration with the Center for Health Care Strategies (CHCS) and Casey Family Programs through which a task force of sixteen stakeholders was convened to participate in building a behavioral and physical health integration model. Additional information on the task force, including meeting agendas and summaries can be found posted on the DCF website. Release of the report and recommendation from this task force was delayed due to the onset of the COVID-19 pandemic but are now also posted with the meeting agendas and summaries here: DCF | Children's System of Care Stakeholder Task Force (nj.gov) . In August 2021, a final stakeholder advisory group was held. During this session, CSOC presented on the progress made toward the previously identified priorities, as well as provided an outline for initiatives in fiscal year 2022. Shortly thereafter, CHCS convened an internal meeting with CSOC leadership to focus on reviewing and committing to identified program initiatives organized under the three main priorities:

- Building capacity for integrated health;
- Increasing the availability of evidence-based and best practice interventions and services; and
- Improving access to CSOC services and supports, as well as including the priority of Service Excellence.

Some highlights of these initiatives include: the Infant and Early Childhood Mental Health (IECMH) Initiative, the Garrett Lee Smith (GLS) Suicide Prevention Grant, and the Developing Resiliency with Engaging Approaches to Maximize Success (DREAMS) Initiative, to implement

the Nurtured Heart Approach in 50 school districts. CSOC has since developed workplans for each of the specific initiatives which has supported the updated work below:

1. IECMH has identified three major objectives: staff development, community collaboration & increased support for families. CSOC has convened a Steering Committee designed to guide the work of this initiative. The charge of this group is to support the planning, guidance and monitoring of our initiative implementation.

2. The GLS grant was awarded to the New Jersey Department of Health (DOH) in November of 2020. Through a memorandum of agreement with DOH, DCF is partnering on several components of the grant: Question, Persuade, and Refer training for schools and other community partners, Regional Care Coordination for youth and families who have been discharged from an emergency room after a suicide attempt, suicide best practices for CSOC providers, and training and support for families and other survivors. Grant year two was from 11/30/21 through 11/29/22 and grant year three is from 11/30/22 through 11/29/23.

3. DCF is finalizing a memorandum of understanding with the Department of Community Affairs (DCA) to transfer funds for the DREAMS initiative to DCF, and will engage with participating school districts no later than July 1, 2023 to begin implementation of the project for the 23-24 school year. The DREAMS initiative will serve up to 50 districts each year as identified by CSOC and the New Jersey Department of Education. Participating districts will receive access to on demand training, virtual live webinars, train the trainer slots for NHA as well as mentoring from a community-based provider for the duration of the school year.

NJ Task Force on Child Abuse and Neglect Prevention

The New Jersey Task Force on Child Abuse and Neglect (NJTFCAN) includes officials from NJ state agencies such as the Office of the Attorney General, Office of the Public Defender, Administrative Office of the Courts, Departments of Health, Corrections and Human Services, elected officials, advocates, and local providers of health care and social services. The purpose of the Task Force is to study and develop recommendations regarding the most effective means of improving the quality and scope of child protective and preventative services provided or supported by state government.

County Councils for Young Children

DCF continued working with the CCYCs which develop strategies to increase access to services that promote the healthy development of children and enhanced family outcomes through referrals and connections to other supportive services. Each of NJ's 18 County Councils is comprised of diverse, culturally, and linguistically competent parents/families, early childhood providers and other community stakeholders. The County Councils play a vital role in supporting and engaging parents. Their feedback will continue to enhance NJUs mixed delivery approach to help families learn about and access childcare options and family support services.

In July 2021, NJ Governor Phil Murphy signed landmark legislation to improve NJ's maternal and infant health outcomes for all NJ families. The new law (S690) establishes a statewide universal newborn home visitation program in the New Jersey Department of Children and Families, advancing New Jersey as a national model for maternal and infant care.[1] In addition to various stakeholders, four Parent Leaders from the CCYC's are participating on the advisory board created to implement the statewide universal home visiting program.

Project HOPE

In October 2018, NJ was one of seven states selected to receive a Technical Assistance Grant from BUILD, Vital Village and Nemours called Project HOPE.[2] Project HOPE is designed to generate real progress towards equitable outcomes for young children (prenatal to age five) and their families by building the capacity of local communities, state leaders, cross-sector state teams, and local coalitions to prevent social adversities in early childhood and to promote child well-being. DCF and the NJ Department of Health (DOH) were co-leads on this initiative.

One of the goals of this pilot was to facilitate stronger links between the workforce agencies and New Jersey's childcare systems, including Head Start and Child Care Resource and Referral Agencies.

In the first phase of this pilot, Project HOPE facilitated meetings between the workforce development and childcare agencies, and assisted the group to identify opportunities, challenges, and next steps. A summary of findings from these initial provider meetings is as follows:

Initial findings: County partners need stronger mechanisms for communicating workforce resources, early care and education resources, and job opportunities. As a result, a Google Group was created for county partners to easily share resources with each other.

Lessons learned: Deepen and share an understanding of the opportunities and challenges for families in Atlantic City and Bridgeton. Support one another's actions to increase access to available state funded or administered programs, services and initiatives tailored to children and their families in Atlantic City or Bridgeton, which will support the well-being, growth, and development of children birth to 5, and their families.

Resource sharing/coordination of services: One-Stop Career Centers are challenged in supporting parents when they omit pertinent information during their intake process, such as child support obligations or child protective services involvement. A shadowing session of a father as he proceeded through the One-Stop Career Center intake process helped to inform the importance of a trusted individual being a part of the process. This father had a trusted Head Start staff person serve as a navigator through the intake process. Both the parent and intake staff felt the navigator role was helpful. This navigator model could be a tool that could support the labor/workforce and early care/education agencies better serve parents.

---

[1] https://www.nj.gov/governor/news/news/562021/20210729a.shtml
[2] https://www.movinghealthcareupstream.org/nemours-project-hope/

Trauma-informed approaches, motivational interviewing, child support and child protective services have also been added to the pilot's list of potential trainings for One- Stop Career Center and workforce development staff. In December 2021, DCF and DOL met with the stakeholders of the labor and early care partnership to discuss the official ending of the Project HOPE Initiative, and the continuation of the partnership as part of the IPG collaboration.

The project ended in September of 2022, and DOL has continued the meetings with the One-Stop Career Center and workforce staff. NJ DOL was awarded a Preschool Development Grant Birth - 5 planning grant from ACF in January 2023 that will focus on workforce development with an early childhood focus and will incorporate the learnings of Project HOPE. Additional information on Project HOPE can be found online at https://www.movinghealthcareupstream.org/nemours-project-hope/.

Central Intake

Connecting NJ3F, formerly known as New Jersey Central Intake (CI), is a comprehensive prevention system, managed by DCF in partnership with the Department of Health (DOH). It provides communities one single point of access for family assessment and referral to family support services. Connecting NJ addresses both care coordination and system integration by improving communication between families and providers across sectors. This single based point of entry allows families access to information, eligibility, assessment, and referral to local family support services, while attempting to reduce duplication of services. Connecting NJ strives to increase family supports that improve prenatal and preventative care and improve birth outcomes. Additional information available online at http://www.nj.gov/connectingnj.

Help Me Grow

Since April 2012, the Office of Early Childhood Services (OECS) has led the Help Me Grow New Jersey (HMG NJ) initiative. Help Me Grow promotes the development of an integrated early childhood system that supports children (0-8 years old) and their families to achieve optimal wellness. HMG NJ is building upon New Jersey's strong foundation in early childhood systems to improve coordination and integration of services and programs. HMG NJ streamlines services across systems of care that encompass four core departments: DOH, DHS, DOE, and DCF. As a result, pregnant women and parents of infants and young children will have access to earlier prevention, detection, intervention, and treatment services.

In August 2013, DCF received funding through the Health Resources and Services Administration (HRSA) to implement the Early Childhood Comprehensive Systems Initiative (ECCS) – with priorities parallel to those of Help Me Grow, and August 2016, DCF was awarded the competitive continuation contract, now titled ECCS Impact. In September 2019, the ECCS work expanded to the entire statewide New Jersey Connecting NJ (formerly Central Intake system) in all 21 counties with support and implementation of the Early Childhood supported by the Preschool Development Grant Birth-5. In CY 2022, the statewide Connecting NJ system remained steady with developmental health promotion and screening, adding 2633 completed ASQ developmental screenings, a 32% increase from 2021

Activities Related to this Section that the State would like to Highlight

On January 1, 2019, the Supportive Housing Connection (SHC) was transferred to the Department of Community Affairs (DCA), Division of Housing and Community Services (DHCS). All direct care staff of the SHC were transferred to DCA, DHCS as hourly employees as they were for the New Jersey Housing and Mortgage Finance Agency (NJHMFA). DCA, DHCS employed an SHC supervisor and began recruitment for vacant positions within the SHC. The role and function of the SHC remains intact; the changes are in the physical location of SHC and its employees, now housed at the DCA's Trenton, NJ location. The Memorandum of Agreement (MOA) between the NJHMFA and the Department of Human Services (DHS)/ Division of Mental Health and Addiction Services (DMHAS), expired December 31, 2018. The new MOA between DCA and DHS/DMHAS, has an effective date of January 1, 2019.

DMHAS and DCA entered into a MOA to have the Supportive Housing Connection (SHC), begin the process of paying the subsidies for individuals served by applicable DMHAS programs. Under this MOA, the SHC acts as fiscal agent and by agreement follows all DHS policy decisions. The SHC contracts with property managers and owners, completes all necessary apartment inspections makes subsidy payments to property managers and landlords. The SHC recruits landlords, provides training, assists with consumers completing paperwork and distributes welcome packets to afford a smooth transition for consumers. The SHC assists consumers in referrals for affordable housing units, administers DMHAS housing subsidies, and expands relationships for housing opportunities through developers and or other DCA housing projects. In the event of disputes between consumers and landlords, the SHC brokers disputes and contracting issues.

The Supportive Housing Connection (SHC) continues to manage supportive housing subsidies, conducting crucial related services such as apartment inspections and rental payments to landlords. The SHC responds to all submitted subsidy applications within one business day of receiving a complete package. The SHC provides apartment inspections within five days of the provider's submitted request. The SHC also makes rental payments by the payment due date for all individuals with a subsidy managed by the SHC. The target compliance threshold for all of these requirements is 90%. These timeframes enable DMHAS and the SHC to maintain a low vacancy rate, with only new units or units becoming vacant as individuals move.

Environmental Factors and Plan

21. State Planning/Advisory Council and Input on the Mental Health/Substance use disorder Block Grant Application- Required for MHBG

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council to carry out the statutory functions as described in 42 U.S. C. 300x-3 for adults with SMI and children with SED. To meet the needs of states that are integrating services supported by MHBG and SUPTRS BG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, SUD treatment, and recovery representation, referred to here as an Advisory/Planning Council (PC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance misuse prevention, SUD treatment, and recovery advisory council to ensure that the council reviews issues and services for persons with, or at risk, for substance misuse and SUDs. To assist with implementing a PC, SAMHSA has created **Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.**[1]

Planning Councils are required by statute to review state plans and implementation reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as an advocate for individuals with M/SUD problems. SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

[1] **https://www.samhsa.gov/grants/block-grants/resources [samhsa.gov]**

Please consider the following items as a guide when preparing the description of the state's system:

1. How was the Council involved in the development and review of the state plan and report? Attach supporting documentation (e.g. meeting minutes, letters of support, etc.)

The New Jersey Behavioral Health Planning Council (BHPC) / NJ Mental Health Citizens Advisory Board (CAB) is a full partner in the development and review of the MHBG and SABG. The SMHA is very proactive in involving the community in the state planning process. In SFY 2023 alone, the NJ Division of Mental Health and Addiction Services (DMHAS), which is both the State Mental Health Authority (SMHA) and the Single State Authority (SSA) for substance abuse treatment hosted seven separate public presentations at the meetings of the NJ Behavioral Health Planning Council on the MHBG, SUPTR and related topics—July 2022 & August 2023 ((regarding the MHBG Mini-plan), September 2023 (regarding URS Fiscal tables), November 2022 & December 2022 (regarding the MHBG & SABG) Implementation Report), February 2023 (regarding the use of WebBGas), and June 2023 (regarding the Block Grant application, and gaps in services).

Whenever possible, the SMHA/SSA reviews all its submissions (e.g., Implementation Reports and block grant applications) with the Council, prior to submission. These discussions are held in open, public meetings that are accessible both in-person and via conference call. These meetings are announced via announcements published in four major newspapers as well as on the on the state website (https://www.state.nj.us/humanservices/dmhas/home/councils/bhpc.html).

2. What mechanism does the state use to plan and implement community mental health treatment, substance misuse prevention, SUD treatment, and recovery support services?

Substance use disorder services are planned based on a needs assessment process completed by the State. State funding is allocated to counties based on a funding formula. Substance Use Prevention and Treatment Block Grant funding is allocated to third party contracts and fee-for-service contracts for prevention, early intervention, treatment and recovery services based on the needs assessment. As needs emerge, new Requests Proposals are drafted for contracts, which may be renewed annually, as needed.
The SMHA includes and updates the Planning Council & Community on its mental health and SUD treatment and recovery support services, through regular updates. In July 2022 the Council received an update on Substance Abuse Prevention & Treatment Block Grant. In September 2022 the Council received a briefing on the SAPTBG fiscal tables. In October 2022 the Council received a briefing on statewide nicotine cessation programming. In November & December 2022, the Council was briefed on the MHBG and SAPTBG Implementation Report. In January 2023, the Council was given a presentation on the NJ State Opioid Response Grant (SOR): Evidence Based Practice Initiative [EBPI]. From June thru August 2023 meeting, the Planning Council received and the Block Grant Planning Council Subcommittee received briefings on the Mental Health Block Grant and the Substance Use Prevention, Treatment and Recovery Services (SUPTRS) Block Grant.

3. Has the Council successfully integrated substance misuse prevention and SUD treatment and recovery or co-occurring disorder issues, concerns, and activities into its work? (●) Yes ( ) No

4. Is the membership representative of the service area population (e.g. ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?

○ Yes ◉ No

5. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

The NJ Behavioral Health Planning Council strives to be a forum where people in recovery, and their families/other stakeholders can advocate for people with SMI and/or SED. The issue of "Advocacy" is so deeply embedded in the Council, that since 2012 the Council has had a long-standing "Advocacy Committee", specifically designed to be a dedicated mechanism where the Council can identify, advocate for, and correct issues and gaps in the system of care that are most profoundly experienced by individuals (and families) facing SMI/SED. Some of the issues tackled by the Advocacy Committee have included: increased identification of sub-standard boarding homes, Medicaid funding for tobacco cessation efforts, smoother transitions of care (e.g.., from youth to adult services & from acute care to community settings), improved training for front line provider staff, and decreasing wait times for youth seeking emergency psychiatric services.

Please indicate areas of technical assistance needed related to this section.

At the February 2023 and May 2023 meetings of the New Jersey Behavioral Health Planning Council, the Council expressed its desire to receive technical assistance in the following areas: Block Grant 101, The Role of an Effective Council, Effective Advocacy by the Council, Strategies to increase diversity among council membership, Strategies to recruit families of children with SED, and assistance with the development of a Planning Council Orientation Manual for new members.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

NEW JERSEY BEHAVIORAL HEALTH PLANNING COUNCIL
Minutes
September 13, 10:00 am

This meeting was conducted exclusively through MS Teams video teleconference & conference call

Microsoft Teams meeting
Click here to join the meeting
Or Call in
+1 609-300-7196, PIN: 306216820#

Notices of the meeting were sent to the Asbury Park Press, The Times (Trenton), Bergen Record, The Press (Pleasantville), and the Courier-Post (Cherry Hill).

Participants:

Darlema Bey (Chair)	Connie.Greene (Vice Chair)	Michael Ippoliti	Harry Coe
Ann Marie Flory	Jennifer Rutberg	Francis Walker	Julia Barugel
Tracy Maksel	Heather Simms	Donna Migliorino	Jonathan Sabin
John Tkacz	Suzanne Smith	Krista Connelly	Winifred Chain
Joseph Gutstein	Maurice Ingram	Robin Weiss	Robert DePlatt

DMHAS, CSOC. DDD, DMAHS & DoH Staff:

Wyndee Davis	Brittany Thorne	Helen Staton	Yunqing Li
Mark Kruszczynski	Suzanne Borys	Barbara Ferrick	Nancy Edouard

Guests:

Nancy Edouard	Nina Smuklasky	Mark Williams	Joe Cuffari
Michael Litterer	Eric McIntyre	Elena Kravitz	

I. **Administrative Issues/Correspondence** (Darlema Bey)
   A. Attendance, 20/35, 57.1% attendance, quorum exceeded.
   B. Minutes of September 2023 General Meeting Approved
   C. Upcoming Technical Assistance (TA) from SAMHA/Advocates for Human Potential
      1. Review of issues including: Roles and Responsibilities, Creating a diverse membership, Meeting protocols, etc.

II. **Quality Improvement Plan: RWJ/Barnabas Health Institute For Prevention and Recovery** (Michael Litterer, RWJ/Barnabas Institute for Recovery)
   A. Presentation shared via PowerPoint and previously sent to BHPC ListSERV

III. **Community Mental Health Block Grant Fiscal Overview** (Morris Friedman)
   A. Not presented due to unexpected scheduling conflicts with the DMHAS Fiscal Office
   B. Review of WebBGAS login. https://bgas.samhsa.gov/ Username: citizennj, Password: citizen

IV. System Partner Updates

A. Children's System of Care (Wyndee Davis)

1. The DREAMS initiative that occurred during the 2021-2022 school year will return for the 2023-2024 school year.
2. This is a collaboration between DOE & DCF to bring "Nurtured Heart"/ trauma informed care approach in schools through training and mentoring by local partners.
3. School staff champions will be trained as trainers to provide for sustainability of the initiative.
4. This is funded with ARP funds and will operate for three years.
.5. 48 School districts will be participating this year.
6. For more information : SafeSupportiveSchools@doe.nj.gov

B. DDD (Jonathan Sabin):

1. On August 8, 2023, the Division released updated policy manuals for its Community Care Program and Supports Program.
   i. Changes can be found here – https://nj.gov/humanservices/ddd/assets/documents/community-care-program-policy-manual.pdf & https://nj.gov/humanservices/ddd/assets/documents/supports-program-policy-manual.pdf
   ii. Page two of each manual contains a summary of changes.

2. As you may be aware, the Division of Developmental Disabilities (DDD) offers individuals the option to self-direct some or all their services through one of two self-directed service models: Vendor Fiscal/Employer Agent (VF/EA) or Agency with Choice (ACW). The state contracts with a financial management service provider/fiscal intermediary to administer each of these models, and the contract with the fiscal intermediary for the VF/EA model (Public Partnerships LLC) is ending. This requires the state to begin the process of re-procuring financial management services for the VF/EA model. To meet this requirement, DDD, within the NJ Department of Human Services, issued the following on August 14, 2023:
   i. NOFA - https://www.state.nj.us/humanservices/providers/grants/nofa/NOFAfiles/NOFA_FINAL.pdf
   ii. RFP - https://www.state.nj.us/humanservices/providers/grants/rfprfi/RFPfiles/DDD%20FI-VFEA%20RFP_FINAL.pdf

3. The primary purpose of the Emergency Capacity Services Programs (ECS) Programs is to provide community residential/day supports for individuals with intellectual and/or developmental disabilities who are in need of immediate services due to homelessness or other emergent circumstances.
   i. On August 30, 2023, the Division of Developmental Disabilities (DDD) issued an RFP (Found here https://www.nj.gov/humanservices/providers/grants/rfprfi/RFPfiles/ECS%20RFP.pdf

ii. Through this RFP, two or more providers (which may include the currently-contracted providers who apply) will be awarded funding to operate eight existing Emergency Capacity Services (ECS) Programs.

C. Division of Aging (Jennifer Rutberg)
   1. New funding for counties to increase number of participants and increase funding to county offices. JACK – Need nursing home level of care, not on Medicaid, to access see county office on aging.
   2. For further questions contact Jennifer.Rutberg@dhs.nj.gov
   3. Ocean county Caregiver Coalition: www.OceanCareGivers.com
   4. Copies of PowerPoint materials previously shared by Division of Aging are available on request

D. Division of Juvenile Justice Commission (Francis Walker, Philomena DiNuzzo)
   1. New staffing/leadership at JJC, information forthcoming

E. Department of education
   1. Mental Health program, comprehensive Mental Health Resource guide. Free statewide training will be provided.
      https://ccsmh.rutgers.edu/njdoe/

F. Division of Vocational Rehabilitation Services (DVRS). No presentation

G. Department of Corrections (K. Connelly)
   1. The next Edna Mahan Correctional Facility Public Meeting is September 22 at 10:30am. The meeting can be accessed on the NJDOC homepage (state.nj.us/corrections) by clicking the banner link or using the following link: https://tinyurl.com/EMCFmeeting. Questions can be submitted ahead of time at https://bit.ly/EMCFsubmit.
   2. Link to Edna Mahan Correctional Facility Federal Monitor Reports: https://www.state.nj.us/corrections/FederalMonitorReports/index.shtml

V. Open Public Comment and Announcements Darlema Bey

A. Announcements
   1. NAMI NJ Walk, Middlesex Community College, 10/14/23
   2. DRNJ Conference Center of Mercer www.at4.nj.org

VI. Adjournment (11:44 am) Darlema Bey

A. Next meeting: 10/11/23

B. Future Agenda Items
   1. 2024-2025 Community Mental Health and Substance Use Prevention and Treatment Block Grants, Fiscal Tables, (Morris F)
   2. Quality Improvement Plan (QIP): (Connie Greene)
   3. Steve Crimando (Disaster & Terrorism)
   4. NJ Dept of Corrections: Criminal Justice System Overview, October 2023 (Krista Connelly)
   5. NJ DoE Threat Assessment Protocols

C. October 2023 Subcommittee Meetings

9:30 Membership

12:00 Advocacy

NEW JERSEY BEHAVIORAL HEALTH PLANNING COUNCIL
Minutes
April 12, 2022, 10:00 am

This meeting was conducted exclusively through MS Teams video teleconference & conference call

Notices of the meeting were sent to the Asbury Park Press, The Times (Trenton), Bergen Record, The Press (Pleasantville), and the Courier-Post (Cherry Hill).

Participants:

Darlema Bey (Chair)	Winifred Chain	Krista Connelly	Damian Petino
Francis Walker	Joe Gutstein	Barb Johnston	Diane Riley
Jennifer Rutberg	John Tkacz	Suzanne Smith	
Julia Barugel	Donna Migliorino	Chris Morrison	
Heather Simms	Michelle Madiou	Pamela Taylor	

DMHAS, CSOC. DDD, DMAHS & DoH Staff:

Nicholas Pecht	Mark Kruszczynski	Jonathan Sabin
Yunqing Li	Suzanne Borys	

Guests:

Nina Smuklawsky	Amanda Kolacy (alt)	Matt Camarda (NAMI)
Rachel Morgan (alt)	Nancy Edouard (alt)	Kurt Baker
Maurice Ingram (alt)	Mike Marotta (DRNJ, presenter)	

Minutes:

I. **Administrative Issues/Correspondence** (Darlema Bey)
   A. Attendance, 17/35, 48% attendance, quorum reached
   B. Minutes of March 2023 meeting approved.
   C. Solicitation for more members to consider running for election to Council Chair and Vice-Chair positions.

II. **Assistive Technology and how it can benefit people with Mental Health Concerns** (Mike Marotta, Disability Rights New Jersey (DRNJ))
   A. See PowerPoint sent to the Council on 04/12/23 and sharing during the presentation.
      1. bit.ly/atac-atia

   B. Presentation was Coordinated by John Tkacz from DVRS who holds the Public Health and Assistive Technology contract with Disability Rights New Jersey, John.Tkacz@dol.nj.gov

   C. Division of Aging has resources (tablets and training) for older adults.

D. Assistive Technology Advocacy Center (ATAC) https://at4nj.org/ offers free Learning Center, webinars/training, loan library/demo center, resource information and Goodwill home medical information.

E. Q&A:
1. Q: Resources for other items (e.g., automobiles). A: No, but DRNJ has an office to connect people to resources/referrals.
2. DRNJ are seeking an ethics trainer.

III. System Partner Updates

A. Children Systems of Care (Nick Pecht)
1. CSOC is implementing Project Connect in order to ensure youth are connected with CSOC services after an Emergency Department discharge following a suicide attempt or ideation. Goals include:
   a. Increase engagement in community mental health services after hospital discharge
   b. Reduce Emergency Department and Hospital admissions for suicide attempts
   c. Improved safety and well-being for youth and families
2. Two hospitals will pilot the program and we will be happy to provide further details at a future meeting.

B. Department of Education (Damian Petino & Maurice Ingram):
1. School Discipline Guidance https://www.nj.gov/education/specialed/programs/additionalsupports/behavior/index.shtml
2. Comprehensive School MH Coaching https://ccsmh.rutgers.edu/njdoe/ 4/14/23

C. Division of Senior Services (Jennifer Rutburg)
1. Rutgers University School of Social Work: Continuing Education, very actively designs and delivers customized webinar trainings,: Continuing Education | School of Social Work (rutgers.edu)

D. Department of Corrections (Krista Connelly)
1. Post pandemic operations are beginning to resume in the light of few/new outbreaks of Covid19.
2. Visitation protocols being revised.
3. Gov. Murphy has allowed funds for new, centrally located prison facility, with a focus on services, groups and treatment of incarcertated women.

E. Division of Developmental Disabilities (J. Sabin).
1. DDD is pleased to release its updated Residential, Day Program, and Support Coordinator COVID-19 Policy. The policy provides additional information and flexibility related to COVID-19 which include, but are not limited to:
   a. The option to move away from daily screening of individuals, staff, and visitors so long as all are made aware of Criteria and Actions related to exposure to, symptoms of, and positivity for COVID-19
   b. Residential settings are still required to monitor residents for sudden or emerging symptoms/signs of illness, which includes taking and recording their temperature.

c. Instruction to Support Coordinators on face-to-face visit requirements.
d. Continuation of the requirement for staff to be up-to-date with their COVID-19 vaccination or, if granted a medical or religious exemption, be tested once or twice weekly.
e. Continuation of masking recommendations from previous policy, as well as maintaining the option for a more restrictive policy.

2. Please see Residential, Day Program, and Support Coordinator COVID-19 Policy for complete information.
https://www.nj.gov/humanservices/ddd/documents/covid19-residential-and-day-program-screening-policy.pdf

3. Since the pandemic began, DDD has permitted Temporary Service Modifications regarding the relaxing of requirements for services to be delivered in-person and/or in community settings. These "flexibilities" include:
   a. Remote provision of services for Day Habilitation, classes, etc.
   b. Parent, Spouse, Guardian to be a Self-Directed Employee.
   c. For list of all Temporary Service Modifications, please visit
https://www.state.nj.us/humanservices/ddd/assets/documents/Temp-Service-Mod.pdf.

4. As the Federal Public Health Emergency (PHE) will now sunset on May 11, 2023, DDD will need to sunset some flexibilities on November 7, 2023.
   a. DDD has made policy changes to allow the following flexibilities to continue permanently:
   b. Remote provision of virtual classes through Goods and Services up to 12 hours per week.
   c. Allowance for Parent, Spouse, Guardian to be a Self-Directed Employee (SDE).
   d. The Division is reviewing making the allowance for SDE overtime permanent.

5. The following flexibilities will sunset on November 7, 2023:
   a. Remote/Virtual provision of DDD services outside of Classes through Goods and Services.
   b. Day habilitation occurring outside of daytime hours and on weekends. Includes remote/virtual services.
   c. Certain services to overlap. For example, remote day habilitation occurring at the same time as Individual Supports 15-minute increment.
   d. Support Coordinator Visits to be held remotely/virtually.Consumers should plan accordingly.

G. Division Of Vocational Rehabilitation (J. T. Tkacz): See above, Item II "Assistive Technology and how it can benefit people with Mental Health Concerns"

IV. Subcommittee Updates

A. By-laws:
   1. Importance of having leadership (Chair and vice-chair) of Council that represent both Serious Mental Illness and Substance Use Disorders.
   2. Advocating for members to get involved and possible run for Chair and Vice Chair.

B. Advocacy: Meeting 041213 1200.

V. Open Public Comment and Announcements Darlema Bey

A. None

VI. Adjournment Darlema Bey

A. Meeting adjourned.

B. Future Agenda Items

1. May 2023
    a. Jennifer R., Division of Aging Services
    b. Mark K. & Yunqing Li: WebBGAS tutorial

C. Next General Meeting May 10, 2022

Microsoft Teams meeting

Join on your computer or mobile app

Click here to join the meeting

Or call in (audio only)

+1 609-300-7196, PIN: 306216820#

1. Subcommittee meetings on 5/10/22
    a. 9:00 By Laws
    b. 12:00 Advocacy

NEW JERSEY BEHAVIORAL HEALTH PLANNING COUNCIL
Advocacy Committee
Minutes
April 12, 2022, 10:00 am

This meeting was conducted exclusively through MS Teams video teleconference & conference call

Participants:
Darlema Bey, Julia Barugel Matt Camarda, Bernadette Moore, Rachel Morgan, Mark Kruszczynski, Susanne Mills

I. Advocacy for Youth in Emergency Services

A. Follow-up on letter to Assistant Commissioners Mielke (DMHAS) and Assistant Commissioner Stephanie Mozgai (DoH).

NEW JERSEY BEHAVIORAL HEALTH PLANNING COUNCIL
Minutes
August 14, 10:00 am

This meeting was conducted exclusively through MS Teams video teleconference & conference call

Microsoft Teams meeting
Click here to join the meeting
Or Call in
+1 609-300-7196, PIN: 306216820#

Notices of the meeting were sent to the Asbury Park Press, The Times (Trenton), Bergen Record, The Press (Pleasantville), and the Courier-Post (Cherry Hill).

Participants:

Darlema Bey (Chair)	Connie.Greene (Vice Chair)	Michael Ippoliti	Shenal Pugh
Ann Marie Flory	Jennifer Rutberg	Francis Walker	Julia Barugel
Amanda Kolacy	Heather Simms	Donna Migliorino	Jonathan Sabin
Julia Barugel	David Moore	Krista Connelly	

DMHAS, CSOC. DDD, DMAHS & DoH Staff:

Nicholas Pecht	Brittany Thorne	Helen Staton
Mark Kruszczynski	Mike Colston	Suzanne Borys

Guests:

Kurt Baker	Nancy Edouard	Nina Smuklasky	Joe Cuffari
Eric McIntyre	Mike Marmota	Elena Kravitz	Cristine Chickadel

I. **Administrative Issues/Correspondence** (Darlema Bey)
   A. Attendance, 15/35, 42.8% attendance, quorum exceeded.
   B. Minutes of July 2023 General Meeting Approved

II. **Community Mental Health Block Grant Overview, Priority Indicators Substance Use Block Grant, and Children's System of Care**
   A. Adult Mental Health
      1. Review of WebBGAS login. https://bgas.samhsa.gov/ Username: citizennj, Password: citizen
      2. Review of Sections
      3. Review of Step 2: Additional Unmet Service Needs and Gaps FY24-25.
         a. Possible respite wraparound services (H. Simms)
         b. Outpatient restoration program for incarcerated populations (Ann Marie Flory, NJ DoH). DMM: Discussed possible technical assistance opportunity for this that her and Chris Morrison discussed this last week.

B. Substance Abuse Prevention Block Grant/ Substance Use Prevention Treatment & Recovery Supports (SUPTRS). Suzanne Borys

1. Indicators: All Step 2 Sections are in review with DMHAS Executive Management.
2. Environmental Factors, 11 Criteria
3. Treatment needs for alcoholism exceeded needs for heroin abuse.
4. Extensive gaps and needs sections (individuals with SUD).
5. Use of data

C. Children's System of Care (N. Pecht)

1.
2. Planning Step 2: Unmet Needs
   a. Integration of primary & mental health care
   b. Workforce challenges
   c. Need to expands service array to include youth under age of 5
3. Planning Step 3 Priority areas
   a. Primary & MH Integration
   b. ARC model
   c. 0-5 Helping Infants to Thrive program.

III. NJ ABLE Accounts (Achieving a Better Life Experience) Cristine Chickadel, NJ DVRS (Presentation shared with Planning Council prior to meeting in in PowerPoint During meeting)

A. Law passed in NJ 2016

B. NJ Part of NJ ABLE Alliance

C. NJ DVRS is to be a one location for consumers to get resources they need.

D. NJ ABLE Accounts do not get factored into Medicaid Means Testing

E. Eligibility

1. Disability present before age 26 (but in 2026 that onset age will be raised to 46)
2. Must be eligible for SSI, or blind, or have a similarly severe disability with written diagnosis from licensed physician.

F. Use of Funds: Qualified disability expenses, incurred a result of living with a disability and is intended to improve the quality of life.

1. Education, health and wellness, housing, transportation, legal fees, financial management, employment training and technology, personal support devices oversight and monitoring, funeral and burial expenses.

G. Special Tax Advantages

1. Earnings may compound federally, tax deferred

H. ABLE Accounts have no impact on consumers current benefits.

1. SSI: balances of $100k or less are excluded from SSI resource limit
2. Medicaid: ABLE resource are disregarded. NJ ABLE is subject to "Medicaid Payback" provision.

I. ABLE Facts

1. Beneficiary is account owner/the person with the disability
2. Can open an account in any states that allows outside residents (49, including Washington DC)

J. User Friendly!

K. Additional Contributions Above $17k "ABLE to work act".

L. How to enroll?

1. 1.888.609.8869
2. SavewithABLE.com

M. FAQs
   1. Who can open? Individuals with disabilities and caregivers
   2. ABLE savings do not affect HUD subsidies
   3. Advantages of NJ ABLE Account, verses Special Needs Trust/Pooled Income Trust fund/
N. Statements from ABLE Account Holder
O. Able Resources
   1. WWW.Ablenrc.org
   2. www.abletoday.org
P. Q&A
   1. Q: When will age limit increase from 26 to 46? A: in 2026.

IV. System Partner Updates Dept of Education (M. Ingram):

A. Children's System of Care (Nick Pecht)
   1. Zero to Five: Helping Children Thrive initiative
      a. DCF has goal for NJ residents be safe, healthy, and connected, CSOC has engaged in the, which has three major objectives:
         i. staff development among our MRSS and IIC partners to ensure we have a high-quality and competent workforce able to deliver developmentally appropriate interventions;
         ii. enhancing our integrated system of care for families of infants and young children, through collaboration with our partners; and
         iii. increasing our support for families by introducing them to parent-child interventions that promote the understanding of child development and well-being, as well as caregiver capacity.

      b. Staff development is ongoing: we have been focusing on workforce development before we roll out anything specific to serving youth ages 0-5 to ensure our partners are prepared and have the capacity to work with this population. Our partners at Montclair State University are continuing their efforts by launching the next round of trainings, including "Reflective Supervision/Consultation," and the "Clinical Practice Series in IECHM," this September.
      c. At the system level, a Mobile Practice Workgroup was convened and identified functions that may need to be adjusted or adapted to better support the 0-5 population; the Birth to Five Steering Committee will use these recommendations to inform next steps and to develop specific strategies or efforts to enhance cross-system collaboration in the field of infant mental health.

      d. This exciting initiative, though still in the learning phase and not yet implemented for service delivery, will enhance our system of care by providing families not only with the tools they need thrive, but also to hopefully avoid more costly downstream interventions.

B. Inspira (David Moore)
   1. Police Mental Health initiative to start in the fall of 2023.
   2. Hospital based violence intervention program to be starting.
   3. Diagnostic center in Woodbury, NJ to be opening up soon to support families in south Jersey dealing with autism.

C. DDD (Jonathan Sabin):

1. As part of the FY24 Budget, certain Fee-For-Service rates are increasing. The required Public Notice and impacted Rates were published on June 30, 2023. The new rates were implemented on July 8, 2023 via iRecord. For more information (including information on claiming and new Up-To Budget amounts) please review the following: https://www.state.nj.us/humanservices/ddd/documents/FY24_Rate_Increase.pdf

2. The Division of Developmental Disabilities has updated the policy and procedure manuals for our Home and Community Based Services (HCBS) waiver programs, the Community Care Program and Supports Program. You will find a summary of changes on page two of each manual (Community Care Program Policy Manual - https://www.state.nj.us/humanservices/ddd/assets/documents/community-care-program-policy-manual.pdf) (Supports Program Policy Manual - https://www.state.nj.us/humanservices/ddd/assets/documents/supports-program-policy-manual.pdf), and a detailed overview will be provided at the next DDD Update Webinar on August 24 (Register Now).

D. Division of Aging (Jennifer Rutberg)
    1. Not presentation available

E. Division of Juvenile Justice Commission (Francis Walker, Philomena DiNuzzo)
    1. Not available

F. Division of Vocational Rehabilitation Services (DVRS). No presentation

G. Department of Corrections (K. Connelly)
    1. Request for suggestions for locations for incarcerated populations to display their art.
    2. Solicitation of interest on presentation of the criminal justice system
    3. Link to Edna Mahan Correctional Facility Federal Monitor Reports: https://www.state.nj.us/corrections/FederalMonitorReports/index.shtml

V. Open Public Comment and Announcements Darlema Bey

A. Comments:
    1. NJ DoE Schools Threat Assessment Protocols.

Announcements
1. RWJ/Barnabas: Recovery Month, August 31, 2023. Wear Purple in September.
2. DMHAS Suicide Prevention Conference in October 19, 2023.
3. NAMI Walk, Middlesex Community College

VI. Adjournment Darlema Bey

A. Next meeting: 9/9/23

B. Future Agenda Items
    1. Fiscal Tables for Block Grant: September 2023, (Morris Friedman)
    2. Quality Improvement Plan (QIP): (Connie Greene)
    3. Steve Crimando (Disaster & Terrorism)
    5. NJ Dept of Corrections: Criminal Justice System Overview, October 2023 (Krista Connelly)
    6. NJ DoE Threat Assessment Protocols

C. September 2023 Subcommittee Meetings

9:30 Membership

12:00 Advocacy

NEW JERSEY BEHAVIORAL HEALTH PLANNING COUNCIL
Minutes
January 11, 2023, 10:00 am

This meeting was conducted exclusively through MS Teams video teleconference & conference call

Microsoft Teams meeting
Click here to join the meeting
Or Call in
+1 609-300-7196, PIN: 306216820#

Notices of the meeting were sent to the Asbury Park Press, The Times (Trenton), Bergen Record, The Press (Pleasantville), and the Courier-Post (Cherry Hill).

Participants:

Darlema Bey (Chair)	John Tkacz	Winifred Chain	Debra Wentz
Maurice Ingram	Julia Barugel	Suzanne Smith	Jennifer Rutberg
Harry Coe	Michael Ippoliti	Robin Weiss	Barbara Johnston
Heather Simms	Joe Gutstein	Diane Riley	Robert DePlatt
Tonia Ahern	Chris Morrison	Damian Petino	Michelle Madiou
Mark Kruszczynski			

DMHAS, CSOC. DDD, DMAHS & DoH Staff:

Yunqing Li	Nicholas Pecht	Brittany Thorne	Jonathan Sabin
Carlie Davis	Donna Blasdell (JBS Int.)		
Angie Jones (JBS Int.)			

Guests:

Rachel Morgan	Matt Camarda	Nina Smuklawsky
LeAnn DiBenedetto	Jaslean LaTalliade	Anne Smullen-Thieling

I. Administrative Issues/Correspondence (Darlema Bey)
- A. Attendance,20/35, 57.1% attendance, quorum reached
- B. Minutes of December 2022 General Meeting Approved
- C. Correspondence

II. Selection of Chair and Vice-Chair, Nominations Committee Darlema Bey
- A, Review of BHPC By-Laws, Article IV, Section 2 “Duties of Chair and Vice-Chair”
- B. Solicitation of Members of Nominations Committee: Harry Coe, Julia Barugel, John Tkacz
- C. Rachel Morgan indicated her interest/willingness to be a Member of the Planning Council. The membership committee will deliberate on forwarding her name to the Assistant Commissioner for Membership on the Council
- D. Nominations:

1. Julia Barugel

E. Vote will occur at the February 8, 2023 meeting of the Council.

III. State Opioid Response Grant (SOR): Evidence Based Practice Initiative [EBPI]
Angie Jones & Donna Blasdell (JBS International)
[See PowerPoint Presentation

A. PowerPoint

B. Q&A
1. Q: Will slides be available? A: Yes
2. Q: Are agencies required to participate in the EBPI? A: This is a voluntary initiative, but Carlie will check with V. Freslone.
3. Q: JBS =? JBS = Johnson, Bason and Shah.
4. Q: Can the list of providers participating in the EBPI be provided. A: Yes.
5. Q: Of the 87 agencies, are all counties represented? A: We might only be missing one or two. Q: Is Gloucester County Represented? A: Yes
6. Q: OMNI Outcome Data, how is it showed that consumers situation changed?
A: All practitioners take clinical knowledge assessment (baseline test) and then after the program they take it again.
Q: How are client outcomes measured? A: Consumer surveys are conducted
Q: How is fidelity to these EBPs measured? A: Fidelity monitoring forms are collected. If clinicians do not exceed 80% they are asked to take the training again.
Q: Nina Smuklavskiy of Stress Care recommends EBPI

C. Contact dbladsell@jbsinternational.com

IV. System Partner Updates Chairs of Subcommittees

A. Dept of Education (D. Petino and M. Ingram):
1. October / November 2022 the feds put out application for grant for School Based MH ($2.7M for five years, and matching state dollars), and NJ DoE has received it.
2. School Based MH Demonstration Grant has been applied for but grant was not received.

B. Children's System of Care (Nick Pecht)
1. Thanks to American Rescue Plan funding, the Children's System of Care is expanding its service array to include an exciting new pilot program. Intensive Mobile Treatment Services for youth with Intellectual or Developmental Disabilities, or IMTS-IDD, will deliver safe, stable, and therapeutically supported intensive treatment to DD eligible youth, age 5 to 20, with complex, challenging behavioral and/or co-occurring mental health needs (a mental health diagnosis is not required). The program will be available to youth in Bergen and Middlesex Counties but will serve youth in neighboring counties on a case-by-case basis. It is anticipated that the ITMS-IDD program will be fully operational by February 2023.
2. This program will meet the unique needs of youth who would otherwise be eligible for residential treatment by bringing intensive specialized services and supports into a youth's home and by engaging with the youth's caregiving system and natural supports. Consisting of behavioral, psychiatric, medical, and other experts and specialists, the IMTS-IDD team will, through an individualized and family-centered approach, assist the youth with acquiring, improving, and retaining the behavioral, relational, communication, and other skills needed to enhance relationships and increase independence and functioning. Services will be accessible 24/7 and consist of daily check points among the treatment team and with the family to assess the effectiveness of treatment interventions

and supports, making adjustments, as needed, to improve outcomes. Q: How does this differ from Mobile Response? A: Mobile Response is CSOC's short-term crisis intervention service, available to all youth. ITMS IDD provides the youth with I/DD needs and their family with a team of experts to help them reach their goals and prevent unnecessary residential treatments.

C. DDD (Jonathan Sabin)

3. We are pleased to share that in 2023 the Division will again administer the National Core Indicators (NCI) surveys for individuals and their families and guardians (https://www.nationalcoreindicators.org/). Beginning in this month, Division staff will begin outreach to individuals and families to request voluntary participation in one of the following surveys:
   - In-Person Survey
   - Adult Family Survey
   - Family/Guardian Survey

4. A wage increase for direct support professionals (DSPs) and supervisors was included in New Jersey's FY2023 Appropriations Act. It will be implemented January 1st via increases to the fee-for-service reimbursement rates for many services.

5. Beginning April 1, 2023 all States, including New Jersey, are required to resume their Medicaid Eligibility Processes. The Division recommends that stakeholders review this material, especially the Frequently Asked Questions found at the Community Toolkit (https://nj.gov/humanservices/dmahs/staycoverednj/toolkit/index.shtml).

6. Reminders for Service Providers on the HCBS Settings Final Rule:
   - March 2023 remains the deadline for compliance with Home and Community Based Services (HCBS) Settings Final Rule. Helpful information for Service Providers can be found here - https://nj.gov/humanservices/ddd/assets/documents/providers/DDD-Provider-Guide-to-HCBS-Settings-Rule-Final.pdf - This guide assists service providers with information, best practices, and examples to assist in HCBS compliance.
   - Additional information can be found at the Division of Medical Assistance and Health Services Statewide Transition Plan Website https://www.state.nj.us/humanservices/dmahs/info/hcbs_trans.html or at the Division's HCBS Statewide Transition Plan Website https://nj.gov/humanservices/ddd/providers/federalrequirements/hcbsplan/.

D. Division of Aging (Jennifer Rutberg)

1. Older Adult Anti-Social Isolation Efforts. Div. of Aging has free classes for older adults to take online learning classes. DHS purchased 50,000 classes on https://getsetup.io/partner/NJ for older adults (age 60 and older). Anyone with web access and speakers can participate. The best is when the person also has a microphone and camera, so they can interactively participate. The classes are LIVE, not recorded.

2. The idea is so that older adults who are socially isolated can be part of a group online that interests them. There are over 500 class topics, everything from sewing groups to fitness to caregiving to using an iPad. All classes are taught by older adults, so they are peer-led.

E. NJAMHAA (Debra Wentz)
   1. See https://www.NJAMHAA.org/events

F. NAMI-NJ (Matt Camarda): Looking at MH Care Through a Cultural Lens. A two-part series, 1/19/23, 10:00 am, and 2/9/23, 10:00 am.

V. Open Public Comment and Announcements Darlema Bey

A. Review of By-Laws and Committees
   1. Council members should review each area of its purview

B. Pre-Trial Services should be discussed/shared with the Council.

C. Retirement of Steve Fishbein from DMHAS.

D. Upcoming Training for Crisis Intervention Training (Veterans Response Team) in Atlantic City next week, based on a model in Delaware.

E. Announcement of Special Olympics Polar Bear Plunge, 1/14/23, Wildwood, NJ https://support.sonj.org/fundraiser/4255638

F. Crisis Intervention Training Information: CIT Training (R. Morgan) https://cit-nj.org/about/

G. SHA (D. Riley) , Section 8 Waitlist opens 1/17/23: https://www.nj.gov/dca/vouchers.html#:~:text=For%20DCA%2C%20the%20specified%20area,through%20a%20random%20lottery%20process

VI. Adjournment Darlema Bey

A. Request from Chair of Council to have members raise any possible statewide issues and/or challenges.

B. Next meeting: 2/8/23

Microsoft Teams meeting
Join on your computer or mobile app
Click here to join the meeting
Or call in (audio only): +1 609-300-7196, PIN# 306216820#

Subcommittee Meetings

9:00 Nominations

12:00 TBA

NEW JERSEY BEHAVIORAL HEALTH PLANNING COUNCIL
Minutes
February 8 2023, 10:00 am

This meeting was conducted exclusively through MS Teams video teleconference & conference call

Microsoft Teams meeting
Click here to join the meeting
Or Call in
+1 609-300-7196, PIN: 306216820#

Notices of the meeting were sent to the Asbury Park Press, The Times (Trenton), Bergen Record, The Press (Pleasantville), and the Courier-Post (Cherry Hill).

Participants:

Darlema Bey (Chair)	John Tkacz	Winifred Chain	Krista Connelly
Damian Petino	Julia Barugel	Suzanne Smith	Jennifer Rutberg
Harry Coe	Michael Ippoliti	Robin Weiss	Amanda Kolacy
Heather Simms	Joe Gutstein	Diane Riley	Filomena DiNuzzo
Chris Morrison	Michelle Madiou	Heather Simms	Tracy Maksel
Donna Migliorino	Connue Greene		

DMHAS, CSOC. DDD, DMAHS & DoH Staff:

Yunqing Li	Nicholas Pecht	Brittany Thorne	Jonathan Sabin
Suzanne Borys	Mark Kruszczynski		

Guests:

Rachel Morgan	Bernadette Moore	Nina Smuklawsky
Anne Smulllen-Theiling		

I. Administrative Issues/Correspondence (Darlema Bey)

- A. Attendance, 22/35, 62.8% attendance, quorum reached
- B. Minutes of January 2023 General Meeting Approved
- C. Correspondence
- D. Nominations Committee Darlema Bey
  1. Julia Barugel
  2. Other Nominations: None
  3. Results: Julia Barugel is elected to position of Vice-Chair of Planning Council, with a term that lasts until 6/30/23.
- E. Contacts: At request of Council MK will send out survey to members of Council to see if members would like for their emails to be available to the members of the Council.

II. Review of By-Laws

- A. [See by-laws dated October 2014]
- B. Comments:

1. Can word "consumer" be changed to reflect "person receiving services".
2. State plan is found at:
https://www.state.nj.us/humanservices/dmhas/publications/federal/FY%202020-21%20SAPT%20CMHS%20Block%20Grant%20Application%20Plan.pdf

3. Welcome To WebBGAS (samhsa.gov). The credentials are: Username: CitizenNJ Password: citizen

III. Technical Assistance

A. Topics: Block Grant 101
Councils Role
Effective Advocacy by the Council
Strategies to increase diversity among council membership
Strategies to recruit families of children with SED
Orientation Manual

IV. System Partner Updates Chairs of Subcommittees

A. Dept of Education (D. Petino and M. Ingram):
   1. School based mental health webinars:
      a. https://homeroom5.doe.state.nj.us/events/details.php?t=2;recid=40676 2/15/23,2:00 – 3:00.
      b. Announcement of Grant from US DOE regarding school based mental health https://www.nj.gov/education/news/2023/NJDOEReceives14MillionFederalGranttoSupportYouthMentalHealthEfforts.pdf
      c. Broadcast from DoE regarding psychiatric clearance. Announcement expected later today: https://www.nj.gov/education/broadcasts/
      d. https://at4nj.org/

B. Children's System of Care (Nick Pecht)
   1. Upcoming presentations expected
   2. Question: Would CSOC presentations be welcomed by the council? A: Yes!

C. DDD (Jonathan Sabin):
   1. A wage increase for direct support professionals (DSPs) and supervisors was included in New Jersey's FY2023 Appropriations Act. It will be implemented January 1st via increases to the fee-for-service reimbursement rates for many services.

   2. Reminders for Service Providers on the HCBS Settings Final Rule:
      a. March 2023 remains the deadline for compliance with Home and Community Based Services (HCBS) Settings Final Rule. Helpful information for Service Providers can be found here - https://nj.gov/humanservices/ddd/assets/documents/providers/DDD-Provider-Guide-to-HCBS-Settings-Rule-Final.pdf - This guide assists service providers with information, best practices, and examples to assist in HCBS compliance.

      b. Additional information can be found at the Division of Medical Assistance and Health Services Statewide Transition Plan Website https://www.state.nj.us/humanservices/dmahs/info/hcbs_trans.html or at the

Division's HCBS Statewide Transition Plan Website
https://nj.gov/humanservices/ddd/providers/federalrequirements/hcbsplan/.

1. March 2023 remains the deadline for compliance with Home and Community Based Services (HCBS) Settings Final Rule. Helpful information for Service Providers can be found here - https://nj.gov/humanservices/ddd/assets/documents/providers/DDD-Provider-Guide-to-HCBS-Settings-Rule-Final.pdf - This guide assists service providers with information, best practices, and examples to assist in HCBS compliance.

2. Additional information can be found at the Division of Medical Assistance and Health Services Statewide Transition Plan Website https://www.state.nj.us/humanservices/dmahs/info/hcbs_trans.html or at the Division's HCBS Statewide Transition Plan Website https://nj.gov/humanservices/ddd/providers/federalrequirements/hcbsplan/.

3. State Medicaid eligibility issues associated with the April 1, 2023 deadline:

D. Division of Aging (Jennifer Rutberg)
   1. Live online classes for seniors
   2. Claris tablets being distributed to improve access to the internet for those 60 yrs and older. Accessed via County Office on Aging. Technical support is available. Very "senior friendly" hardware, software and packaging.
   3. https://www.state.nj.us/humanservices/dds/resources/cntrindlivindex.html

E. Division of Vocational Rehabilitation Services (DVRS), John Tkcaz

F. Department of Corrections (Krista.Connelly@doc.nj.gov)
   1. Strict COVID-19 quarantine procedures still in place, but hopefully easing
   2. Regarding Edna Mahan Facility, it will be closed. There are plans regarding a new location for the women but not publically available yet.
   3. Solicitation for ideas for presentation from Dept. of Corrections.
   4. Possible presentation on Medication Assisted (substance use disorder) Treatment (MAT)

V. Open Public Comment and Announcements Darlema Bey

A. NJ SAMHSA Grantee CCBHC Lead Measures YE 6/20 3 & YE 6/21 and Family Satisfaction Survey (Agg. Results - Ancora, Ann Klein, Greystone, Trenton) e-mail joe@joegutstein.com

B. BRT Crisis Intervention Training. NJ is the third state in the nation. We are receiving technical assistance from Delaware.

VI. Adjournment Darlema Bey

A. Next meeting: 3/8/23

Microsoft Teams meeting
Join on your computer or mobile app
[Click here to join the meeting]
Or call in (audio only)
+1 609-300-7196, PIN: 306216820#

B. Future Agenda Items
1. Request for update on 988 program
2. April 2023: Assisted Technology & How it Can Benefit Mental Health Concerns
3. Request for content from Dept. of Corrections.

March 2023 Subcommittee Meetings

9:00 TBA

12:00 TBA

NEW JERSEY BEHAVIORAL HEALTH PLANNING COUNCIL
Minutes
July 14, 10:00 am

This meeting was conducted exclusively through MS Teams video teleconference & conference call

Microsoft Teams meeting
Click here to join the meeting
Or Call in
+1 609-300-7196, PIN: 306216820#

Notices of the meeting were sent to the Asbury Park Press, The Times (Trenton), Bergen Record, The Press (Pleasantville), and the Courier-Post (Cherry Hill).

Participants:

Darlema Bey (Chair)	Michael Ippoliti	Winifred Chain	Shenal Pugh
Suzanne Smith	Jennifer Rutberg	Harry Coe	Francis Walker
Amanda Kolacy	Heather Simms	Joe Gutstein	
Connie Greene (vice chair)	Donna Migliorino	Shelley Weiss	David Moore
Rachel Morgan	Nick Loizzi		

DMHAS, CSOC. DDD, DMAHS & DoH Staff:

Nicholas Pecht	Brittany Thorne	Helen Staton	Suzanne Borys
Yunqing Li	Mark Kruszczynski		

Guests:

Kurt Baker	Nancy Edouard	Nina Smuklasky	Joe Cuffari
Bernadette Moore	Filomena DiNuzzo		

I. **Administrative Issues/Correspondence** (Darlema Bey)
   A. Attendance, 17/35, 48.5% attendance, quorum exceeded.
   B. Minutes of June 2023 General Meeting Approved

II. **Community Mental Health Block Grant Overview, Priority Indicators Substance Use Block Grant, and Children's System of Care**
   A. Performance Indicators: Ideally there should be about 3 for each domain (Adult, SUD, Children's)
      1. We are trying to align our indicators with priority populations
      2. We are looking to eliminate one of the CSS indicators as it is duplicative. The current block grant has the following CSS indicators:
         a. Number served in CSS and
         b. Stability in Housing
      3. We are looking to just have one performance indicator for CSS. Stability in housing (consumers who remain in CSS in a SFY). The narrative also includes

the number served in CSS which is needed to determine the number of consumers who remain in CSS.

4. Medication adherence among consumers who need psychotropic medication for Coordinated Specialty Care.
    a. Comments:
        i. Tracking medication compliance is not a person-driven performance indicator.
        ii. Medication is one of many strategies utilized by a CSC team. This performance indicator is a continuation of an indicator from the previous plan. Early Psychosis is a priority population and we can continue to look at other indicators going forward for this program as we go live with the USTF+

5. Behavioral Health Crisis Services: One of the three areas championed by SAMHSA: call centers, mobile crisis outreach and crisis receiving stabilization centers.
    1. Indicator for call centers: Goal is 85% answer rate for 2024 and 90% answer rate for SFY2025. We were are at 77% in SFY22 and saw an increase to 79% in SFY 23 = 79%.

6. We are discussing the possibility of removing the cultural competency Indicator which has been in the MHBG for many years since we are adding an indicator for the behavioral health crisis population.

7. Information requested where the SAMHSA evidence-based practice be found: https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf

B. Substance Abuse Prevention Block Grant/ Substance Use Prevention Treatment & Recovery Supports (SUPTRS)
    1. All same indicators from last year.
    2. Five prevention indicators
        a. Tobacco use, 12-17
        b. Bing drinking among youth
        c. Marijuana use
        d. Decrease in percent of prescription opioid use.
        e. Heroin use
    3. Priority Population Indicators
        a. Pregnant women
        b. Intravenous drug users
        c. Opioid users
        c. Increase in MAT use
        e/ Tuberculosis populations

C. Children's System of Care (N. Pecht)
    1. Integration of physical and mental health of kids, by increasing Pediatric Psychiatric Collaborative (PCC). Pediatricians enroll in this. Increase # of pediatricians who make referrals to the system of care

2. Increase access to evidence based services and supports. To provide Attachment Regulation and Competency (ARC) model, and EBP, CSOC is looking to train 40 clinicians in year 1, then in year 2, ten of those clinicians will be trained to be able to train other clinicians (train the trainer model)
3. Expanding system capacity to better serve young youth (age 0 – 5). "Clinical practice Series in Early Childhood Mental Health". Part of "Zero to Five: Helping Families to Thrive). The indicator is 40 clinicians and supervisors in both year 1 and year two.

III. CCIS Building Capacity Initiative Diana.Salvador@dcf.nj.gov, CSOC Clinical Director., Dr. Mary Beinre, & Cynthia.Kaserkie@dcf.nj.gov , CCIS Clinical Capacity Improvement Project Program Lead:

A. Complex youth issues. Formal and informal consultation process (500 clinical consultations in 2022).
B. Goal is to do system overhaul.
C. Trends found:
   1. Acute care system is really struggling to meet the demands across NJ. Youth languishing in Emergency Rooms. Issue of kids hospitalized with intense needs who are discharge ready but have nowhere to do.

2. Issue is the CSOC does not contract with acute facilities (hospitals, screening centers).

D. CCIS
   1. Funding for screening centers, medical centers
   2. Goals
      a. Communication improvements: Medical Directors.
      b. Ensure that inpatient capacity (for youth and adolescents) can be created, to work with nine units to conduct needs assessment in the children's inpatient system. Funding made for local, state, and national experts to bring training resources to bear for 24/7 settings. Program begin at end of 2022 and should end in 2025. Several needs assessments will be conducted. Beginning, midway and end of project cycle.

IV. System Partner Updates Chairs of https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdfees

A. Dept of Education (M. Ingram):

B. Children's System of Care (Nick Pecht)

C. DDD (Jonathan Sabin):

D. Division of Aging (Jennifer Rutberg)
   1. Legislation was passed to start an Alzheimer's Long Term Commission.

E. Division of Juvenile Justice Commission (Francis Walker, Philomena DiNuzzo)
   1. JJC is having its Recovery Walk in September 2023. Dates to be announced.

F. Division of Vocational Rehabilitation Services (DVRS). No presentation

G. Department of Corrections (K. Connelly)

V. Open Public Comment and Announcements Darlema Bey

A. Comments:

1. Comment of concern of "social isolation" of people who work at home. Is anyone looking into this?

2. Online articles and resources
https://thelivproject.org/ .

https://thesunpapers.com/2023/07/02/letting-teens-known-theyre-not-a-burden/?amp&fbclid=IwAR2G8O0qkge9sZqp0gyH-UMakG3p0AGLAlW8AT3uZIrHE9m7wIpL3-Djg2U

3. Disaster and Terrorism MH training.

4. Housing. Discussion of "balanced billing". Concerns that landlords became aware of the State voucher programs, so they raised their rents. This puts increased housing stress on consumers.

B. Announcements

1. The Juvenile Justice Commission's "Recovery Walk" is October4, 2023. Save the date, more information will be available soon.

VI. Adjournment Darlema Bey

A. Next meeting: 8/9/23

B. Future Agenda Items

1. NJ ABLE Presentation 8/9/23.
1. Needs and Gaps: SUD, Connie Greene
2. Quality Improvement Plan (QIP): Connie Greene
3. Steve Crimando (Disaster & Terrorism)

Microsoft Teams meeting

Join on your computer or mobile app

Click here to join the meeting

Or call in (audio only)

+1 609-300-7196, PIN#: 306216820#

C. Future Agenda Items

1. Housing
2. 988 Update
3. Covid Supplemental Grant Initiatives Update

August 2023 Subcommittee Meetings

9:00	None
9:30	Block Grant
12:00	Advocacy

NEW JERSEY BEHAVIORAL HEALTH PLANNING COUNCIL
Minutes
June 14, 10:00 am

This meeting was conducted exclusively through MS Teams video teleconference & conference call

Microsoft Teams meeting
Click here to join the meeting
Or Call in
+1 609-300-7196, PIN: 306216820#

Notices of the meeting were sent to the Asbury Park Press, The Times (Trenton), Bergen Record, The Press (Pleasantville), and the Courier-Post (Cherry Hill).

Participants:

Darlema Bey (Chair)	Tracy Maksel	Maurice Ingram	Filomena DiNuzzo
Julia Barugel (Vice Chair)	Suzanne Smith	Jennifer Rutberg	Harry Coe
Amanda Kolacy	Heather Simms	Joe Gutstein	Krista Connelly
Shenal Pugh	Connie Greene	Donna Migliorino	Shelley Weiss

DMHAS, CSOC. DDD, DMAHS & DoH Staff:

Nicholas Pecht	Brittany Thorne	Jonathan Sabin	Helen Staton
Mark Kruszczynski	Suzanne Borys	Yunqing Li	

Guests:

Kurt Baker   Nancy Edouard   Nina Smuklasky   Matt Camarda   Eric.McIntire

I. **Administrative Issues/Correspondence** (Darlema Bey)
   A. Attendance, 15/35, 42% attendance, quorum exceeded.
   B. Minutes of May 2023 General Meeting Approved
   C. Correspondence, n/a
   E. Election of Candidates for Chair and Vice-Chair, each for a two-year term. (Chair of Nominations Committee: Harry Coe)
      1. Nominations Committee:
         a. Nominated Darlema Bey as candidate for Chair of Council.
         b. Nominated Connie Greene as candidate for Vice-Chair of Council.
      2. Nominations Committee Announcement of Candidates
         a. Chair: Darlema Bey
         b. Vice Chair: Connie Greene
      3. Nomination of Other Candidates
      4. Election for Chair, Two-year term (July 1, 2023 – June 30, 2025)
         a. Darlema Bey: 14 Votes, unanimous approval

      5. Election for Vice-Chair, Two-year term ((July 1, 2023 – June 30, 2025)

b. Connie Greene: 14 Votes, unanimous approval

II. Block Grant Update: New Guidance, Gaps in Services

A. New Guidance received from SAMHSA

B. Adult Mental Health

1. Critical Needs and Gaps
2. Membership Tables
    a. 50%< consumers/family members
    b. Desired constituent groups
3. Three domains of the Crisis Toolkit – required reporting in block grant
    i. 988 call centers (someone to talk to)
    ii. Mobile Outreach: Someone to respond),
    iii. Crisis Receiving Stabilization Centers (somewhere to go)
4. Yunqing Li & Brittany Thorne
    a. Compare SFY24 guidance with previous guidance
        i. Not much changes in structure
        ii. Content- notable emphasis on crisis services
    b. Components of Block Grant Application
        i. Four Steps
            - Strengths &Needs Service system
            - Unmet need and gaps
            - Prioritize state planning activities, target populations
            - Develop goals, objectives, strategies and performance indicators
        ii. Tables
            - Changes in 2 fiscal tables to include reporting for block grant supplemental funds (Covid Supplemental, American Rescue Plan Act (ARPA), and Bipartisan Safer Communities Act (BSCA))
            - Table 2 state agency planned expenditures
            - Table 6 Expenditures for System Development/Non-Direct-Service Activities
    c. Emphasis on Crisis Services: emphasized in all planning steps.
    d. Priority Populations for mental health block grant
        i. SMI
        ii. Children with SED
        iii. Older adults with SMI
        iv. SMI/SED rural and homeless populations
        v. Individuals in need of behavioral health crisis services
        vi. Individuals with Early Serious Mental Illness

    e. Environmental Factors, not much has changed except:
        i. Crisis services used to be requested for MH only, but in this block grant it is required for MH and requested for SUD
        ii. Early Serious Mental Illness required reporting for Coordinated Specialty Care/First Episode Psychosis.

    f. DMHAS has extended levels of care to eight levels of care
        i. Prevention and Early Intervention Services
        ii. Crisis Stabilization (less than 24 hours)
        iii. Diversionary services (24 hours or more)

iv. Acute care services
v. Peer recovery Supports
vi. Family Support services
vii. Treatment and rehab supports
viii. State and County psychiatric hospitals

g. Planning Tables
i. Covid 19 relief funds
ii. American Recovery Plan Act (ARPA)
iii. Bipartisan Safer Communities Act (BSCA)

5. Comments:
a. JB: Staffing gaps across the system of care. "In Monmouth County there are concerns about the development of the 988 crisis response. We have a very strong PESS/EISS model, we are concerned that we will be competing in contracts for other entities, and we already cannot staff existing positions. There is a concern that we will be competing for crisis response.
b. JB: 988 updates would be valuable at each meeting.
c. JB: Concerns regarding Family Support and concern of decreasing the numbers of families to less than a quarter of the families supported by CSOC.
d. JB: Concern of Threat assessment at schools, adequate resourcing
e. JG: The time spent in ER is horrible, looking at other patients receive care while one still waits. Concerns of [lack of] follow-up for people in ERs. Follow-up is a duty [of the system of care]. There is a real need for follow-up. "You just walk out, and no-one cares…" Concerns about dignity and respect for consumers in psychiatric care.
f. Comment of Joe Cuffari: Offered to speak offline with JG. The NJ Senate will be listening to a bill about expanding 72-hour commitment time frame to 144 hours. The bill is due to: no beds in certain areas, (so unfortunately judges discharge people who do have not received care). What is supposed to happen when someone is in crisis, they are not being linked with someone they can see on regular basis.
g. DMM Comment: We are working to bring additional crisis services on board including mobile outreach and Crisis Receiving and Stabilization Centers.
JB: Is the plan still for 5 centers?
DMM: Yes, the plan is still for 5 programs. The goal of these centers is to reduce the number of admissions to emergency rooms and inpatient settings and to provide linkages to services and supports in the community.
JB: Are the Crisis Receiving Stabilization Centers for youth as well?
DMM: These centers will be for ages 18 and older.
h. HSimms: Comment on NJ State Senate hearing. Respite facilities are not used while EDs are filled. Why aren't referrals coming into peer-run respite centers? We go to all SRC meetings and announce our services. They offer a high level of care, but there are few referrals.
i. Comment of Joe Cuffari: Challenge of homeless consumers.
j. Question of DB: How do we deal with housing? Answer of Suzanne B: SAMHSA is not paying for rent, case closed. Case management can be

supported however.

k. SSmith: Do we have end dates of the funding sources?
DMM: Yes, the Covid Supplemental funds expire 3/14/23 and the ARPA funds end 9/30/25. Many of the initiatives that have started with Covid Supplemental funding will continue with ARPA funding.

C. SUD SUPTRS Grant
1. Guidance received this morning
2. Opioid settlement portal
3. Comment: Connie Greene has some recommendations she will email us, that went into the Opioid settlement portal,

III. System Partner Updates Chairs of Subcommittees

A. Dept of Education (M. Ingram):
1. 7/10/23, 9:00 – 12:00 : Rethinking School Safety Panel, Burlington Township High School Performing Arts Center, 610 Fountain Avenue, Burlington, NJ, 08016.
https://www.nj.gov/education/broadcasts/2023/june/8/SchoolSafetySpeakerSeriesRethinkingSchoolSafetyAParentsPerspective.pdf

B. Children's System of Care (Nick Pecht)
1. As a result of increases in suicides and suicide attempts and the advocacy of our system partners, the Children's System of Care was granted the opportunity to work with the Educational Development Center (EDC) on Zero Suicide.

2. The foundational belief of Zero Suicide is that suicide deaths for individuals under the care of health and behavioral health systems are preventable. For systems dedicated to improving patient safety, Zero Suicide presents an aspirational challenge and practical framework for system-wide transformation toward safer suicide care.

3. Our partnership with EDC is a two-year investment, that started with the implementation of Zero Suicide within our Care Management and Family Support organizations as well as a handful of our out of home treatment programs. Year 2 looks to include teams from additional OOH organizations as well as the organizations that oversee our Mobile Response Stabilization Services.

4. As a result of working with the EDC to implement the Zero Suicide Framework, our partners have created and updated policies regarding suicide prevention, attempts, and protocols and some have engaged in agency-wide staff training, policy consultation, workforce readiness surveys, and piloted screening projects that regularly assess a youth's potential for suicidal thoughts or ideations, and, if identified, guide the youth onto a pathway that will build their resilience and coping skills, reducing risk and helping them to thrive. Some of our partners have also included individuals with living experience on their Zero Suicide teams. The Zero Suicide EDC website is zerosuicide.edc.org

1. CSOC observes increase in suicide and attempts.

a. CSOC granted opportunity to work with EDC on "Zero Suicide Initiative" a transformational approach that suicide is preventable. Presents an aspirational challenge and practical framework. Training and consultation is available. CSOC has two year partnership with ZSI. zerosuicide.edc.org

C. DDD (Jonathan Sabin):

1. Medicaid Unwinding
   a. From April 2023 through March 2024, the Division of Medical Assistance and Health Services (DMAHS) is required to conduct redeterminations for everyone enrolled on Medicaid/NJ Family Care. This is due to the end of the Federal Public Health Emergency.

   b. Monthly, DMAHS sends DDD a list of individuals enrolled in its programs (e.g.: Supports Program, Supports Program Plus Private Duty Nursing, or Community Care Program) who are due for their redetermination.

   c. When the Division receives each monthly list from DMAHS, Waiver Unit staff notify the assigned Support Coordinator of the impacted individual. The entire DDD Waiver Unit is involved in this project.

   d. General questions about the Unwinding can be sent to the Medicaid Eligibility HelpDesk (DDD.Medielighelpdesk@dhs.nj.gov).

2. The NCI-IDD State of the Workforce Survey 2022 (formerly called the Staff Stability Survey) In April 2023, provider agencies who employ direct support professionals received an invitation along with instructions from the Division of Developmental Disabilities (DDD) to participate in the National Core Indicators (NCI) State of the Workforce Survey for Calendar Year 2022 (https://idd.nationalcoreindicators.org/staff-providers/). Provider agencies can take part in the NCI State of the Workforce Survey through June 30, 2023. It is critical that we hear from as many members of the DDD Provider Community as possible to ensure valid results.

   Employee On-Boarding Extension: The Department of Human Services (DHS) Office of Program Integrity and Accountability (OPIA) will provide expedited approval of emergency hiring requests until further notice.

D. Division of Aging (Jennifer Rutberg)

1. Ready Seniors Workshop by FEMA: registration https://bit.ly/ReadySeniorsPassaic July 26th, 2023 9:00AM—4:00PM at Passaic County Police Academy, 214 Oldham Road Wayne, NJ. This in-person workshop is for emergency planners for nursing homes, mental and behavioral health services, assisted living facilities, senior community centers, senior housing, adult day care centers, home meal delivery services, charitable organizations, and others who provide services to senior citizens and those with disabilities, access and functional needs. Contact: deborah.costa@fema.dhs.gov

E. Division of Juvenile Justice Commission (Philomena DiNuzzo)

F. Division of Vocational Rehabilitation Services (DVRS). No presentation

G. Department of Corrections (K. Connelly)
  1. Adding DOC to list of agencies who find housing to be an issue and barrier for our patients who are released that receive MH and/or SUD services.
     All visitation guidelines have returned to pre-pandemic levels; however, visits still need to be scheduled in advance.

  2. NJDOC has partnered with a local Trenton Starbucks to offer a barista training program. The program takes place within a restaurant on Central Office Headquarters grounds, Mates' Inn, which is part of the culinary training program and provides lunches and special events. The first group of men are currently in training, which lasts 8 weeks.

  3. Under the Covid Public Health Emergency, the was an extensive decarceration effort, including several large-scale releases from DOC in a single day. Researchers from Rutgers and Johns Hopkins recently published a study showing that the risk of overdose and SUD-related death did *not* increase after these releases.

IV. Open Public Comment and Announcements Darlema Bey

A. COMCHO meeting to be rescheduled to 6/28/23. Looking to increase membership.

B. Concern of School-based threat assessment program putting undue stress on the children's acute mental health care.

V. Adjournment Darlema Bey

A. Next meeting: 7/14/23

B. Future Agenda Items
  1. Needs and Gaps: SUD, Connie Greene
  2. Quality Improvement Plan (QIP): Connie Greene

Microsoft Teams meeting

Join on your computer or mobile app

Click here to join the meeting

Or call in (audio only)

+1 609-300-7196, PIN: 306216820#

C. Future Agenda Items
  1. Housing
  2. 988 Update
  3. Covid Supplemental Grant Initiatives Update

July 2023 Subcommittee Meetings

9:00 TBD

9:30 MHBG Subcommittee

12:00 Advocacy

NEW JERSEY BEHAVIORAL HEALTH PLANNING COUNCIL
Minutes
March 9, 2022, 10:00 am

This meeting was conducted exclusively through MS Teams video teleconference & conference call

Notices of the meeting were sent to the Asbury Park Press, The Times (Trenton), Bergen Record, The Press (Pleasantville), and the Courier-Post (Cherry Hill).

Participants:

Darlema Bey (Chair)	Winifred Chain	Krista Connelly	Debra Wentz
Robin Weiss	Joe Gutstein	Amanda Kolacy	Connie Greene
Jennifer Rutberg	John Tkacz	Suzanne Smith	Maurice Ingram
Julia Barugel	Rachel Morgan	Donna Migliorino	Michael Ippoliti
Filomena DiNuzzo			

DMHAS, CSOC. DDD, DMAHS & DoH Staff:

Morris Friedman	Nicholas Pecht	Mark Kruszczynski	Jonathan Sabin
Yunqing Li	Suzanne Borys	Nadina Cryan	

Guests:

Nina Smuklawsky	Bernadette Moore	Matt Camarda (NAMI)	Bernadette Moore

Minutes:

I. Administrative Issues/Correspondence (Phil Lubitz)

Review of Previous Meeting Minutes

A. Attendance, 17/35, 48% attendance, quorum reached

B. Minutes of February 2023 meeting approved

II. SFY 2024 State Budget (Morris Friedman, DMHAS)

A. See PowerPoint sent to the Council on 030823 1054.

B. As always, the Divisions SFY24 budget is subject to change, prior to its finalization in the annual Appropriation Act that is expected to be signed before July 1, 2023.

. C. Questions and Answers

1. Q: Drawdown, $23M in SFY23 and $10M in SFY24.
   A: The rates will be the rates, and there will be ways to manage any issues.

2. Q: Please provide more details on the $13 million growth for State Aid."

3. Q: FMRs? Are we using the Small (HUD) level or county level FMRs? A: We always follow the HUD FMRs. For certain counties, that means that small area (zip-code based) rates are used while for others, the higher level county FMR's are used.

4. Q: Will there be an increased funding to compensate for the increased FMR? A: While maintaining housing capacity and keeping up with FMR's is a policy priority, that will be determined as the Division analyzes is spending plan during SFY24 and available resources.

5. Q: (NAMI NJ): Will there be any changes to 988 funding?
A: Response: No – there are no anticipated changes to 988 Funding. The Governor's proposed Budget for SFY24 reflects a continuation of the $12.8 million for 988 and $16 million for Mobile Response, for a total of$28M SFY24. Both line items are expected to be combined into one overall appropriation. In SFY23, the $12.8 million for 988 was included in the Division's Community Care appropriation.

III. System Partner Updates

A. Children Systems of Care (Nick Pecht)
   1. The Data Hub was developed collaboratively by the New Jersey Department of Children and Families and the Institute for Families at Rutgers University School of Social Work. Built upon the principles of transparency and accountability, the Data Hub seeks to improve the lives of children and families by making New Jersey child welfare and well-being data available to the public.

   2. The following reports are now in the Data Portal section of the Data Hub:
      a. Youth Open with CSOC in the Year
      b. Youth Receiving Mobile Response Stabilization in the Year
      c. Youth Receiving Intensive In-Community/Behavioral Assistance Services in the Year
      d. Youth Served by Family Support Organizations in the Year

   3. See: https://www.nj.gov/dcf/childdata/protection/hub/

B. Department of Education (Damian Petino): No presentations

C. Division of Senior Services (Jennifer Rutburg)
   1. Smart tablets for those age 65 and older, which includes web connection. In order to get one, speak to one's County Office on Aging (Contact DOAS@dhs.nj.gov if there is any issue)

D. Department of Corrections (Krista Connelly)
   1. Governor Murphy has announced a $90 million funding package to build a new women's facility. The new facility will be centrally located and will include lots of space for visitation, group activities, and other resources. There is no timeline yet, but we have already begun a transition period by moving women who aren't housed in any specialty units to a satellite facility, William H Fauver Youth Correctional Facility, which is a previously consolidated location that has been refurbished. Feedback from the women has been positive so far. The most recent Edna Mahan site inspection by the federal monitor went well, and the next one is scheduled for September.

E. Division of Developmental Disabilities (J. Sabin). No reports available

G. Division Of Vocational Rehabilitation Services (J. Tkacz):

1. The New Jersey Division of Vocational Rehabilitation (DVRS) and its State Rehabilitation Council (SRC) will be conducting virtual public forums during the month of April 2023 (see specific dates below).

3. DVRS is a division within the NJ Department of Labor and Workforce Development that provides services to eligible individuals with disabilities to achieve employment outcomes consistent with their strengths, priorities, needs, abilities and capabilities. T

4. The SRC provides oversight and advises the DVRS. The SRC is comprised of partnerships of people with disabilities, advocates and other interested persons, and it is committed to ensuring through policy development, implementation and advocacy that New Jersey has a rehabilitation program that is not only comprehensive and consumer- responsive but also effective, efficient and adequately funded.

5. Input during these forums helps develop the State Plan as mandated by the Workforce Innovation and Opportunity Act (WIOA), and assists in reviewing topical issues impacting consumers, vendor communication and dialogue with employers. Your voice is extremely important to both the DVRS and the SRC and will help to mold program delivery and policy to ensure that people with disabilities receive rehabilitation services that result in employment.

6. Representatives from the DVRS and the SRC will be available to provide information on available services, and to hear public comments and testimony.

7. Topics:
    a. While attendees will have the opportunity to make remarks on any topics from people with disabilities, family members of people with disabilities, educators and others about their lived experience with **transition planning and/or services**. We are hoping to have the opportunity to learn the areas of issues, concerns, strengths, and suggestions you may have about transition from school to work in our state generally, and as it pertains to DVRS specifically.

Location	Date	Time
Virtual	Date: April 11th, 2023 Registration Deadline: March 28th, 2023,	10:00 AM- 11:30 AM
Virtual	Date: April 11th, 2023 Registration Deadline: March 28th, 2023,	2:00 PM - 3:30 PM

    c. Online Registration closes on March 28th, 2023. You can register, leave comments and request accommodations on the Department of Labor and Workforce Development's website (public forum section).
    d. Website link is below: Click here to register. (If link is not opening automatically, please hold the ctrl button and click on link)

https://njdol.prod.simpligov.com/prod/portal/ShowWorkFlow/AnonymousEmbed/6c39c135-341b-408b-bd84-699abe23eda9

IV. Subcommittee Updates

A. By-laws: Council members are encouraged to sign up for upcoming by-laws Committee

B. Advocacy: About six months ago, the Committee sent a letter and discussed with Assistant Commissioners on DoH, DCF and DMHAS. Since then there has been little publically-visible movement.

V. Open Public Comment and Announcements Darlema Bey

A. NJAMHAA (Robert DePlatt, NJAMHAA)
NJAMHAA's position on the NJ Proposed SFY24 State Budget
https://www.insidernj.com/press-release/njamhaa-applauds-increased-funding-for-the-behavioral-healthcare-workforce-in-governor-murphys-proposed-fy2024-budget/

VI. Adjournment Darlema Bey

A. Meeting adjourned.

B. Future Agenda Items

1. April 2023: Assistive Technology and how it can benefit people with Mental Health Concerns

C. Next General Meeting April 12, 2022

Microsoft Teams meeting

Join on your computer or mobile app

Click here to join the meeting

Or call in (audio only)

+1 609-300-7196, PIN: 306216820#

1. Subcommittee meetings on 4/12/22
   a. 9:00
   b. 12:00

NEW JERSEY BEHAVIORAL HEALTH PLANNING COUNCIL
Minutes
May 10, 10:00 am

This meeting was conducted exclusively through MS Teams video teleconference & conference call

Microsoft Teams meeting
Click here to join the meeting
Or Call in
+1 609-300-7196, PIN: 306216820#

Notices of the meeting were sent to the Asbury Park Press, The Times (Trenton), Bergen Record, The Press (Pleasantville), and the Courier-Post (Cherry Hill).

Participants:

Darlema Bey (Chair)	John Tkacz	Winifred Chain	Maurice Ingram
Julia Barugel	Suzanne Smith	Jennifer Rutberg	Harry Coe
Amanda Kolacy	Heather Simms	Joe Gutstein	Filomena DiNuzzo
Michelle Madiou	Connie Greene	David Moore	Francis Walker
Heather Reid	Irina Stuchinsky	Kurt Baker	Nancy Edouard
Shelley Weiss	Shenal Pugh	Sucharitha Reddy	

DMHAS, CSOC. DDD, DMAHS & DoH Staff:

Nicholas Pecht　Brittany Thorne　Jonathan Sabin　Helen Staton

Guests:

Rachel Morgan　Bernadette Moore　Yamaris Figueroa

I. Administrative Issues/Correspondence (Darlema Bey)

A. Attendance, 23/35, 65.7%% attendance, quorum reached
B. Minutes of April 2023 General Meeting Approved
C. Correspondence
D. Nominations Committee Darlema Bey
  1. Connie Greene-Nominated for vice chair
  2. Elections will be done in the subcommittee meeting before the next BHPC

.

II. Review of By-Laws

A. [See by-laws dated October 2014]
B. Comments:
  1. Can word “consumer” be changed to reflect “person receiving services”.
  2. State plan is found at:

https://www.state.nj.us/humanservices/dmhas/publications/federal/FY%202020-21%20SAPT%20CMHS%20Block%20Grant%20Application%20Plan.pdf

3. Welcome To WebBGAS (samhsa.gov). The credentials are: Username: CitizenNJ Password: citizen
    - Mark-is possible to send out instructions on how to get to this particular portion on webBGAS. Print out and email to council.

III. Technical Assistance

A. Requested Topics: Block Grant 101
Councils Role
Effective Advocacy by the Council
Strategies to increase diversity among council membership
Strategies to recruit families of children with SED
Orientation Manual

IV. System Partner Updates Chairs of Subcommittees

A. Dept of Education (M. Ingram):
1. Awarded a grant
    a. 5/31/23-Statewide training for any educator at Camden County Community College. 6/1-6/2/23- Rutgers training
    b. https://www.nj.gov/education/broadcasts/2023/may/3/StatewideTrainingsonEnhancingMentalHealthServicesforStudents.pdf
    c. Project website includes info session https://ccsmh.rutgers.edu/njdoe/
    d. Project is 3 years long

B. Children's System of Care (Nick Pecht)
1. Children's System of Care make Community Resource Development funds available to all Care Management Organizations on an annual basis.
2. This year, have awarded nearly 950,000 dollars to fund 21 different programs across the state.

C. DDD (Jonathan Sabin):
1. On April 3, 2023, Governor Murphy released Executive Order 325. The release of this order affected the following high-risk congregate settings funded by the Division: Licensed Community Residences for Individuals with Intellectual and Developmental Disabilities (IDD); Certified Day Programs for Individuals with IDD; and Support Coordination Agency Staff

2. Executive Order 325 removed the following State COVID-19 vaccination mandates: Requirement that staff working in covered settings be up to-date with their COVID-19 vaccinations; and Requirement that staff who received a qualified medical or religious exemption from COVID-19 vaccination be tested once or twice weekly for COVID-19
    a. If you need additional details, please review Residential, Day Program, and Support Coordinator COVID-19 Policy at https://www.nj.gov/humanservices/ddd/documents/covid19-residential-and-day-program-screening-policy.pdf

    b. Reminder - The Federal Public Health Emergency will end on May 11, 2023

3. Self-Directed Employee Mandatory Training Requirement

a. The Division's Waiver Programs have requirements around staff training. These requirements are mandatory and apply to Direct Support Professionals and Self-Directed Employees (SDEs). These requirements are outlined in Appendix E of the Supports Program and Community Care Program Manuals and are found at the links below.

b. Supports Program - https://www.nj.gov/humanservices/ddd/assets/documents/supports-program-policy-manual.pdf

c. Community Care Program https://www.nj.gov/humanservices/ddd/documents/community-care-program-policy-manual.pdf

4. Fiscal Intermediary Update
   a. In 2016, the Department of Human Services (DHS) contracted with Public Partnerships, LLC (PPL) to provide fiscal intermediary services for three self-directed programs. These programs previously had separate contracts and vendors. The current fiscal intermediary contract ends in November 2023
   b. After reviewing operation of the consolidated contract, DHS has determined that program needs are best served through a different procurement approach. DHS will be re-procuring these services in three ways:
      i. DMAHS/Medicaid (Personal Preference Program) - Service provision will shift to managed care organizations (MCOs). Each MCO will provide or contract for fiscal intermediary services according to specific requirements defined and monitored by DMAHS.
      ii. Division of Developmental Disabilities (DDD) Vendor Fiscal/Employer Agent - DHS will issue a Request for Proposal (RFP) for the operation of this program
      iii. Division of Aging Services (DoAS) Jersey Assistance for Community Caregiving (JACC) - DHS will issue a Request for Proposal (RFP) for the operation of this program

D. Division of Aging (Jennifer Rutberg)
   1. Live online classes for seniors
   2. Overview about aging services, program guide online
   3. Aging.nj.gov

E. Division of Vocational Rehabilitation Services (DVRS), John Tkcaz

F. Department of Corrections (Krista.Connelly@doc.nj.gov)
   1. Strict COVID-19 quarantine procedures still in place, but hopefully easing
   2. Regarding Edna Mahan Facility, it will be closed. There are plans regarding a new location for the women but not publically available yet.
   3. Solicitation for ideas for presentation from Dept. of Corrections.
   4. Possible presentation on Medication Assisted (substance use disorder) Treatment (MAT)

V. Open Public Comment and Announcements Darlema Bey

A. Burlington County Children Services playing movie "My Sister Liv" on suicide prevention at 3 different locations

B. https://thelivproject.org/

VI. Adjournment Darlema Bey

A. Next meeting: 6/14/23

Microsoft Teams meeting

Join on your computer or mobile app

Click here to join the meeting

Or call in (audio only)

+1 609-300-7196, PIN: 306216820#

B. Future Agenda Items

1. SAMHSA Grant

June 2023 Subcommittee Meetings

9:00 Nominations
9:30 Block Grant
12:00 Membership

NEW JERSEY BEHAVIORAL HEALTH PLANNING COUNCIL
Minutes
October 13, 10:00 am

This meeting was conducted exclusively through MS Teams video teleconference & conference call

Microsoft Teams meeting
Click here to join the meeting
Or Call in
+1 609-300-7196, PIN: 306216820#

Notices of the meeting were sent to the Asbury Park Press, The Times (Trenton), Bergen Record, The Press (Pleasantville), and the Courier-Post (Cherry Hill).

Participants:

Darlema Bey (Chair)	Connie.Greene (Vice Chair)	Harry Coe
Laura Richter	Jennifer Rutberg	Maurice Ingram
Heather Simms	Mark Kruszczynski	Thomas Pyle
John Tkacz	Krista Connelly	Winifred Chain
Joseph Gutstein	Robin Weiss	Diane Riley
Steven Hirsch	Suzanne Smith	

DMHAS, CSOC. DDD, DMAHS & DoH Staff:

Nick Pecht	Brittany Thorne	Helen Staton
Brielle Easton		

Guests:

Nancy Edouard	Ellen Radis (AHP/SAMHSA)	Ann Denton (AHP/SAMHSA)
Damian Petino	Eric McIntyre	Bernadette Moore
Rachel Morgan	Nancy Edouard	Morgan Thompson

I. **Administrative Issues/Correspondence** (Darlema Bey)
   A. Attendance, 17/35, 48.57% attendance, quorum exceeded.
   B. Minutes of September 2023 General Meeting Approved
   C. Introduction of Ann Denton and Ellen Radis (AHD/SAMHSA) Upcoming Technical Assistance (TA) from SAMHA/Advocates for Human Potential
      1. Review of issues including: Roles and Responsibilities, Creating a diverse membership, Meeting protocols, etc.

II. **Climate Change – Behavioral Health Nexus**
   A. This presentation given to US DoE, US State Department
   B. See PowerPoint presentation shared with BHPC via ListSERV on 10/11/23
      1. Climate change is a scientific question, not a political one
   C. Q&A:
      1. Comment (TP): Caution on over-reliance on models

III. System Partner Updates

A. Children's System of Care (Nicholas Pect)

1. Request for Proposal for Youth Assertive Community Treatment

   a. Evidence-based and promising practices provide flexible, comprehensive, in-home treatment, rehabilitation, and support services to those youth ages 5 to 20 who are likely to experience psychiatric crises, and their families.

   b. Service goals include stabilizing youth so they may remain in their home, reducing the likelihood of inpatient psychiatric hospitalization and residential placement, and preventing youth from further decompensation and presentation at emergency rooms, psychiatric screening centers, and psychiatric inpatient units.

   c. DCF will fund one award to provide holistic care through two treatment teams, serving a total of 40 male and female youth and young adults in Cape May and Atlantic Counties. The multi-disciplinary treatment teams will be comprised of licensed therapists and psychiatric experts, supported by a team of other professionals, including those with lived experience as a family member

   d. In vivo community based and telehealth services will be available 7 days a week with a staff member on call 24/7, including outside of normal business hours, to address and stabilize emerging crises.

   e. Research demonstrates that the ACT model effectively reduces hospitalization, is no more expensive than traditional care, and is more satisfactory to youth and families than standard care.

   f. Responses to the RFP are due November 1, 2023. For more information on the bidding process, you can go to: https://www.nj.gov/dcf/providers/notices/requests/

   g. Questions should be directed to the dcf.askrfp@dcf.nj.gov e-mail.

B. DDD: No presentation given

C. Division of Aging (Jennifer Rutberg)

1. Be aware of how difference in temperature can effect the effacy and recommended dosages of medications
2. Impact of temperatures on individuals with Alzheimer's Disease
3. Open Enrollment season for Medicare
4. SHIP Program: https://NJ.gov/humanservices./doas/services/ship/
   Hotline: 1.800.792.8820
5. Recent award of three year grant, for Stressbusters for Family Caregivers"

D. Division of Juvenile Justice Commission: No presentation given

E. Department of Education (Damian Petino)

1. https://www.nj.gov/education/broadcasts
2. DoE was awarded $8.6M federal grant of Vocational Rehabilitation Services
   a. Goal of grant is to work closely with system partners around transition for students with disabilities into adulthood, competitive integrated

employment, integrated employment, jobs with at least the minimum wage, jobs integrated with non disabled persons.

b. Joann Johnson is the lead with the grant, assisted by D. Petino

c. Five year grant, many state partners involved

i. Transition related "hub", one-stop shop that holds information for all partners.

ii. Located in several parts of NJ (Edison, Pinelands, etc.)

3. BH Toolkits, Society for Prevention of Teen Suicide
4. https://sptsusa.org/behavioral-health-toolkit/

F. Division of Vocational Rehabilitation Services (DVRS). John Tkacz

1. October is Disability Awareness Employment Month (DEAM), to celebrate the accomplishments of individuals with disabilities in the workplace as well as those employers hiring people with disabilities

G. Department of Corrections (K. Connelly)

1. The most recent public meeting regarding Edna Mahan Correctional Facility was held Sept 22nd. A recording of the meeting can be found on the NJDOC website or at this link https://www.youtube.com/watch?v=9T5cQg43r6I.
   a. The first phase of the closure of the facility is expected to be complete by the end of October. About half of the women have been or will shortly be relocated to a satellite facility nearby.
   b. Once this is complete, approximately half of the existing Edna Mahan Facility will be closed. The budget signed by Governor Murphy includes $90 million for phase one of the construction of a new centrally located facility.
   c. Working groups with incarcerated women, several state agencies, and other stakeholders are ongoing to ensure progress is being made.

V. Open Public Comment and Announcements Darlema Bey

A. Announcements

1. (Rachel Morgan) 988 awareness campaign.
2. (R Morgan) Ride-along, $60M for two person teams, 24/7, 365 availability. Funding is through DMHAS.
   a. ARRIVE Together is a co-responder law enforcement and behavioral health professional co-responder model. It is a transformative and powerful model, de-escalating situations without use of force with a dramatic decrease in transport to the emergency department/room. The initiative is led by and directed by the NJ Attorney General's office in partnership with DHS the program has continued to expand since initiated and will be available in select municipalities in all 21 counties municipalities before the end of SFY2024.
3. SHA Conference, 11/3/23 (D.Riley), www.SHANJ.org Open to public (with registration), at the Palace, in Somerset NJ.
4. Autism NJ Conference in October
5. NAMI Walk, 10/20/23, 10am 2:00 pm, Middlesex Community College. www.Namiwalk.org

VI. Adjournment (11:44 am) Darlema Bey

A. Next meeting: 11/8/23

B. Future Agenda Items

1. 2024-2025 Community Mental Health and Substance Use Prevention and Treatment Block Grants, Fiscal Tables, (Morris F)
2. Quality Improvement Plan (QIP): (Connie Greene)
3. NJ Dept of Corrections: Criminal Justice System Overview, October 2023 (Krista Connelly)
4. NJ DoE Threat Assessment Protocols
5. Ride Together Presentation (see Rachel Morgan for details)

C. November 2023 Subcommittee Meetings

9:30 Membership
12:00 Advocacy

State of New Jersey

DEPARTMENT OF HUMAN SERVICES
NEW JERSEY COMMUNITY MENTAL HEALTH CITIZENS' ADVISORY BOARD
BEHAVIORAL HEALTH PLANNING COUNCIL[1]
5 COMMERCE WAY
HAMILTON, NEW JERSEY 08625

PHILIP D. MURPHY
Governor

SHEILA Y. OLIVER
Lt. Governor

SARAH ADELMAN
Commissioner

VALERIE L. MIELKE, MSW
Assistant Commissioner

August 24, 2023

Valerie L. Mielke, MSW
Assistant Commissioner
Division of Mental Health & Addiction Services
NJ Department of Human Services
5 Commerce Way
PO Box 362
Hamilton, NJ 08691

RE: Support of the NJ Behavioral Health Planning Council for the 2024-2025 Block Grant Application

Dear Mrs. Mielke:

On behalf of the New Jersey Behavioral Health Planning Council, I am pleased to support the Division of Mental Health and Addiction Services (DMHAS) in its application for funding under the Substance Abuse and Mental Health Services Administration's (SAMHSA) 2024-2025 Community Mental Health Services Plan and Substance Use Prevention, Treatment, & Recovery Services Block Grant (SUPTRS BG).

As the federally mandated planning body in the State, our membership is well aware of the need for continued enhancement of New Jersey's behavioral health system. This grant award will enhance the existing infrastructure and help individuals with Serious Mental Illness, Substance Use Disorders, and Serious Emotional Disturbances across the Garden State.

The Behavioral Health Planning Council is excited that New Jersey is seeking to continue its Block Grant funding to improve behavioral health services for the residents of New Jersey. I trust that SAMHSA will look favorably upon the State's application for funding.

Sincerely,

Darlema Bey

Darlema Bey
Chairperson

New Jersey Is An Equal Opportunity Employer

[1]The New Jersey Community Mental Health Citizens Advisory Board (created under NJSA 30:9A-2) and the Behavioral Health Planning Council (created under Title XIX, Part B, Subpart I, Section 1914 of the Public Health Service Act) are composed of a unique partnership of providers, consumers, and families of consumers. They serve as advocates and advisors to the Department for the development of behavioral health services in the community.

Environmental Factors and Plan

Advisory Council Members

For the Mental Health Block Grant, **there are specific agency representation requirements** for the State representatives. States MUST identify the individuals who are representing these state agencies.

State Education Agency
State Vocational Rehabilitation Agency
State Criminal Justice Agency
State Housing Agency
State Social Services Agency
State Health (MH) Agency.
State Medicaid Agency

Start Year: 2024 End Year: 2025

Name	Type of Membership*	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Donna Migliorino	State Employees	NJ Div. of Mental Health & Addiction Svc		
Damian Petino	State Employees	NJ Dept of Education	PH: 973-766-9331	Damian.Petino@doe.nj.gov
Tonia Ahern	Family Members of Individuals in Recovery (to include family members of adults with SMI)			
Julia Barugel	Family Members of Individuals in Recovery (to include family members of adults with SMI)			barugel@optonline.net
Darlema Bey	Family Members of Individuals in Recovery (to include family members of adults with SMI)			darlemabey@gmail.com
Winifred Chain	Family Members of Individuals in Recovery (to include family members of adults with SMI)			winifredchain@gmail.com
Harry Coe	Family Members of Individuals in Recovery (to include family members of adults with SMI)			harrybcoe@gmail.com
Krista Connelly	State Employees	NJ Dept of Corrections		
Maryanne Evanko	Family Members of Individuals in Recovery (to include family members of adults with SMI)			
Christina Fagan	Family Members of Individuals in Recovery (to include family members of adults with SMI)			
James Fowler	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Julian Fowler	State Employees		NJ Housing, Mortgage and Finance Agency Trenton NJ, 08611	jfowler@njhmfa.state.nj.us
	Individuals in Recovery (to include adults			

Joseph Gutstein	with SMI who are receiving, or have received, mental health services)			
Michael Ippoliti	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Barbara Johnston	Providers			
Scott Kelsey	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Nick Loizzi	Others (Advocates who are not State employees or providers)	NJ County Drug and Alcohol Directors Association		
Michele Madiou	Others (Advocates who are not State employees or providers)	NJ Association of Mental Health Administrators		
Tracy Maksel	Others (Advocates who are not State employees or providers)	Board of Freeholders OceanCounty Dept.Hum Srvcs		
Chris Morrison	State Employees			Chris.Morrison@doh.nj.gov
Lisa Negron	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Joanne Oppelt	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Nicholas Pecht	State Employees	NJ Dept of Children & Families		
Thomas Pyle	Family Members of Individuals in Recovery (to include family members of adults with SMI)			
Diane Riley	Others (Advocates who are not State employees or providers)	Supportive Housing Association of NJ	SHA NJ South Orange NJ, 07029	diane.riley@shanj.org
Jennifer Ruthberg	State Employees	NJ Div. of Aging Services		
Jonathan Sabin	State Employees	NJ Div. of Developental Disabilities		
Regina Sessoms	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Heather Simms	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			hsimms@cspnj.org
Suzanne Smith	Family Members of Individuals in Recovery (to include family members of adults with SMI)			STSSHS@aol.com
Marie Snyder	State Employees	NJ Division of Family Development (Social Services)		
Irina Stuchinsky	State Employees	NJ Div of Medical Asst & Health Srvcs		
Pamela Taylor	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			

John Tckacz	State Employees	NJ Division of Vocational Rehabilitation		
Richard Thompson	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Robin Weiss	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Debra Wentz	Providers	NJ Association of MH and Addiction Agencies	NJAMHAA Mercerville NJ, 08619 PH: 609-838-5488	dwentz@njamhaa.org

*Council members should be listed only once by type of membership and Agency/organization represented.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

The permanent representative from the Housing Agency (NJ Housing Mortgage and Finance Agency), has not been named, however, their alternate designee (Julian Fowler) has been indicated.

Environmental Factors and Plan

Advisory Council Composition by Member Type

Start Year: 2024 End Year: 2025

Type of Membership	Number	Percentage of Total Membership
Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	11	
Family Members of Individuals in Recovery (to include family members of adults with SMI)	9	
Parents of children with SED	0	
Vacancies (individual & family members)	0	
Others (Advocates who are not State employees or providers)	4	
Total Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services), Family Members and Others	**24**	**64.86%**
State Employees	11	
Providers	2	
Vacancies	0	
Total State Employees & Providers	**13**	**35.14%**
Individuals/Family Members from Diverse Racial and Ethnic Populations	5	
Individuals/Family Members from LGBTQI+ Populations	1	
Persons in recovery from or providing treatment for or advocating for SUD services	0	
Representatives from Federally Recognized Tribes	0	
Youth/adolescent representative (or member from an organization serving young people)	0	
Total Membership (Should count all members of the council)	**43**	

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

The NJ Behavioral Health Planning Council (BHPC) has a vacant position for a parent of a child with SED. This vacancy has been discussed at membership meetings and at the BHPC meetings. The NJ Department of Children and Families (DCF) Children's System of Care (CSOC) has reached out to contacts in attempts to recruit a parent member. Additionally, the SMHA has reached out to the three CSC providers in an attempt to recruit a parent of a child with SED. Without success, and looking for innovative recruitment strategies, BHPC and DMHAS requested technical assistance from SAMHSA for the BHPC. The BHPC is currently receiving technical assistance supported by SAMHSA from its representatives at the Advocates for Human Potential (AHP). One of the specific areas the BHPC is receiving technical assistance in, is how to foster a more diverse membership—including recruitment of members that have children with SED.

Environmental Factors and Plan

22. Public Comment on the State Plan - Required

Narrative Question

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. § 300x-51) requires, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?

a) Public meetings or hearings? (●) Yes ( ) No

b) Posting of the plan on the web for public comment? (●) Yes ( ) No

If yes, provide URL:

Public Access to Block Grant Applications (WebBGas): https://bgas.samhsa.gov/Module/BGAS/Users
User name: citizennj
Password: citizen

If yes for the previous plan year, was the final version posted for the previous year? Please provide that URL:

Public Access to Block Grant Applications (WebBGas): https://bgas.samhsa.gov/Module/BGAS/Users
User name: citizennj
Password: citizen

c) Other (e.g. public service announcements, print media) (●) Yes ( ) No

Please indicate areas of technical assistance needed related to this section.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

The attached Notice of Solicitation Comment was posted on the Division Mental Health and Addiction Services' website at https://www.nj.gov/humanservices/dmhas/provider/notices/.

The Notice was also published on August 10, 2023 in the following newspapers: Asbury Park Press, The Times of Trenton, Bergen Record, Press of Atlantic City, and the Camden Courier Post.

NOTICE OF SOLICITATION OF COMMENT

The Division of Mental Health and Addiction Services (DMHAS), within the New Jersey Department of Human Services, is soliciting comment on the Community Mental Health Services Block Grant and Substance Use Prevention, Treatment, and Recovery Services Block Grant FY 2024–2025 draft Application Plan from any interested person, including any Federal or other public agency, during the development and after submission of the application to the Federal Substance Abuse and Mental Health Services Administration.

Please email dmhas@dhs.nj.gov to receive login credentials to view the report as it is drafted and posted online.

Written comments concerning the State Application Plan can be sent to DMHAS at the email or postal address indicated below.

New Jersey Department of Human Services
Division of Mental Health and Addiction Services
P.O. Box 362
Trenton, NJ 08625-0362

Electronic Mail: dmhas@dhs.nj.gov

Environmental Factors and Plan

23. Syringe Services Program (SSP) - Required if planning for approved use of SUBG Funding for SSP in FY 24

Planning Period Start Date: 7/1/2023 Planning Period End Date: 6/30/2024

Narrative Question:

The Substance Abuse Prevention and Treatment Block Grant (SABG) restriction[1,2] on the use of federal funds for programs distributing sterile needles or syringes (referred to as syringe services programs (SSP)) was modified by the **Consolidated Appropriations Act**, 2018 (P.L. 115-141) signed by President Trump on March 23, 2018[3].

Section 520. *Notwithstanding any other provisions of this Act, no funds appropriated in this Act shall be used to purchase sterile needles or syringes for the hypodermic injection of any illegal drug: Provided, that such limitation does not apply to the use of funds for elements of a program other than making such purchases if the relevant State or local health department, in consultation with the Centers for Disease Control and Prevention, determines that the State or local jurisdiction, as applicable, is experiencing, or is at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, and such program is operating in accordance with State and local law.*

A state experiencing, or at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, (as determined by CDC), may propose to use SABG to fund elements of an SSP other than to purchase sterile needles or syringes. States interested in directing SABG funds to SSPs must provide the information requested below and receive approval from the State Project Officer. Please note that the term used in the SABG statute and regulation, *intravenous drug user* (IVDU) is being replaced for the purposes of this discussion by the term now used by the federal government, *persons who inject drugs* (PWID).

States may consider making SABG funds available to either one or more entities to establish elements of a SSP or to establish a relationship with an existing SSP. States should keep in mind the related PWID SABG authorizing legislation and implementing regulation requirements when developing its Plan, specifically, requirements to provide outreach to PWID, SUD treatment and recovery services for PWID, and to routinely collaborate with other healthcare providers, which may include HIV/STD clinics, public health providers, emergency departments, and mental health centers[4]. SAMHSA funds cannot be supplanted, in other words, used to fund an existing SSP so that state or other non-federal funds can then be used for another program.

In the first half of calendar year 2016, the federal government released three guidance documents regarding SSPs[5]: These documents can be found on the Hiv.gov website: **https://www.hiv.gov/federal-response/policies-issues/syringe-services-programs**,

1. **Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016** from The US Department of Health and Human Services, Office of HIV/AIDS and Infectious Disease Policy **https://www.samhsa.gov/sites/default/files/grants/ssp-guidance-for-hiv-grants.pdf** ,
2. **Centers for Disease Control and Prevention (CDC)Program Guidance for Implementing Certain Components of Syringe ServicesPrograms,2016** The Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention, Division of Hepatitis Prevention **http://www.cdc.gov/hiv/pdf/risk/cdc-hiv-syringe-exchange-services.pdf**,
3. **The Substance Abuse and Mental Health Services Administration (SAMHSA)-specific Guidance for States Requesting Use of Substance Abuse Prevention and Treatment Block Grant Funds to Implement SSPs** **http://www.samhsa.gov/sites/default/files/grants/ssp-guidance-state-block-grants.pdf** ,

Please refer to the guidance documents above and follow the steps below when requesting to direct FY 2021 funds to SSPs.

- **Step 1** - Request a Determination of Need from the CDC
- **Step 2** - Include request in the FFY 2021 Mini-Application to expend FFY 2020 - 2021 funds and support an existing SSP or establish a new SSP
  - Include proposed protocols, timeline for implementation, and overall budget
  - Submit planned expenditures and agency information on Table A listed below
- **Step 3** - Obtain State Project Officer Approval

Future years are subject to authorizing language in appropriations bills.

End Notes

[1] Section 1923 (b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-23(b)) and 45 CFR § 96.126(e) requires entities that receive SABG funds to provide substance use disorder (SUD) treatment services to PWID to also conduct outreach activities to encourage such persons to undergo SUD treatment. Any state or jurisdiction that plans to re-obligate FY 2020-2021 SABG funds previously made available such entities for the purposes of providing substance use disorder treatment services to PWID and outreach to such persons may submit a request via its plan to SAMHSA for the purpose of incorporating elements of a SSP in one or more such entities insofar as the plan request is applicable to the FY 2020-2021 SABG funds ***only*** and is consistent with guidance issued by SAMHSA.

[2] Section 1931(a(1)(F) of Title XIX, Part B, Subpart II of the Public Health Service (PHS) Act (42 U.S.C.§ 300x-31(a)(1)(F)) and 45 CFR § 96.135(a)(6) explicitly prohibits the use of SABG funds to provide PWID with hypodermic needles or syringes so that such persons may inject illegal drugs unless the Surgeon General of the United States determines that a demonstration needle exchange program would be effective in reducing injection drug use and the risk of HIV transmission to others. On February 23, 2011, the Secretary of the U.S. Department of Health and Human Services published a notice in the Federal Register (76 FR 10038) indicating that the Surgeon General of the United States had made a determination that syringe services programs, when part of a comprehensive HIV prevention strategy, play a critical role in preventing HIV among PWID, facilitate entry into SUD treatment and primary care, and do not increase the illicit use of drugs.

[3] Division H Departments of Labor, Health and Human Services and Education and Related Agencies, Title V General Provisions, Section 520 of the Consolidated Appropriations Act, 2018 (P.L. 115-141)

[4] Section 1924(a) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-24(a)) and 45 CFR § 96.127 requires entities that receives SABG funds to routinely make available, directly or through other public or nonprofit private entities, tuberculosis services as described in section 1924(b)(2) of the PHS Act to each person receiving SUD treatment and recovery services.

Section 1924(b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-24(b)) and 45 CFR 96.128 requires "designated states" as defined in Section 1924(b)(2) of the PHS Act to set- aside SABG funds to carry out 1 or more projects to make available early intervention services for HIV as defined in section 1924(b)(7)(B) at the sites at which persons are receiving SUD treatment and recovery services.

Section 1928(a) of Title XXI, Part B, Subpart II of the PHS Act (42 U.S.C. 300x-28(c)) and 45 CFR 96.132(c) requires states to ensure that substance abuse prevention and SUD treatment and recovery services providers coordinate such services with the provision of other services including, but not limited to, health services.

[5] ***Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016*** describes an SSP as a comprehensive prevention program for PWID that includes the provision of sterile needles, syringes and other drug preparation equipment and disposal services, and some or all the following services:

- Comprehensive HIV risk reduction counseling related to sexual and injection and/or prescription drug misuse;
- HIV, viral hepatitis, sexually transmitted diseases (STD), and tuberculosis (TB) screening;
- Provision of naloxone (Narcan?) to reverse opiate overdoses;
- Referral and linkage to HIV, viral hepatitis, STD, and TB prevention care and treatment services;
- Referral and linkage to hepatitis A virus and hepatitis B virus vaccinations; and
- Referral to SUD treatment and recovery services, primary medical care and mental health services.

Centers for Disease Control and Prevention (CDC) Program Guidance for Implementing Certain Components of Syringe Services Programs, 2016 includes a **description of the elements of an SSP** that can be supported with federal funds.

- Personnel (e.g., program staff, as well as staff for planning, monitoring, evaluation, and quality assurance);
- Supplies, exclusive of needles/syringes and devices solely used in the preparation of substances for illicit drug injection, e.g., cookers;
- Testing kits for HCV and HIV;
- Syringe disposal services (e.g., contract or other arrangement for disposal of bio- hazardous material);
- Navigation services to ensure linkage to HIV and viral hepatitis prevention, treatment and care services, including antiretroviral therapy for HCV and HIV, pre-exposure prophylaxis, post-exposure prophylaxis, prevention of mother to child transmission and partner services; HAV and

HBV vaccination, substance use disorder treatment, recovery support services and medical and mental health services;

- Provision of naloxone to reverse opioid overdoses
- Educational materials, including information about safer injection practices, overdose prevention and reversing an opioid overdose with naloxone, HIV and viral hepatitis prevention, treatment and care services, and mental health and substance use disorder treatment including medication-assisted treatment and recovery support services;
- Condoms to reduce sexual risk of sexual transmission of HIV, viral hepatitis, and other STDs;
- Communication and outreach activities; and
- Planning and non-research evaluation activities.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

New Jersey does not use SUBG funds to support Syringe Services Programs (SSPs).

Environmental Factors and Plan

Syringe Services Program (SSP) Information – Table A - Required if planning for approved use of SUBG Funding for SSP in FY 24

Planning Period Start Date: 7/1/2023 Planning Period End Date: 6/30/2024

Syringe Services Program (SSP) Agency Name	Main Address of SSP	Planned Dollar Amount of SUBG Funds to be Expended for SSP	SUD Treatment Provider (Yes or No)	# of locations (include any mobile location)	Naloxone Provider (Yes or No)
No Data Available					

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

New Jersey does not use SUBG funds to support Syringe Services Programs (SSPs).