I: State Information

State Information

Plan Year

Start Year:
2014

End Year:
2015

State SAPT DUNS Number

Number
806418257

Expiration Date

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, Information Systems and Technology

Mailing Address
222 South Warren Street, 4th Floor, Capital Place One, PO Box 700

City
Trenton

Zip Code
08625-0700

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

First Name
Suzanne

Last Name
Borys

Agency Name
Division of Mental Health and Addiction Services

Mailing Address
222 South Warren Street, 4th Floor, Capital Place One, PO Box 700

City
Trenton

Zip Code
08625-0700

Telephone
609-984-4050

Fax
609-341-2317

Email Address
Suzanne.Borys@dhs.state.nj.us

State CMHS DUNS Number

Number
806418257

Expiration Date

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

Agency Name

Division of Mental Health and Addiction Services

Organizational Unit

Office of Planning, Research, Evaluation, Information Systems and Technology

Mailing Address

222 South Warren Street, 4th Floor, Capital Place One, PO Box 700

City

Trenton

Zip Code

08625-0700

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

First Name

Donna

Last Name

Migliorino

Agency Name

Division of Mental Health and Addiction Services

Mailing Address

222 South Warren Street, 4th Floor, Capital Place One, PO Box 700

City

Trenton

Zip Code

08625-0700

Telephone

609-777-0669

Fax

609-341-2319

Email Address

Donna.Migliorino@dhs.state.nj.us

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

From

To

IV. Date Submitted

NOTE: this field will be automatically populated when the application is submitted.

Submission Date

Revision Date

V. Contact Person Responsible for Application Submission

First Name

Helen

Last Name

Staton

Telephone

609-633-8781

Fax

609-341-2317

Email Address

helen.staton@dhs.state.nj.us

Footnotes:

Children's Mental Health Planner - Geri Dietrich, Phone 609-888-7191, Fax 609-292-3743, Email Geri.Dietrich@dcf.state.nj.us
National Treatment Network Representative – Vicki Fresolone, Phone 609-777-0750, Fax 609-2312, Email Vicki.Fresolone@dhs.state.nj.us
National Prevention Network Representative – Donald Hallcom, Phone 609-984-4049, Fax 609-2315, Email Donald.Hallcom@dhs.state.nj.us

State of New Jersey
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MENTAL HEALTH AND ADDICTION SERVICES
222 SOUTH WARREN STREET
PO BOX 700
TRENTON, NJ 08625-0700

CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

JENNIFER VELEZ
Commissioner

LYNN A. KOVICH
Assistant Commissioner

August 21, 2013

Ms. Virginia Simmons
Supervisory Grants Management Specialist
Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 7-1109
Rockville, MD 20850

Re: 2014 SAPT and CMHS Block Grant Combined Application

Dear Ms. Simmons:

The State of New Jersey is pleased to submit the Fiscal Year 2014 Substance Abuse Prevention and Treatment (SAPT) and Community Mental Health Services (CMHS) Block Grant combined application. Our combined application has been submitted online through the Web-Based Block Grant Application System. Enclosed are the signed originals of the necessary Certifications, Assurances, and Funding Agreements.

Please contact me if you have any questions as I have been designated by the Governor with the signatory power and authority for the SAPT and CMHS Block Grant and recognized as the Single State Authority for Substance Abuse and the State Mental Health Authority. A copy of my designation letter is enclosed. I can be reached at (609) 777-0702.

Sincerely,

Lynn A. Kovich
Assistant Commissioner

Enclosures

New Jersey Is An Equal Opportunity Employer

State of New Jersey
OFFICE OF THE GOVERNOR
PO Box 001
TRENTON, NJ 08625-0001

CHRIS CHRISTIE
Governor

February 14, 2012

Lynn A. Kovich, Assistant Commissioner
Division of Mental Health and Addiction Services
Department of Human Services
Capital Center, 50 East State Street
PO Box 727
Trenton, NJ 08625-0727

Dear Ms. Kovich:

This letter delegates to you, in your capacity as Assistant Commissioner for the Division of Mental Health and Addiction Services within the New Jersey Department of Human Services, the authority to administer both the Substance Abuse Prevention and Treatment (SAPT) Block Grant and the Community Mental Health Services Block Grant. I specifically delegate to you, as the Assistant Commissioner, on behalf of the State of New Jersey, the authority to sign funding agreements and certifications, provide assurances of compliance to the Secretary of the U.S. Department of Human Services and to perform similar acts relevant to the administration of the SAPT Block Grant until such time as this delegation of authority is rescinded.

Sincerely,

Chris Christie
Governor

c: Virginia Simmons, SAMHSA
Marquitta Duvernay, SAMHSA

I: State Information

Assurance - Non-Construction Programs

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

Note: 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 nineteen 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 with the 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 of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

Name	Lynn A. Kovich
Title	Assistant Commissioner
Organization	Division of Mental Health and Addiction Services

---

Signature: _____ Date: _____

Footnotes:

I: State Information

Assurance - Non-Construction Programs

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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.
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17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

Name	Lynn A. Kovich
Title	Assistant Commissioner
Organization	Division of Mental Health and Addiction Services

Signature: _____ Date: 5/13/13

Footnotes:

I: State Information

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 45 CFR Part 76, and its principals:

a. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
b. have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
c. are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and
d. have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with subgrantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

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 45 CFR Part 76 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), ?, (d), ?, and (f).

For purposes of paragraph ? regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget

Department of Health and Human Services
200 Independence Avenue, S.W., Room 517-D
Washington, D.C. 20201

3. Certifications Regarding Lobbying

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 (45 CFR Part 93).

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)

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.

Name	Lynn A. Kovich
Title	Assistant Commissioner
Organization	Division of Mental Health and Addiction Services

---

Signature: _____ Date: _____

Footnotes:

I: State Information

Certifications

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b. have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
c. are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and
d. have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with subgrantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

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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), ?, (d), ?, and (f).

For purposes of paragraph ? regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget

Department of Health and Human Services
200 Independence Avenue, S.W., Room 517-D
Washington, D.C. 20201

3. Certifications Regarding Lobbying

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 (45 CFR Part 93).

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)

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.

Name	Lynn A. Kovich
Title	Assistant Commissioner
Organization	Division of Mental Health and Addiction Services

Signature: _____ Date: 8/13/13

Footnotes:

Chief Executive Officer's Funding Agreements (Form 3) - Fiscal Year 2014 [SA]

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
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

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.

Name of Chief Executive Officer (CEO) or Designee: Lynn A. Kovich

Title: Assistant Commissioner

Signature of CEO or Designee[1]: _____ Date: _____

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

Footnotes:

I: State Information

Chief Executive Officer's Funding Agreements (Form 3) - Fiscal Year 2014 [SA]

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Name of Chief Executive Officer (CEO) or Designee: Lynn A. Kovich

Title: Assistant Commissioner

Signature of CEO or Designee[1]:  Date: 8/13/13

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

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Chief Executive Officer's Funding Agreements (Form 3) - Fiscal Year 2014 [MH]

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Title XIX, Part B, Subpart I of the Public Health Service Act		
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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
Title XIX, Part B, Subpart III of the Public Health Service Act		
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Name of Chief Executive Officer (CEO) or Designee	Lynn A. Kovich
Title	Assistant Commissioner

Signature of CEO or Designee[1]: _____ Date: _____

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Name of Chief Executive Officer (CEO) or Designee	Lynn A. Kovich
Title	Assistant Commissioner

Signature of CEO or Designee[1]: _____ Date: 8/13/13

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

Footnotes:

I: 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	Lynn A. Kovich
Title	Assistant Commissioner
Organization	Division of Mental Health and Addiction Services

Signature: _____ Date: _____

Footnotes:

THIS FORM IS NOT APPLICABLE.

I: 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	Lynn A. Kovich
Title	Assistant Commissioner
Organization	Division of Mental Health and Addiction Services

Signature: _____ Date: 8/13/13

Footnotes:

THIS FORM IS NOT APPLICABLE.

II: Planning Steps

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

Narrative Question:

Provide an overview of the State's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health 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 SSA, the SMHA and other state agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, tribal, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic and sexual gender minorities.

Footnotes:

Planning Step 1: Assess the strengths and needs of the service system to address the specific populations

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

New Jersey manages the public behavioral health system separately for adult and children services. The adult and children's mental health systems were separated in 2006 for those programs that served children only. The Children's Crisis Intervention Services (CCIS) and blended mental health programs (serving both children and adults) are still under the purview of DMHAS. The substance abuse programs that serve children under 18 years were transferred in July 2013. Specifically, 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) Division of Children's System of Care.

The DHS serves more than one million of New Jersey's most vulnerable citizens, or about one of every eight New Jersey residents. DHS serves individuals and families with low incomes, people with mental illnesses and/or substance abuse issues, developmental disabilities, late-onset disabilities, the blind, visually impaired, deaf, hard of hearing, or deaf-blind, and most recently, 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 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; Division of Aging Services; and DMHAS. DHS also provides many support systems for the families served by DCF.

In 2011, DHS merged its Division of Mental Health Services and the Division of Addiction Services into DMHAS. DHS formed the Merger Advisory Council (MAC) as a consulting body to advise the Department on key issues related to the merger of the two divisions. The MAC had representatives from several DHS divisions, the Community Mental Health Citizen's Advisory Board and Mental Health Planning Council, and other consumer stakeholder agencies. The MAC was formed to get input on the division merger and to distribute information on the merger to different stakeholder groups. Based on a recommendation of the MAC, the state convened seven consumer forums and, during the forums, spoke with approximately 250 consumers to hear their concerns and feedback regarding the merger

The merger provides 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 of August 2013, all offices are now co-located into one building with the exception of our Intoxicated Driving Program. The Assistant Commissioner, and former member of the Mental

Health Planning Council, was appointed in the summer of 2011 to lead the combined Division. In March 2012 an Assistant Director for Research, Planning and Evaluation was appointed so all behavioral health planning and research activities are coordinated through this office, which also includes the preparation of this block grant application. In December 2012, this office was expanded to include information systems and technology.

In 2004, legislation created the Office of Children's Services within DHS. This Office acted as a single umbrella over three Divisions most concerned with children's welfare: the Division of Youth and Family Services (DYFS - the state's child welfare agency) and two new Divisions, the Division of Child Behavioral Health Services (DCBHS – the state's child behavioral/mental health agency), and the Division of Prevention and Community Partnerships (DPCP). An Office of Training was also created as a vital component of the Office of Children's Services.

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 DYFS, DCBHS, DPCP, the Office of Education and the New Jersey Child Welfare Training Academy.

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 transition of these services to DCF's Division of Children's System of Care (DCSOC) from DHS began January 1, 2013. The bill also established and renamed four divisions within DCF. 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 Division of Children's System of Care (DCSOC) 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 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.

II. Overview of the Public Behavioral Health System

Substance Abuse Services

DMHAS is the Single State Authority (SSA) on substance abuse in New Jersey. Between the Substance Abuse Prevention and Treatment (SAPT) Block Grant and other federal and state resources, in FFY 2012 and 2013, the SSA funds: a) 17 community-based prevention coalitions

for the provision of prevention programs with a focus on environmental strategies, b) over 60 community-based prevention providers that offer a variety of evidence-based curricula, c) two state institutions of higher education for early intervention services, Rutgers University and William Paterson University d) two intensive supported housing programs, e) a 24-hour Addictions Hotline, f) two non-profit corporations for the operation of recovery support centers, Recovery Center at Eva's Village and Living Proof Recovery Center, g) tobacco cessation services, h) a workforce development initiative, and i) 21 county governments for the provision of services throughout the continuum of care. As of June 2013, there were 209 licensed outpatient providers accounting for 305 sites and 38 licensed residential providers accounting for 66 sites delivering substance abuse treatment services.

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 DUI who meet diagnostic criteria for treatment through the 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 American Society for Addiction Medicine Patient Placement Criteria, 2nd Revised Edition (ASAM PPC-2R).

In Calendar Year 2012, there were 75,754 substance abuse treatment admissions and 73,416 discharges reported to the SSA through its New Jersey Substance Abuse Monitoring System (NJ-SAMS). Of these admissions, 53,713 were unduplicated. For primary drug at admission, 44% reported heroin and other opiates and 31% reported alcohol. Methadone was planned to be used in treatment for 11% and Suboxone for 7% of the clients. Most admissions were to outpatient care (28%), followed by intensive outpatient care (22%). Regarding age, 5% were under 18 years old, 11% were 18-21 years old, 29% were 22-29 years old, 50% were 30 to 54 years old and 6% were over 55 years old. For race/ethnicity, 64% were white, 22% were black and 14% were of Hispanic origin. About half of the clients did not have insurance at admission (50%).

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 operates three non-forensic, regionally-based, adult psychiatric hospitals, one adult forensic hospital, and contracts with approximately 120 not-for-profit community provider agencies. In addition to its network of state psychiatric hospitals and contracted community providers, five county-operated psychiatric facilities function as part of the continuum of services and receive most of their funding from the SMHA.

New Jersey's21 counties are organized into three mental health service regions; North, Central, and South. Each county has a Mental Health Board that is staffed by a Mental Health

Administrator. The Boards advise the SMHA and the Mental Health Planning Council of issues and programs that are of significance to their locale and residents. In each county, an Acute Care 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, 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. In addition, 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 three levels of care in each county: (1) acute care programs and crisis stabilization; (2) intermediate care and rehabilitation; and (3) extended/ongoing support programs. The SMHA contracts for statewide, regional and county/local behavioral health services. Statewide contracted services include services for specialty populations such as: Statewide Clinical Consultation and Training (SCCAT) program which provides consultation and training to our hospital and community provider community 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; *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: Mental Health Cultural Competence Training Centers to provide training and information to providers regarding cultural competence, co-occurring inpatient services for individuals with substance use disorders and a mental illness, and housing for specialty populations.

In SFY 2011, the SMHA served 285,217 unduplicated adult consumers in community settings—including county hospitals and STCFs, of whom 122,852 or 43.1% were Seriously Mentally Ill (SMI). Although complete FY 2012 USTF data is unavailable at the time of writing, the number of unduplicated consumers served in community agencies, county hospitals and short term care facilities in the first three quarters of SFY 2012 (spanning the time period from July 1, 2011 to March 31, 2012) is 286,885, of whom, 122,333 or 42.6% were SMI. If county hospitals were excluded, then 278,107 unduplicated adults were provided services in the community in the first three quarters of SFY 2012, of whom 114,352 or 41.1% were SMI.

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 abuse disorders, hearing impairment, developmental disabilities, and criminal justice involvement. Many of the activities of the SMHA focus on inter-organizational coordination and collaboration to improve access by special needs populations. This is achieved through interface

with the various divisions within the DHS including the Division of Developmental Disabilities, 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 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 with the Department of Corrections.

Children's Behavioral Health Services

Currently the Division of Children's System of Care (DCSOC) within the DCF is responsible for providing mental health services to children. Planning has been underway the past year to transfer the management of programs for youth who are under 18 and have substance use disorders to the DCSOC. The bulk of these programs were transferred in July 2013. The next transfer will be for young adults 18 to 21 years old who have substance abuse disorders. However, young adults needing methadone treatment and those mandated to Drug Court or requiring state psychiatric hospitalization will remain with DMHAS. Finally, the children currently remaining in the SMHA "blended" programs, i.e., those serving both adults and children, will be transferred. However, children requiring Children's Crisis Intervention Services (CCIS) and emergency services will be served by the SMHA. Cost modeling has been completed and funds were transferred from DMHAS to DCF to serve the additional populations transferred.

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

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 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 abuse treatment provider agencies for quality assurance and compliance with required assessment and treatment protocols and for other contractual requirements.

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 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. 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 substance abusers and addicts. Originally, the scope of these plans was limited to the needs of alcoholics. 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 illicit drug users and addicts. 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, DMHAS oversees county comprehensive planning in a 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 DMHAS 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. DMHAS has also launching an education, training, and technical assistance initiative for county planners in conjunction with the continuing education department of Rutgers, The State University of New Jersey. Planners who successfully complete the program will earn a Certificate in Community-Based Planning issued by the Rutgers School of Social Work.

The current county planning activities focus on the period between 2015 and 2018. As federal and state governments implement the Affordable Care Act and New Jersey implements 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 and mental health disorders. Thus, the county Mental Health Administrators have been invited to participate in the community-based planning certificate program 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.

New Jersey's 21 counties are organized into three mental health service regions; north, central, and south. Each county has a mental health board that is staffed by a mental health administrator. The boards advise the SMHA and the Mental 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 Mental Health Planning Council.

IV. 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 the SMHA 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 Mental 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: the development of a Behavioral Health Administrative Service Organization (ASO)/Managed Behavioral Health Organization (MBHO), transitioning of services for consumers with the dual diagnosis of Intellectual/Developmental Disorders and Behavioral Health Disorders from the Medicaid Managed Care Organizations to the new ASO/MBHO, and Managed Long Term Services and Supports (MLTSS) and the development of Behavioral Health Home (BHH) Services.

The DHMAS and DMAHS will be issuing a Request for Proposals (RFP) jointly to procure the ASO/MBHO. The ASO will manage Medicaid funding, state only and block grant funded behavioral health programs. The two Divisions have collaborated on the design and authored that RFP jointly. The Health Home SPA is also being developed jointly and both partners will have responsibilities for implementation of the service upon approval of the SPA. The SSA and DMHAS are also collaborating on the implementation of the Medication Assisted Treatment Initiative (MATI) program component of the Waiver. Behavioral health services for MLTSS participants will be carved in to the Managed Care Organizations and will not be managed by the ASO/MBHO. The DMHAS is working with DMAHS and the Division on Aging Services (DoAs) to develop the behavioral health requirements for MLTSS.

In collaboration with Medicaid, the SMHA initiated work on a disease management program with the goal of educating physicians in the Best Practices of prescribing medications to mental health consumers. The SMHA launched this as a pilot program with Medicaid and the Department of Health (DOH) to coordinate and provide primary medical care services between a community mental health program and a federally qualified health center (FQHC), thus meeting a consumer's mental health care needs in a primary health care facility (the FQHC). The pilot phase has ended, and due to its success, this program continues on its own without DMHAS

funding. This program (Greater Trenton) is still operating as described, and is now one of four mental health agencies that are being funded by a SAMHSA Primary and Behavioral Health Care Integration Grant to coordinate with FQHCs for primary care services. The grant, which is in the first year, has consumers being medically screened and referred to the local FQHC by a nurse care manager situated at the mental health agency. This is combined with wellness activities in the mental health program.

Department of Human Services, Division of Developmental Disabilities (DDD). SMHA staff collaborates with DDD staff regarding discharge planning of dually diagnosed consumers with both intellectual developmental disabilities and mental illness (DD/MI) in the state psychiatric hospitals. Staff from DDD are also members of the Mental Health Planning Council. As a result of this collaboration, SMHA and DDD staff has developed an RFP process to promote the development of community-based supportive housing opportunities and other support services for DDD service eligible patients residing in our state hospitals. The Division plans to utilize this RFP process to develop the resources to facilitate the discharge of 20 DD/MI consumers from our state hospital system during this calendar year. The DD/MI consumers for this initiative will be jointly chosen by SMHA and DDD staff. In March 2012, the Commissioner of DHS re-convened the Task Force on Developmental Disabilities (DD)/Mental Illness (MI) to present and review the following: plans to be implemented in the state FY 2013 budget for the transfer of the responsibility for the delivery services for developmentally disabled children and youth through age 21 from DHS to DCF; the outline and status of the Medicaid Comprehensive Waiver Application presented to CMS by the state; and plans to develop a Medicaid healthcare system operated by an ASO/MBHO system (managed by an agency yet to be determined through an RFP process) that would coordinate and provide Medicaid reimbursement for the delivery of behavioral health and physical health services to eligible individuals who are DD and/or MI consumers throughout the state. As a result of this meeting, Task Force members were asked for their feedback and have continued to provide feedback and recommendations regarding all of these initiatives.

In October 2012, the SMHA convened an intellectual developmental disabilities/DD and MI/SUD Treatment Work Group, comprised of Medicaid Comprehensive Waiver Behavioral Health Stakeholder Steering Committee members, families, and other DD/MI service providers and DDD staff, to review and provide recommendations to the SMHA regarding how best to develop a Specialized/Preferred Provider Network to treat individuals with I/DD and MI and/or substance use disorders. These recommendations are being used to: develop Network Provider Criteria and Competencies; and develop a specialized array of Behavioral Health Services for individuals with I/DD and MI and/or SUD.

Department of Children and Families. Interdivisional and interdepartmental collaboration between DMHAS and the DCF DCSOC is frequent. Executive Staff from each division have collaborated to make system recommendations for youth with mental illness and families currently served in the DCSOC 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 DCSOC attend monthly Mental Health Planning Council meetings to better coordinate services.

Treatment for parents with substance use disorders is currently addressed via a Memorandum of Understanding between the SSA and DCF Division of Child Protection & Permanency (DCP&P). The SSA coordinates its efforts with those of DCF to provide more effective and far-reaching services while minimizing unnecessary service duplication. As part of the Child Welfare Reform, the DCF will continue to provide funding to the SSA to support an initiative for gender specific treatment with specialized services in all modalities of care to women with dependent children and parents who are at risk of losing custody of their young children due to the abuse or neglect of these children resulting from, or aggravated by their substance abuse.

Department of Health. Chaired by the SMHA Medical Director, the Primary Care and Behavioral Health Care Task Force is examining the specific causative factors for early mortality, most of which is related to potentially preventable risk factors that shorten life expectancy (e.g., smoking, lack of exercise, poor nutrition, substance use, and exposure to communicable diseases). The main goal of the Task Force is to increase access to primary care and improve collaboration between mental health agencies and health care providers. In addition, the aim of the Task Force was to address the co-morbidity issues experienced by persons with SMI and to address disparities in primary health indicators among SMI and non-SMI populations[1]. The SMHA implemented this task force as an essential component of its Wellness and Recovery Transformation Action Plan (see http://www.state.nj.us/humanservices/dmhs/recovery/Welln_Recov_action_plan_jan2008_Dec2010.pdf). This Task Force and its subcommittees included consumers, family members and medical professionals. There were three subcommittees: 1. Integration of Behavioral Health and Primary Care; 2. Promotion of Consumer Self-Management; and 3. Morbidity and Mortality Surveillance. The goal of this Task Force is to provide recommendations that will improve the care and integration of mental health consumers for both physical and mental health. The recommendations from the Primary Care and Behavioral Health Care Task Force are expected to be completed in the near future.

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 Drug Court applicants who are deemed legally and clinically eligible for Drug Court. State funding appropriated to the AOC for this purpose will be 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.

New Jersey State Parole Board and the Department of Corrections. A Memorandum of Agreement (MOA) will continue between the New Jersey State Parole Board (NJSPB) and the SSA to purchase, within a fee-for-service (FFS) network, community-based residential beds for NJSPB parolees under the Mutual Agreement Program (MAP). A similar verbal agreement will continue between the New Jersey Department of Corrections (NJDOC) and the SSA to purchase, within a FFS network, community-based residential beds for NJDOC inmates. The NJDOC has requested an expansion of services within the provider network starting SFY 2014 that will

[1] http://www.state.nj.us/humanservices/dmhs/recovery/

include Short Term Residential level of care and enhancement services (urinalysis and oral swabs).

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 will be to reduce risky behaviors and promote adoption of health enhancing behaviors. Additionally, the SSA will continue to collaborate with the DOE in identifying and creating 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.

V. Description of Regional, County and Local Entities that Provide Behavioral Health Services

In New Jersey, the administration and organization of the mental health system is centralized, rather than county or locally based. A broad array of mental health services are offered in the community. The SMHA funds community agencies that in turn provide an array of services including intensive services such as Integrated Case Management Services (ICMS) which consumers are linked to upon discharge from a state hospital or Short Term Care Facility (STCF) for 12 months post discharge from the inpatient setting. Other mental health services include PACT, Outpatient, Acute Partial, Partial Hospital, Supported Employment, Supported Housing, Jail Diversion, etc.

County Resources. Chapter 51 of the Laws of 1989, C.26:2BB-12 et seq, amended an act of 1983 that established the "Alcohol, Education, Rehabilitation and Enforcement Fund" (AEREF). The AEREF is a non-lapsing, revolving fund from which the 21 counties receive annual allocations equaling 10.75% of the annual revenues from a tax on the sale of alcoholic beverages to plan and deliver comprehensive addiction services across the full continuum of care, including prevention, early intervention, treatment and recovery support, based on a county-sponsored, community-based needs assessment and planning process. Under this program, counties must match 25% of their respective annual AEREF allocation with a contribution of county revenues. The funds support county-wide needs assessment, planning, coordination and provision of the full range of addiction services for indigent adult and adolescent county residents.

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. As established by statute, 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 LACADAs are required to develop and present to their county boards of freeholders a County Comprehensive Plan (CCP) for adoption. 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 Alliance (MA) that stems from 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. Through the CASS, the MA plans are coordinated with the LACADA's CCP through a process known as "Unification Planning." Beginning in FFY 2012 and with the next cycle of Unification Planning, the SSA, in collaboration with the GCADA, intends to: 1) help counties identify and implement a greater number of evidence-based prevention programs and 2) support counties to establish environmental approaches to prevention planning at the county and municipal levels. The plan will also provide direction in the development of future prevention funding opportunities made available by the SSA over the next five years.

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

Substance Abuse Services

Prevention

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 is 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) of SAMHSA's Center for Substance Abuse Prevention (CSAP) and a recent Addictions Prevention Strategic Planning Committee process within DMHAS, the SSA plans prevention and early intervention services in the state, awards funding to providers through RFPs and funds more than 60 community-based providers that offer a variety of evidence-based curricula to reduce substance abuse related problems in the communities they serve. The SSA monitors contracts, provides on-going technical assistance to contracted provider agencies, and oversees outcome evaluations for each program.

Childhood Drinking Initiative. The SSA provides funding annually to the New Jersey Prevention Network to oversee and coordinate the statewide Childhood Drinking (CD) Coalition. The CD Coalition aims to initiate a comprehensive strategy to prevent underage drinking. Each county in New Jersey also hosts a countywide CD Coalition to address the local issues related to underage drinking. Advocacy efforts and parents and youth programs are provided.

Strategic Prevention Framework State Incentive Grant (SPF-SIG). The SSA has funded eleven communities with federal SPF-SIG funds to adopt and implement the SPF to deliver and sustain effective substance abuse prevention and mental health promotion programs in their communities by institutionalizing a data-driven planning process to decrease both underage drinking and the harmful consequences of alcohol and drug use among 18 to 25 year olds at the community level. The New Jersey SPF is a public health, outcomes-based prevention approach that uses data to drive prevention decision-making. The goals and objectives of the New Jersey

SPF are being achieved through strong collaborations among state, community, and academic partners, who work together to implement the New Jersey SPF, and develop prevention expertise and infrastructure to sustain the process in selected communities.

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. The odds of substance use for gay, lesbian bisexual, transgendered and questioning (GLBTQ) youth are on average 190 percent higher than for heterosexual youth, according to a study by University of Pittsburgh researchers published in the April 2008 issue of *Addiction*[2]. The SSA awarded funding to the North Jersey Community Research Initiative to expand their existing programs for high-risk GLBTQ youth of color by using a prevention model developed by the Centers for Disease Control and Prevention, early intervention services, social marketing, and structured recreational activities.

Stigma Reduction. The many New Jersey residents with an alcohol or drug addiction, 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. NCADD- New Jersey provides extensive education and public information to help reduce the incidence of stigma related to alcoholism or drug addiction.

Drug Free Communities Support Program (DFCSP). New Jersey is home to seven DFCSP grantees. Additionally, extensive prevention programming and education is provided by other state agencies such as: the Department of Education's Office of Safe and Drug-Free Schools, the DCF, the Juvenile Justice Commission, the Department of Health, the Division of Highway Safety, and law enforcement agencies.

Governor's Council on Alcoholism and Drug Abuse (GCADA). The SSA works collaboratively with the GCADA on various addiction prevention related projects, including participation on the Prevention Unification Planning Process. The Unification Planning process is designed to provide guidance in the identification of prevention priorities and goals that will be instrumental in the development of an RFP to fund individual and family prevention programming that will be issued in early 2014.

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

[2] Marshal, Michael P., Friedman, Mark S., Stall, Ron, King, Kevin M., et. al. (2008). Sexual orientation and adolescent substance use: a meta-analysis and methodological review. *Addiction, 103*(4), 546-556.

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 395 grants to 529 municipalities throughout New Jersey, with the majority of grants averaging between $10,000 - $20,000. 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.

Early Identification/Intervention

The SSA has initiated several programs to develop and provide early intervention services.

211 Hotline. "2-1-1" is a growing national model, with over 190 million Americans in 46 states having access to community resources via the service. On February 10, 2005, the New Jersey 2-1-1 Partnership, a subsidiary of the United Way of New Jersey, launched New Jersey's statewide 2-1-1 system. It is currently operational by landline, cell phone and internet. In 2010, the SSA awarded a contract to the New Jersey 2-1-1 Partnership to incorporate its Addictions Information and Referral Hotline in order to leverage 2-1-1's existing telephony system. Callers who seek information on substance abuse are transferred to the Hotline where an addiction's professional: 1) assesses the caller's needs using a validated telephone screening tool, 2) identifies appropriate resources and service delivery mode(s) using a uniform electronic income eligibility and program eligibility module, 3) provides enough information about each organization to help inquirers make an informed choice of services they want, and 4) makes "live" referrals to approved SSA organizations capable of meeting those needs. In situations where services are unavailable, staff will engage in problem solving to help the inquirer identify alternative strategies.

SBIRT. In July 2012, SAMHSA awarded DMHAS a five-year $7.5 million cooperative agreement for Screening, Brief Intervention and Referral to Treatment (SBIRT) services. Entitled *NJ SBIRT*, the project is a partnership between the DMHAS and the Henry J. Austin Health Center (HJA), a FQHC in Trenton. The NJ SBIRT project seeks to expand and enhance the existing continuum of care by integrating evidence-based services, proven effective in reducing substance use and associated negative health consequences, in primary care and community health settings. The project goals are to: 1) reduce alcohol and drug consumption and its negative health impact; 2) increase abstinence; 3) reduce costly health care utilization among Trenton residents accessing primary care services through an FQHC and hospital outpatient clinics; and 4) promote policy and systems change that identify and overcome barriers to consumers accessing and engaging in treatment.

The HJA will implement SBIRT services in three existing primary care sites and two hospital outpatient residency programs throughout the city of Trenton. Services provided include universal screening of adult patients for the identification of substance use risk and clinically appropriate brief intervention, brief treatment, referral to specialty treatment and care

coordination services for those identified in need. Approximately 44,000 screenings are estimated to be conducted over the five-year project period.

College Campuses. This initiative awarded funds to Rutgers University and William Paterson University to provide recovery support and/or 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/or 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.

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.

Treatment

Between the SAPT Block Grant and other state resources, the SSA supports the following levels of care for substance abuse treatment, which comport with SSA regulations and ASAM PPC-2R standards. Full service descriptions are included as an attachment to this application.

Residential. New Jersey's system of care for residential treatment services is comprised of five levels: 1) medically monitored detoxification Level 111.7D, 2) medically monitored detoxification enhanced Level 111.7D Enhanced, 3) short-term residential treatment Level 111.7, 4) long-term residential treatment Level 111.5, and 5) halfway house services Level 111.1. Certain 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, 3a) intensive outpatient (IOP) Level 11.1 and 3b) methadone intensive outpatient (MIOP), 4) partial care Level 11.5, 5) ambulatory detoxification, and 6) opioid maintenance therapy. 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.

SAPT Women's Set-Aside. 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.

Child Welfare//Women with Dependent Children Programs. The SSA provides state funding to a statewide network of licensed substance abuse treatment providers in all modalities of care including intensive outpatient, methadone intensive outpatient, long term residential and halfway house for substance abuse treatment to women with dependent children under the supervision of DCF's Division of Child Protection and Permanency (DCP&P). The overall treatment goal for the women involved is the sustainable recovery of each woman with positive outcome of healthy reunification with her children. Programs provide gender specific substance abuse treatment and other therapeutic interventions for women which may address relationships, parenting, therapeutic interventions for children in custody of women in treatment, children's developmental needs, and child protection issues. Services also include transportation, case management, linkages for healthcare and recovery supports.

Child Welfare/Fathers with Dependent Children Programs. The Child Welfare Fathers with Children Initiative provides substance abuse treatment services to fathers with children under the supervision of DCP&P. Four licensed substance abuse treatment providers in Camden, Essex and Ocean counties provide intensive outpatient level of care treatment and methadone intensive outpatient treatment to fathers with dependent children.

Medication Assisted Treatment Initiative. Through funding legislated through the Bloodborne Disease Harm Reduction Act, the SSA has developed the Medication Assisted Treatment Initiative (MATI). This initiative includes mobile medication units with corresponding outreach, office based services and case management, as well as supportive housing, sub-acute enhanced medically managed detoxification, vouchers for other treatment services, and an evaluation of the project. The mobile medication units prioritize the provision of pharmacological treatment to individuals in cities and towns that have no access and/or limited access to methadone and suboxone treatment, and to clients referred through the Sterile Syringe Exchange Programs.

Drug Court. Drug 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 implements a complete continuum of care for Drug Court offenders sentenced in New Jersey Superior Court. Drug Court participation is voluntary and clinically-driven. Fifteen vicinage serving all 21 counties Drug 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. New Drug Court Legislation S881was signed into law in July 2012. The bill stipulated a two phase Drug Court expansion: 1) phase one broadened the legal eligibility to include second degree burglary and robbery, 2) phase two required a phase-in mandatory sentencing to Drug Court. New beds have been added via a request for letters of interest to fulfill the first phase of the expansion, and a request for proposals will be issued during this FY for further expansion.

Mutual Agreement Program. The SSA oversees the Mutual Agreement Program (MAP), an Inmate/Parolee Substance Abuse Treatment Project implemented through Memoranda of Agreement between the SSA and the State Parole Board (SPB) and a verbal agreement with DOC. This funding is a combination of direct appropriations to DMHAS and funds transferred from the DOC and SPB. Funding for long term residential is available for DOC inmates pending parole through a network of FFS providers. For SPB, 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, intensive outpatient, and outpatient treatment for SPB parolees.

Child Welfare Adolescent Services. The SSA, through state funding, provided a coordinated network of enhanced substance abuse treatment services in licensed facilities targeted to adolescents with first priority to those under the supervision of DCF's DCP&P. Services include long-term residential treatment that provide a structured recovery environment, combined with professional clinical services designed to address addiction and living skill problems for adolescents with substance abuse diagnosis who require longer treatment stays to support and promote recovery. Intervention focuses on reintegrating into the greater community with emphasis on education and vocational development. Outpatient services include individual, group and family counseling and include access to support services. Joint case planning and case conferencing between the DCP&P case worker and the treatment provider are an essential component to this initiative. These services were transferred to the oversight of DCF in July 2013, as all youth services for addiction will fall under DCSOC.

SAPT Funded Adolescent Services. Long-term residential treatment provides a highly structured recovery environment, combined with professional clinical services designed to address addiction and living skill problems for adolescents with substance abuse diagnosis who require longer treatment stays. Short-term residential services provide highly structured environment, combined with a commensurate level of professional services, designed to address specific addiction and living skills problems for youth who are deemed amenable to intervention through short-term treatment. Partial care treatment provides a broad range of clinically intensive treatment services in a structured environment for a minimum of 30 hours per week, during day or evening hours. Treatment includes substance abuse counseling, educational and community support services. Programs have ready access to psychiatric, medical and laboratory services. These services were transferred to the oversight of DCF in July 2013, as all youth services for addiction will fall under DCSOC.

South Jersey Initiative. This state funded initiative targets adolescents (ages 13-18) and young adults (ages 18-24) from eight counties (Ocean, Atlantic, Burlington, Camden, Gloucester, Cape May, Salem and Cumberland). It provides a continuum of care that includes methadone maintenance, detoxification, residential, halfway house, and outpatient treatment services. These services will be transferred to the oversight of the DCF in January 2014.

Services for the Deaf and Hard of Hearing. This funding 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 were identified as Deaf or hard of hearing seeking substance abuse treatment at any level of care.

Driving Under the Influence Initiative. New Jersey set aside $7.5 million in state funds beginning in November 2005 to support the treatment of financially indigent residents of New Jersey who have been convicted of Driving Under the Influence (DUI). Financially indigent drunk drivers can receive the appropriate level and duration of treatment warranted, thus reducing the incidence of recidivism and ultimately creating safer highways. There are over 150 licensed sites in the DUII network providing all levels of treatment services. In addition, there is a pilot Vivitrol Sub-Network that has been created within the DUII, for those clients who are either alcohol or opiate dependent.

HIV Services. The Division funds Early Intervention Services (EIS) and HIV Specialist positions at 17 substance abuse treatment providers statewide at 18 sites, one of which is in a rural locale. Services were available in areas of the state that had the highest rate of HIV infection, as well as the greatest need for these services. Since DMHAS recognizes that individuals with substance use disorders, specifically injectable drug users, are at a higher risk for contracting HIV/AIDS than the general population, DMHAS obligates a portion of its HIV Block Grant funds to implement a Memorandum of Agreement (MOA) with the Robert Wood Johnson (RWJ) Medical School, Department of Pathology and Laboratory Medicine, that provides administrative services including lab directorship, consultation, lab oversight, authorization and technical support through RWJ to ensure rapid HIV testing for clients in several licensed substance abuse treatment facilities statewide.

Tuberculosis (TB) Services. In New Jersey, all treatment facilities receiving contracts were required to conduct TB testing as part of the patients' admissions process. A provision of the guidelines required that patients with TB, who were not admitted for treatment because the funded capacity at that facility has been exceeded, would be referred to another treatment provider.

Intravenous Drug Abuser (IVDA) Services. The SSA will continue to require all drug treatment agencies providing treatment to IVDA to provide outreach activities to encourage IVDA 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 IVDA to ensure that these entities: 1) admit all individuals who request and are determined to be in need of treatment for intravenous drug abuse 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.

Recovery Support

Recovery support is defined as the coordination of personal, family, and community resources to achieve the best possible quality of life for every client entering the substance abuse early intervention and treatment system. The chronic nature of addiction requires sustained recovery support to promote sustained periods of wellness and to continuously reduce the need for additional acute care. Correspondingly, a modern addiction treatment system must support sustained recovery. In New Jersey, substance abuse treatment does not end upon discharge; a continuum of care plan, including personal, family and community resources, must be established. It can range from low level contact such as quarterly telephone conversations to high level contact such as coaching, depending on support needed.

In an effort to increase recovery supports, the existing Mental Health Planning Council is moving to expand membership to include individuals, families and providers involved in substance abuse services. In essence, this increase in membership will evolve the current Planning Council into a more behavioral health focused Planning Council.

The intention of the SSA is to expand addiction recovery support services throughout the state to mirror the extensive mental health support system, which includes both self-help support centers and supportive housing. The SSA currently has two Addiction Recovery Centers, and 63 units of supportive housing, while in contrast, the SMHA provides self-help centers in every county and at every state hospital. In addition, the SMHA provides funding for supportive housing and at the current time, there are over 4,400 supportive housing units.

Hotlines. The SSA provides funding for a 24-hour addictions hotline that provides pre-treatment screening, motivational counseling, and case management/care coordination to engage and support individuals seeking addictions help. In addition, the hotline provides eligibility screening and referrals for clients.

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.

Sober Housing. 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. This funding is provided for the maintenance of the existing homes in New Jersey and the addition of new homes.

Recovery Mentors. Recovery Mentors provide a bridge to treatment during the client's care through outreach and motivational support. Recovery Mentors are included in some Women's programs, the SSA's Medication Assisted Treatment Initiative (MATI) and the New Jersey Recovery Center at Eva's Village and Living Proof Recovery Center. The Recovery Mentor certification is available through the Addiction Professionals Certification Board of New Jersey.

Recovery Centers. The SSA opened New Jersey's first Recovery Center at Eva's Village in Paterson in September 2009 and its programs have continued to grow. The client-centered and client-directed center, which is opened 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, language assistance, self-help advocacy, childcare assistance, 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 (four bus loads) of their program participants to attend the largest Recovery celebration in the tri-state area in Philadelphia.

DMHAS issued a 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. Over the past several months, the center has formed an advisory board and officially named the center "Living Proof Recovery Center." There is a full 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. They continue to recruit new participants and outreach to them on a weekly basis. They also have a strong core of volunteers who are helping with day to day operations and recruitment. Staff and volunteers have received Recovery Mentor training.

Supportive Housing. The SSA has two supportive housing pilot 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 was engaged in a new supportive housing project with planning grant funds from the Robert Wood Johnson Foundation to the Corporation for Supportive Housing (CSH) during FFY 2012 to develop a Keeping Families Together (KFT) model of housing for women who are involved with New Jersey's child welfare agency, the DCP&P, and also have substance abuse issues. This project was to involve collaboration with DCP&P, CSH, the Department of Community Affairs and other state agencies with the goal of leveraging other financing for this project. However, due to organizational changes in the DCF, this project was never funded.

The SSA and DCF collaborated and submitted a grant to the Administration for Children, Youth and Families for an initiative designed to strengthen and keep together families who were unstably housed, involved in the child welfare system and dealing with substance abuse issues. This project would have created 51 units of supported housing for families who had involvement with the child welfare system and problems with substance abuse. Unfortunately, funding was not received. The SSA is now in the process of developing a Women's Intensive Supportive Housing (WISH) Program around the development or expansion of permanent supportive housing for pregnant and/or parenting women with a substance abuse disorder 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 is being developed and is expected to be released in fiscal year 2014. This RFP calls for the development of a WISH team to provide case management and supportive housing services for 17 consumers and their children. The SSA is seeking to partner with a provider that will serve identified WISH Program clients in supportive housing and has demonstrated success in managing permanent supportive housing programs. DMHAS outpatient treatment system will be able to accommodate the substance abuse treatment needs of the project participants. In addition to WISH, DMHAS will provide additional subsidies and DCP&P to develop housing for parents with children in the child welfare system.

Mental Health Services

The SMHA contracts for county/local services including: Consumer Run and Operated Self-Help Centers, Programs for Assertive Community Treatment (PACT), Integrated Case Management Services (ICMS), Residential Services, Supportive Housing (SH), Outpatient Services (OP), Supported Employment (SE) and Supported Education (SEd), Partial Care, Intensive Family Support Services (IFSS), Systems Advocacy including legal services, Intensive Outpatient Treatment and Support Services (IOTSS), Designated Screening Centers (DSC), Affiliated Emergency Services (AES), Early Intervention Support Services (EISS), Justice Involved Services (JIS) and Projects for Assistance in Transition from Homelessness (outreach to persons who are homeless). The SMHA currently designates 413 Short Term Care Facility (STCF) beds in New Jersey. These services are funded with Community Mental Health Block Grant, other federal or state funds.

The programs that the SMHA funds fall within four levels of service along the continuum of care.

1. *Acute Care Services (DSC; AES; STCFs; EISS; Involuntary Outpatient Commitment (IOC); IOTSS and Projects for Assistance in Transition from Homelessness (PATH))*

Acute Care Services. The Acute Care Task Force (ACTF) was charged with making system recommendations to the SMHA's Executive Staff in order to align acute care services with the SMHA's Wellness & Recovery Transformation Action Plan. The goals were to emphasize early interventions, improve access to support services, and to foster cross-system collaboration for special populations in a consumer-friendly and family driven manner. Five subcommittees were formed to identify policy, service delivery, data, fiscal, and legislative issues that impact mental health and need reform. In early SFY 2011, the ACTF report was released (see http://www.state.nj.us/humanservices/dmhs/home/ACTF_Report_Sept_2010.pdf).

The SMHA funds and regulates acute mental health care programs for individuals with intensive outpatient mental health needs and for those experiencing psychiatric crisis. In order to meet the needs of individuals who require involuntary in-patient services, the SMHA allocates roughly $24.6 million in subsidies for 413 STCF beds in New Jersey in 24 general community hospitals. These beds are operated by 24 different agencies and serve all 21 New Jersey counties. Most of these agencies are community hospitals and these beds permit the state's residents to access a hospital based level of psychiatric care at the local community level. Since the end of 2007, community hospital based involuntary psychiatric inpatient service capacity has been increased by approximately 21% (71 beds). During SFY 2012, the average occupancy rate at the STCF units was 89.58%. Through past and recent Certificate of Need (CN) application approvals, an additional 20 STCF beds can be brought on line pending implementation by the relevant hospitals.

Designated Screening Centers (DSC). The SMHA funds 23 Designated Screening Service (Screening and Screening Outreach) programs across the 21 Counties at a total cost to DMHAS of approximately $41.4 million per year. The Screening and Screening Outreach Program is designed to provide 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. During State Fiscal Year 2012, the state's Designated Screening Centers have reported providing 90,617 episodes of crisis care.

Early Intervention Support Service (EISS). In 2008, the SMHA began investing $3.0 million annually in Early Intervention Support Service (EISS) programs in Morris and Atlantic Counties. These programs 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. Access to this intensive diversionary program is intended to provide a direct and specific alternative to hospital emergency department based crisis services. The SMHA now funds seven community based EISS programs at a total annual cost of $7,404,723. These programs provide rapid access to short term, recovery-oriented crisis intervention and stabilization services for persons with a serious mental illness. 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 serve Camden, Essex, Middlesex, Monmouth, and Ocean Counties and are funded in excess of $1M each. In addition two demonstration contracts (in Atlantic and Morris counties) were funded in excess of $1 million each. As part of recent and current RFP processes, an additional $3,951,313 is targeted to implement similar programs in Bergen, Cumberland, Hudson and Mercer Counties.

Intensive Outpatient Treatment Support Service (IOTSS). Since 2008, the SMHA has funded new Intensive Outpatient Treatment Support Service (IOTSS) programs in 19 counties, in order to alleviate strain on the acute mental health system. These new programs are designed to create dedicated access for consumers referred from emergency rooms and other acute settings. The annual cost of these programs is approximately $7.0 million.

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. 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, substance abuse 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.

PATH is widely distributed across the state. 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.

All 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 is provided.

2. *Intermediate and Rehabilitative (SH; Residential Services; Supported Employment; Supported Education (SEd); PACT; IFSS; Illness Management and Recovery (IMR); JIS; Integrated Case Management Services (ICMS); Outpatient Services; Partial Care; Statewide Clinical Outreach Program for the Elderly (S-COPE); and Legal Services*

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 consumers who are at high risk for hospitalizations, 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. Consumers are eligible for PACT throughout the lifespan, as 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 60-75 consumers at any point in time. There are 31 PACT teams in New Jersey, serving all of the 21 counties. The SMHA contracts with 12 different non-profit agencies that operate these teams.

Most facets of the New Jersey PACT program could be deemed high fidelity to the evidence-based research – e.g. would score a 4.00 (Scale of 1 to 5) or higher on the SAMHSA Assertive Community Treatment Scale. This is largely due to the fact that evidence based practice fidelity components for Assertive Community Treatment (ACT) are integrated into the state's regulatory code.

New Jersey PACT team admission criteria are inclusive. Characteristic of ACT services are highly individualized and tailored to service recipients' needs. PACT teams in New Jersey serve individuals of racial, ethnic and sexual/gender minorities.

Consistent with the assertive community treatment model, substance abuse service provision is integrated into the comprehensive service package. By regulation, all New Jersey PACT teams are required to have staff with expertise in the treatment of substance use disorders and thus, PACT teams shall provide highly individualized dual disorder services for enrollees who have co-occurring mental health and substance use disorders. Interventions may be offered via individual and group modalities. Enrollees who do not benefit from (for example, do not or cannot attend) group treatments must be offered individual services. Interventions must take into account each consumer's stage of treatment and will assist consumers in:

- Identifying substance use effects and patterns;
- Recognizing the interactive effects of substance use, psychiatric symptoms, and psychotropic medications;
- Developing motivation for decreasing substance use;
- Developing coping skills and alternatives to minimize substance use;
- Relapse prevention planning; and
- Attending appropriate recovery or self-help meetings.

DMHAS anticipates continued targeting of dedicated funding to expand the state's PACT. 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. In the current fiscal year (SFY 2013) to date, two more PACT teams (Union Team II, Passaic Team II) were expanded by a total of 11 slots. These community slots have been created to facilitate discharge of individuals who are in state psychiatric hospitals and have been placed on CEPP status. SFY 2013 is the fourth consecutive year in which the statewide PACT capacity has been expanded. In total, since SFY 2010, 11 New Jersey PACT teams have been expanded, with the targeted (maximum) capacity of the program going from 2,002 to the current capacity of 2,082

Supportive Housing. The SMHA contracts with approximately 46 Supportive Housing providers (including Medically Enhanced and Enhanced Supportive Housing models) and Supervised Residential providers in all 21 counties. These services range from being completely consumer-driven in the consumer's leased-based housing to supervised settings with 24/7 staffing. In addition, the State funds Residential Intensive Support Teams (RIST) in 17 of the 21 counties – a Supportive Housing model with a higher staff-consumer ratio and SMHA funded rental subsidies serving consumers discharged directly from the state hospital system, as well as those at risk of hospitalization.

Individuals eligible for services through these RFPs may have challenging behaviors related to frequent homelessness and untreated mental illness or lengthy hospitalizations. This may include a history of non-engagement with services, refusal to leave a hospital setting, active substance abuse, 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.

Housing opportunities and program design will 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.

Supportive housing services 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. 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. Staff support should be provided through a flexible schedule that is adjusted as consumer needs or interests change, up to and including 24/7 support.

Homeless Adults/Housing First. The SMHA, the United Way of NJ, and Mercer County are members of the Mercer County Housing First Collaborative and contributing funders of supportive services for the Mercer Housing First Program. The program includes the identification of homeless individuals with disabilities, including SMI and substance use disorders, the provision of permanent supportive housing through vouchers and an array of wrap around services, including behavioral health, primary health monitoring and linkage, referral to financial assistance and vocational services. As of December 2012, there were 105 homeless individuals and families that had been permanently housed.

Supported Employment (SE). The SMHA has been providing the EBP of supported employment since 1988. SE is provided statewide and jointly funded by the Division of Vocational Rehabilitation and the SMHA. 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 22 contracted community mental health provider organizations; at least one in each county.

Supported Education (SEd). Although the SMHA has been promoting the concept of SEd since 1993, contracts for SEd services have only been offered 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 through four existing contracted supported employment community provider organizations SEd 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.

Integrated Case Management Services. ICMS works 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.

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 consumer 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.

Adult educational activities are tied to the learning of daily living 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 consumers 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.

Intensive Family Support Programs (IFSS). IFSS have 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.

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. A recent survey of ethnic backgrounds of the families on the active caseload of each program conducted by the SMHA revealed that 78.12% of families are White. Black or African American families comprised 9.61 % and 7.51% of families are Hispanic or Latino. No other ethnic background comprised greater than 2.58%. 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). NAMI affiliate offices are located in each county. NAMI 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 (SAMHAJ), Chinese American Mental Health Outreach Program (CAMHOP), and the African American Community Takes New Outreach Worldwide (AACT-NOW!).

3. Extended and Ongoing Support Programs (Consumer Operated Services)

Consumer Operated Services. New Jersey continues to expand its commitment to partner with consumers and family members to ensure that programming and services are inclusive, cutting-edge, recovery-based, and respectful of consumer rights. The state seeks to include the voice of consumers and family members in the development of policies and programs, planning and the evaluation and monitoring of systems of care at both the state and local levels.

Specifically DMHAS currently funds and supports 33 Self-Help Centers in the 21 counties across the state, all being consumer-operated and providing dedicated space for mental health consumers to grow in their recovery through self-help, socialization, peer support, opportunities for employment, and specialized wellness programs. During the last several years, all of the

Self-Help Centers in New Jersey have successfully incorporated significant changes as the Wellness and Recovery Model has become an integral part of the overall mission and is being used more actively to inform the service delivery model.

New Jersey Self Help Centers now provide a variety of activities both at the Center itself and off-site. The Centers offer support and services such as: peer support, mutual aid support groups, self-esteem building, cultural competency and diversity activities such as learning a foreign language at some centers. Consumers are offered support to develop their wellness resources like PADs (Psychiatric Advance Directives) development of their Wellness and Recovery Action Plan (WRAP) (M.E. Copeland's model); a variety of resources for consumers who are dually-diagnosed, mobile community outreach, learning to budget, individual savings or financial planning, exercise, walking clubs, dance, yoga, healthy eating and cooking, Hearing Voices Groups, camping trips, shopping activities, sharing meals, meal planning, budgeting, selecting healthy snack alternatives, some faith-based satellite services, certified individual peer wellness coaching, WRAP scrap-booking, smoking cessation groups, movie night, crafts and game night. Other activities include topics like conflict resolution, men's and women's group, meditation and relaxation groups, preparing for education and employment opportunities, SE groups, and many more. Planned Parenthood comes to the self-help centers and provides educational programs for consumers. These educational opportunities are provided at a few of the self-help centers during the year.

The 33 Self Help Centers collectively received funding of approximately $5 million dollars in FY 2013. There are full time Center Managers at every Self-Help Center, which has proven to be a stabilizing force for change and growth at the centers. These Center Managers are required to accept a great deal of responsibility for the well-being of the membership, yet the retention rate for the position is impressively high. This is primarily due to the DMHAS funded Self-Help Leadership Training Academy and to the support and skills of the full-time Life Coach who was hired to assist the Center Managers in performing their duties by providing them with supportive counseling, mentoring and training necessary to handle the stresses associated with the demands of a management position. The centers have vans and transport individuals to and from the center, as well as to sporting and theater performances, community meetings and shopping excursions. Consumers are assisted in daily living skills, if needed, as well as independent living skills. If an individual desires, there are volunteer positions at the centers, through which the members learn sanitary food handling, how to prepare and plan their meals, what to do for general kitchen clean-up, how to properly sanitize the kitchen, including how to properly store and dispose of trash and kitchen cleaning products, storage of food items, and kitchen ware.

DMHAS appropriated funding has allowed the three state psychiatric hospitals to develop their own on-site Self-Help Centers. A particularly exciting development for New Jersey's Self-Help Center Model has been the development of an accountability system called Self-Help Outcomes Tracking (SHOUT). This data tracking system was developed specifically to monitor utilization and to support outcomes evaluation for participants of Self-Help Centers. In addition to these services, there are other service innovations in select Centers across the state that not only serve the population of that particular area well, but also hold great promise for replication should additional funding become available.

DMHAS involves both consumers and family members through several initiatives, funding streams and policies including the Statewide Consumer Advisory Committee (SCAC), which provides the state's guidance as the recovery and wellness based system of care continues to transition. SCAC meets once a month in each of the three regions of the state (northern, central and southern). These meetings are a platform for SCAC members to give input on specific DMHAS-sponsored initiatives. SCAC makes recommendations to DMHAS on all issues affecting consumers like: housing, transportation, medication, co-pays, employment opportunities, etc. During monthly meetings SCAC members share in their ideas on wellness and recovery-focused activities and groups that different self-help centers offer. This permits an open forum for members to exchange their vast assortment of wellness and recovery approaches that are innovative and fresh, and are taking place in the various community centers throughout the state.

DMHAS has a Citizen's Advisory Council (CAC) that is inclusive of individuals in recovery from addictions and their families. Communication is enhanced and a bridge is formed between DMHAS and the community via the member liaison relationship.

DMHAS provides opportunities like peer support recovery programs, family involvement and IFSS programs, the significant number of consumers and family members who hold membership on the Mental Health Planning Council (MHPC), inclusive of MHPC members on state steering committees, service and policy development surveys and forums, consumer participation in on-site monitoring reviews of hospitals and community providers, involvement in the RFP process by both mental health consumers and their family members, and the support of and partnership with advocacy groups throughout the state.

The state has strong working relationships with NAMI of New Jersey which facilitates consumer involvement and assists the state to keep up with the challenges facing consumers and their families. The state's support and funding of peer support and consumer-operated programs is probably the greatest evidence of the state's commitment to fostering a system of care that values the importance of consumer involvement in the recovery process. In Fiscal Year 2012, the state allocated $8,777,991 to support consumer-operated services that promote self-directed care.

The Division has moved forward with their community support services state plan and has received approval for reimbursable Peer Provided Services such as wellness coaching, Peer Outreach Support Teams (POST) and other such roles for which consumers are uniquely qualified. Implementation is pending the adoption of the regulations.

The state actively includes consumers and family members in Patient Services Compliance Unit. In 2012, the Patient Services Compliance Unit conducted five separate on-site reviews in all of the state psychiatric hospitals. The reviews were each conducted for a three-day period and each individual review team included one consumer and one family member. Consumers and family members are in all aspects of the review with the exception of medical records reviews. The process includes a review of therapeutic program, unit observations, patient care and staff development.

In accordance with New Jersey Administrative Code (NJAC) 10;190, consumer and family member participation is also required during on-site reviews of community mental health agencies conducted by DHS Office of Licensure.

In addition to state operated programs, NJ has a strong, active network of public consumer and family member organizations and programs, including but not limited to: Consumer-Operated Transportation Services, Leadership Training Academy, The Learning and Recovery Center of Wildwood, Consumer Advocacy Partnership, The Coalition of Mental Health Consumer Organization (COMHCO), The Institute for Wellness and Recovery Initiatives, Consumer Connections CORE Training, Certified WRAP Training, Certified Wellness Coach Training, CHOICES-a smoking cessation Program active in state hospitals and self-help centers across the state, Hearing Voices, CPA (Consumer Providers Association), NAMI of NJ, NAMI Connection, NAMI NJ en Espanol, Chinese Mental Health Self-Help Group (CAMHOP-NJ), NJ Self-Help Group Clearing House, and Mental Health Association of NJ (MHANJ).

Wellness Recovery Action Plans WRAP. - Certified WRAP trainers from the MHANJ conduct trainings across NJ on the topic of wellness and recovery and WRAP plan development. In 2012, 651 people participated in these trainings, which ranged from an overview of WRAP to workshops designed to help people develop their own individual WRAP.

Psychiatric Advance Directives (PADs). The SMHA has a PAD policy that promotes the empowerment of consumers to direct their own care with regard to the care and treatment they receive. This document is a permanent record in the consumer's chart which can be revoked or amended by legal authority. PADs are submitted to SMHA and available on a 24-hour basis.

Peer Wellness Coaches. The Wellness Coaching role was developed as a workforce innovation to help support people with mental health and substance use disorders with risk factors and medical conditions that impact their recovery. The wellness coaching training curriculum was developed through collaboration between staff at Collaborative Support Programs of New Jersey and faculty in Department of Psychiatric Rehabilitation and Counseling Professions, and Rutgers-School of Health Related Professions.

Wellness for Life. Wellness for Life is a multi-disciplinary pilot project to address the prevention or management of metabolic syndrome for persons diagnosed with mental illness. The eight-week intervention meets weekly for three hour sessions and includes health supports from physical therapy, peer wellness coaching, dietetics, dental hygiene and psychiatric rehabilitation using education, peer wellness coaching and supported exercise. Each participant is provided an individual wellness assessment and is helped to create and attain a personalized health goal. Preliminary outcomes appear positive and evaluation is ongoing.

Consumers Helping Others Improve their Condition by Ending Smoking (CHOICES). This is consumer-driven program for smokers with mental illness in New Jersey. The goal is to increase awareness of the importance of addressing tobacco use and to create a strong peer support network that encourages mental health consumers to make a positive healthy lifestyle change by addressing smoking and tobacco use. CHOICES is innovative because it employs mental health

consumers, called Consumer Tobacco Advocates, to deliver the vital message to smokers with mental illness that addressing tobacco is important and to motivate them to seek treatment.

Financial Management Bill Pay (FMBP) formerly known as Client Trust Account (CTA). It serves more than 300 people statewide. FMBP is an individualized, flexible community-based service product provided by Collaborative Support Programs of New Jersey (CSPNJ) for adult clients with mental health issues and other special needs. The FMBP is a money management service, providing collection and payment of funds on behalf of its clients, financial literacy training and education designed to promote financial stability and security consistent with the concepts of empowerment, personal responsibility and recovery.

Individual Development Account (IDA). This is a matched savings program designed to help people save for and acquire a productive asset, such as a home or business, or to pursue education (including post-secondary education) over the period of five years.

The Emergency Loan Program. This is offered to CSP-NJ/CEC residents assists with short-term financial emergencies and/or unanticipated expenses. The loan terms are usually no more than nine months.

Financial Fitness Self-Help Center (FFSHC). This is a service offered for: answering questions; providing training and support for financial issues, product or services; budgeting and savings; assisting with credit repair; investing, home-buying; starting a business; and paying taxes, among others.

Volunteer Income Tax Assistance (VITA). This is a seasonal income tax preparation service provided to the community, sponsored by Community Enterprise Corporation in collaboration with the Internal Revenue Service. The VITA site is a located at 8 Spring Street in Freehold, offering free income tax preparation to anyone with earned income of $40,000 or less during the tax year.

Consumer Operated Transportation Services. Riverbank Transportation provides transportation to and from work for consumers in Burlington County who otherwise would be unable to get to work. The service also has enabled the consumers employed to become the providers of the service. Operating five days a week from 7:00 am to 10:00 pm, it serves approximately 24 consumers each week. The service employs two drivers and one dispatcher, all of whom are consumer providers.

Roads to Recovery provide transportation to consumers with co-occurring issues enabling them to attend meetings or groups in the community. Over 18 community groups and 16 geographic areas are accessed each week, with over 55 consumers using the service each month. This service employs one driver and one dispatcher who are consumer providers, operating three evenings per week.

Peer-Operated Warm Line. The peer operated warm line is a statewide initiative through the MHMNJ where consumers receive interventions and/or assistance during times of concern, need or crisis using the Intentional Peer Support Model. The Warm Line received national

recognition in 2012 as a recipient of the Innovative Program of the Year from Mental Health America.

Dual Recovery Groups: MICA Link. People with the lived experience of mental illness and with a co-occurrence of substance use comprise a large percentage of the mental health population that CSPNJ serves. The MICA Link project is a way to address the needs of this group of consumers by providing technical assistance, training, support and information. As an addition to a 12-step approach, alternative coping methods, stress reduction techniques, and information on mental illness and substance abuse and their relationship to the whole person are presented.

Self-help center managers and facilitators attend trainings and activities that increase awareness of MICA issues and the need for MICA services while cultivating a growing leadership for MICA and other wellness groups.

Re-entry Groups. These services are provided on the Mental Health Unit of a jail in Bergen County. The meetings take place every Monday, including holidays and provide the men with an opportunity to have support from outside world. The groups engage with six to eight men in a typical week. The Self-Help Center staff provides a confidential environment where the inmates can talk about their mental health concerns, as well as other topics and know that someone is listening and cares. They are offered the support of their Self-Help Centers should they get released. They are also provided housing information and given information on other items pertaining to release. These men are awaiting trial and can stay in the jail for a few days or a few years. They report that they are isolated in the jail system and seldom get a chance to talk to anyone. Through the Re-entry Groups they are connected to someone from the community. They also know that they can talk with other group members, provided opportunity, should they need a listening ear. The facilitator tells them to look around the room at one another and if they need someone to talk to they know they can count on other group members.

Parent Advocacy Project. The Consumer Parent Support Network provides bilingual support services to 34 parents in Passaic County. Parents with a mental illness can receive case management services, one-to-one peer support from another consumer parent, parenting education workshops, advocacy, and on-going parent support.

Health Screenings. The Health Screenings have been occurring at Learning Recovery Center Self-Help Center in Wildwood, Cape May County. The Wellness Institute has also performed screenings and distributed materials at the CSPNJ Annual Wellness Conference.

Self-Help Centers have operated a number of Substance Abuse Support Groups over the past year. These groups included: Substance Abuse MICA Link; Alcohol Anonymous; Double Trouble/DRA /MICA; Narcotics Anonymous, Smoking Cessation; and Nicotine Anonymous. There were 12,438 duplicated attendees.

Visits to Homeless Shelters. The Self-Help Centers provide outreach to homeless shelters. During the visits to shelters, the goal is to engage the homeless consumers into peer-operated self-help centers using peer support, dual recovery groups, etc.

Hearing Voices Network. Voice Hearers groups have been operating for more than a year in New Jersey. This is a philosophical trend in how people who hear voices are viewed. The groups are made up of people who are voice hearers or experience any unusual perceptions. The groups are seeking more holistic health solutions to problematic voices that cause distress to people. Most voice hearers have experienced trauma and the group assists people by creating a safe environment where people make the connection between their voices and their trauma. The groups also offer strategies to deal with voices when they become overwhelming which include: listening to music, reading, journaling, meditation, positive self-talk and affirmations, eating healthy, sleep, TV, radio, praying, imagery etc.

Shared Decision Making Tool. In an effort to further promote recovery-oriented services and consumer driven care, Rutgers, Behavioral Research and Training Institute and the DMHAS have jointly developed a brochure on Sharing Decisions about Medication. This brochure is designed as a helpful tool for consumers and their family members in working together with their service providers, such as doctors, nurses, pharmacists, or mental health/addiction professionals.

Self-Help Center Enhanced Model. The DMHAS has awarded funding for three Enhanced Self-help Centers: The Hudson County Self-help Center in Jersey City, The Learning Recovery Center of Wildwood (Cape May County) and A Way to Freedom (Sussex County). The Enhanced Self-help Center Model was developed to meet specific consumer and/or community needs. With this model, the DMHAS has supported the opportunity to offer a broader range of options to consumers in a unique peer-run environment. Each center has utilized its resources to provide wellness and recovery based services that also meet distinct consumer and community needs.

The Learning Recovery Center of Wildwood (LRC of Wildwood). The newest enhanced self-help 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 self-help center members and other consumers statewide. As happened to The Hudson County Self-help Center, over the past year, the LRC of Wildwood has experienced a sizeable increase in membership of persons in recovery who cope with mental health issues as well as challenges of addiction, homelessness, shelter/motel residency and other special needs. The LRC of Wildwood has worked to develop more extensive and culturally sensitive services that meet the needs of their consumer community. The services include traditional self-help center activities and groups, but the LRC of Wildwood has introduced or expanded a host of other services including: a community food pantry, a winter warmth closet, clothing bank and a nutritious meal. In addition, the LRC of Wildwood has made connections with many agencies in order to better serve community needs as varied as the membership itself.

Consumer Provider Association of New Jersey. The Consumer Provider Association of New Jersey (CPANJ)—the first state-wide Affiliate of the National Association of Peer Specialists (NAPS) is a national network of mental health and co-occurring service providers who have also been consumers/survivors of mental health and co-occurring services. They act as the organization which represents the needs of this specialized workforce that provides recovery oriented support for those who are seeking assistance. Utilizing their unique peer perspective, they help themselves, other professionals, and the general public deal effectively with the

challenges of mental illness and addictions, and also with the challenges presented by the mental health system itself.

Consumer Oriented Recovery Education (CORE) Training. The Mental Health Association of New Jersey (MHANJ) offers CORE training. CORE training has grown to 144 hours, and the WRAP is 18 hours (over three days). Completion of the CORE and WRAP satisfies the education and training component for the Certified Recovery Support Practitioner (CRSP) credential. Additionally, CRSP applicants must document 500 hours of either paid or volunteer related work experience, of which 100 hours must include a supervised practicum.

Institute for Wellness and Recovery. The Institute for Wellness and Recovery Initiatives of CSPNJ was designed to promote and provide innovative, state-of-the-art services aimed at creating wellness and recovery for individuals with and organizations serving persons with special needs. The Institute offers training, workshops, and educational opportunities. Through our many activities, we assist organizations in developing a workforce and service system grounded in a recovery and wellness orientation, and help individuals pursue their own paths towards wellness. The Institute provides innovative, state of the art services aimed at creating and enhancing wellness and recovery. Its monthly newsletter, Words of Wellness, and its website features valuable information and resources, including details about educational events to help people with psychiatric disabilities to achieve and maintain wellness.

Coalition of Mental Health Consumer Organizations (COMHCO). COMHCO is New Jersey's statewide consumer membership organization. Their main purpose is to provide consumers with necessary education about personal and system wide options to enhance the lives of their members and the multitude of others across the state. Through empowerment and advocacy training at the monthly meetings and annual conference, COMHCO members are able to bring voice to the concerns and problems that those suffering mental illness face daily. They also work to raise awareness of the issues that affect mental health consumers by sitting on local, state, and national advisory boards, committees, and councils.

4. State and County Psychiatric Hospitals

State Hospitals

The SMHA operates three non-forensic, regionally-based, adult psychiatric hospitals and one adult forensic hospital that serve people with persistent and severe mental illnesses who are in need of intensive, inpatient care and treatment. Each has person-centered treatment planning, self-help centers (at Ancora, Greystone and Trenton), and shared decision-making. IMR services are also offered. The hospitals are dedicated to patient-focused treatment planning, emphasizing a continuum of care that is: holistic and highly individualized, promotes positive outcomes based on patient strengths and available supports, values the full participation of each patient, relies on shared decision making and client-defined outcomes, and promotes patient choice, empowerment, resilience, and self-reliance.

Ancora Psychiatric Hospital is an adult inpatient facility located in Camden County, primarily serving the residents of southern New Jersey, that offers a multidisciplinary team approach to the

development and implementation of mental health care. It offers acute and chronic psychiatric treatment, gero-psychiatry, sub-acute medical care, forensic care, and dual diagnosis (mentally ill and developmentally disabled) services.

Greystone Park Psychiatric Hospital (GPPH) is located in the northern area of the state in Morris Plains and predominantly serves residents from this geographic area. 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 Hospital facility contains a treatment mall with over 21 rooms for various activities.

Hagedorn Psychiatric Hospital, a 288 bed facility, located in rural Hunterdon County primarily served older adult consumers with mental illness. As a result of the state's Olmstead decree, the state closed Hagedorn Psychiatric Hospital in June 2012. This facility is now used for transitional housing for veterans.

Trenton Psychiatric Hospital (TPH), located in West Trenton in Mercer County, primarily serves the residents of central New Jersey. 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) is co-located in the same campus as TPH and serves New Jersey's statewide forensic population whom require a more secure environment. AKFC provides care and treatment to individuals suffering from mental illness whom are also under the custodianship of the legal system (e.g., Megan's law registrants, those found Not Guilty by Reason of Insanity, etc.)

County Hospitals

In addition to its network of state psychiatric hospitals, DMHAS also supports five county operated psychiatric facilities that operate as part of the continuum of services. These county hospitals receive most of their funding (85%) from the SMHA. In SFY 2012, there were six county operated hospitals until Buttonwood Hospital, in Burlington County, sold its county operated facility to a private vendor with the state finalized in August 2012. In addition, one other hospital is slated to be sold and privatized by the beginning of Calendar Year 2014.

SMHA's Prevention Efforts

In addition to the four levels of service provided within the continuum of care described above, the SMHA has increased its efforts with regards to prevention. The following are the SMHA's specific prevention initiatives:

Behavioral Health Prevention Efforts of the New Jersey 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. Through outreach and education, the Council will send a message that mental health stigma must no longer be tolerated.

Each year the Council gives Ambassador Awards to those who champion the mission to raise mental health awareness and combat stigma, educate the public about mental illness, and engage communities in the process of embracing mental health. The 2013 awards occurred in May, and honored organizations that are exemplary in their hiring practices and maintaining a work environment that supports and accommodates employee mental health and wellness. The award categories are for New Jersey based Corporations, government agencies, small and large businesses, and educational programs that have shown exemplary, creative and/or innovative approaches in creating an environment that is supportive of the mental health and wellness of their staff. Nomination forms are distributed to consumers, families, NAMI organizations and the DMHAS contract agencies.

To provide education to the public, the Governor's Council on Mental Health Stigma partnered with state psychiatric hospital staff to celebrate hope, recovery and wellness in recognition of Mental Illness Awareness Week: October 7 – 15, 2012. Open houses were held at each of the state psychiatric hospitals. Attendance ranged from 75 to 125. Participants heard speeches on wellness and recovery from families and consumers, were able to tour the treatment malls and see programs, and viewed displays of artwork. One hospital program featured a chorus, using a song written and rehearsed for the occasion. For 2013, creative arts festivals will be held, and planning is already underway with the hospital staff. Original works of art, poetry, short stories, music, and dance will be featured. Community agencies will be invited to attend along with families and consumers.

In cooperation with the New Jersey Office of Information Services (OIS), videos relating to stigma, messages of hope and recovery are being produced for posting on the Council's website. These videos will be used in training sessions and presentations statewide. The Council recognizes the importance of cultural competency in all of its efforts and inclusion of all groups in prevention efforts. All community partnerships focus on collaboration with all groups to ensure that all input, information and guidance in regard to messaging, content and approach are accurate and culturally competent.

Suicide Prevention

Suicide remains a significant cause of mortality for far too many of New Jersey's residents. According to the New Jersey's Department of Health's (DOH's) Office of Injury Surveillance and Prevention (OISP), an average of 580 people in New Jersey took their own lives each year between 1994 and 2003[3]. In CY 2011 this number sadly rose to 676 completed suicides in New Jersey[4]. Causality for this grim increase is difficult to posit, but it is possible that this increase may be related to the recent economic recession, Superstorm Sandy, and the unmet needs of returning veterans from the United States armed services.

[3] http://www.nj.gov/health/chs/oisp/documents/njvdrs_suicide_06.pdf
[4] NJ Violent Death Reporting System v.03/06/2013, data obtained from New Jersey Department of Health.

In order to reduce suicide attempts among New Jersey's residents, the DMHAS has expanded the availability of a suicide prevention hotline through the recent award of a contract to Rutgers' University Behavioral HealthCare (UBHC) program. With this additional support provided by DMHAS, this institution can increase staffing and availability of suicide prevention hotlines for the support of New Jersey's residents who are experiencing mental health crises.

This hotline will always be answered live by a trained staff member or volunteer, and callers are never to have their calls handled nor routed by an automated system. UBHC will also accept calls originating in New Jersey that are routed by the National Suicide Prevention Lifeline network. Specifically, the hotline will serve as a backup to the current active Lifeline Crisis Centers and receive and answer calls that are transferred by Lifeline that cannot be answered by these entities during times of excess call volume or after the Lifeline Crisis Centers' operating hours.

In addition, DMHAS continues to work with the New Jersey Governor's Council on Mental Health Stigma, the Mental Health Planning Council, and additional stakeholder groups to spread the word on both the suicide prevention lifelines (e.g., 1.800.273.TALK) and the availability of approachable, and accessible community-based mental health services that can help consumers deal with symptoms leading to suicidality.

VII. Services to Special/Target Populations

Co-Occurring Services. Beginning in SFY 2010 a Co-Occurring Services Network (COSN), comprised of 53 substance abuse licensed treatment providers that meet eligibility criteria provide treatment, on a FFS basis, to clients with co-occurring disorders. In addition, the Detoxification Initiative is a contract wherein DMHAS provides funding to four licensed residential sub-acute detoxification facilities located throughout the state. These funds provide 14 bed slots for persons with co-occurring disorders referred through SMHA designated screening centers.

The SMHA fully supports and promotes creation of a co-occurring competent and seamless system of services for persons living with, and recovering from, co-occurring disorders (COD). Integrated Dual Diagnosis Treatment (IDDT) was implemented in April 2004. The SMHA currently has ten contracted community mental health providers that have fully implemented IDDT into their existing program (ICMS, Partial Care, and Supported Housing) in five different counties. However, IDDT is not fully implemented across the state. IDDT is provided a diverse mixed of consumers: male and female as well as individuals of Caucasian, African American, Hispanic, Asian and Asian Indian backgrounds and from many different countries.

In addition, the Co-Occurring Task Force comprised the SSA, SMHA and community stakeholders, was convened to create a three-to-five-year strategic plan that articulated the vision of a co-occurring and competent system of care for New Jersey. Visit http://www.state.nj.us/humanservices/dmhs/home/CoOccurring_TF_Report-Sept_2010.pdf to view the report. Through subcommittee work focusing on the areas of best practices, financing, policy, and regulatory and legal issues, the Task Force reviewed the current systems and

identified issues and concerns within and across systems of care; and put forth recommendations to assist in the creation of a co-occurring competent and seamless system of services for persons living with, and recovering from, mental illness and substance use disorders.

Military Veterans. The SSA awarded funding to the New Jersey Prevention Network to serve military families by providing 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. Children in military families are often subject to stressful conditions stemming from difficult transitions. The frequent moving characteristic of military life disrupts children's school and social lives while a parent's deployment disrupts family life. In addition to the direct effects of these events, children are affected by their parents' circumstances and ability to cope. The various stressors that arise from these transitions increase children's risk for emotional distress, substance abuse, and other risky behavior. In addition, a culture favorable to alcohol use and abuse puts children in military families and communities at increased risk for underage drinking.

The SSA's most recent household survey, the 2009 New Jersey Household Survey on Drug Use and Health, also included a set of questions on substance use among New Jersey Veterans. This information, in combination with that found in NJSAMS on veteran status, will help to better inform the SSA on the treatment needs for this population.

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. In SFY 2012 approximately 7,000 individuals were provided with a range of services, the most frequent being emergency services, outpatient, partial care, case management, JIS, SE, and SEd. The SMHA and SSA participate in the state's Veterans Services Enhancement Team, the result of participating in SAMHSA's Policy Academy on Service Members, Veterans and their families to better coordinate and provide services to this group in New Jersey.

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 veterans 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 veterans programs such as Vet2Vet and other veterans referral, treatment and training programs.

HIV. The SSA expends 5% of its SAPT Block Grant award to support the HIV Early Intervention Services (EIS) Initiative including 17 funded providers at 18 sites. Of these, the South Jersey Drug Treatment Center provided access to HIV EIS services to substance abuse clients residing in a rural area, defined as a census area of less than 2,500 residents, consistent with SAPT Block Grant requirements. Funding for these early intervention services allowed clients to receive some or all of these services, either provided on-site at the substance abuse

treatment facilities, facilitated by the substance abuse treatment provider at a nearby medical facility in the community or provided at a combination of both of these settings.

Adolescents. The SSA convened an Adolescent Task Force in 2009 to identify strengths, opportunities and challenges in adolescent substance abuse treatment and to recommend changes and improvements to service delivery, systems and workforce. Recommendations identify actionable goals and steps that can be utilized to transform and enhance the adolescent treatment system. A report of the findings can be found at http://www.state.nj.us/humanservices/das/boards/atf/ATF_Feb2011.pdf.

Women and Women with Dependent Children. The SSA will continue to address this population, as evidenced by the SSA being awarded an In-Depth Technical Assistance (IDTA) grant through 2012 by the National Center on Substance Abuse and Child Welfare to improve outcomes for children and families involved with child welfare, substance abuse and the courts. New Jersey is in the process of exploring limited continuation of IDTA through the development of a narrowly focused scope of work that will address emergent issues of concern where New Jersey like many other states, has been experiencing an increase in illicit opioid use among women. The SSA will continue its collaboration with DCF's DCP&P and AOC to facilitate systems change and move towards having a shared role in achieving safety, permanency, and well-being outcomes for substance abusing families.

Justice Involved Services (JIS). The SMHA has been providing 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. Clients receive treatment services, case management, housing and medications. The SMHA provides JIS services through 15 contracted community mental health provider organizations in 15 of the state's 21 counties. 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.

Older Adults. The SMHA awarded a contract effective January 1, 2012, for the development of a program to provide specialized clinical consultation, assessment, treatment and intervention to older adults diagnosed with a mental illness. Trinitas Regional Medical Center in Elizabeth, New Jersey was the recipient. The Statewide Clinical Outreach Program for the Elderly (S-COPE) is available to older adults twenty-four hours a day, seven days a week aged 55 years and older who present and/or are referred to a designated screening center, affiliated emergency service provider, contracted SMHA residential providers, the SMHA Preadmission and Resident Review (PASRR) Unit and/or the SMHA Centralized Admissions Unit. These specialized services will ensure the appropriate assessment and treatment of this at risk population in order to facilitate and support their continued residence in the community. The target population is older adults aged 55 years of age and older who are diagnosed with a mental illness. The individual is a

resident of a nursing facility, long- term care setting or currently engaged in contracted residential services through the SMHA and at risk of psychiatric hospitalization.

S-COPE provides training to increase the knowledge and positively affect the attitudes and behaviors of staff from designated screening centers, affiliated emergency service providers, contracted SMHA residential providers, nursing facilities and other long term care settings who are responsible for the care of the target population resulting in improved management of behavioral disturbances and crisis and enhanced lifestyle for these individuals. It will have the capacity of statewide service provision which may include multiple service sites. All service sites collaborate and use uniform and consistent promising practices and/or evidence-based practices and policy and procedures for training, assessing, developing treatment, providing treatment, managing behavioral disturbances and stabilization of crises for the targeted population.

S-COPE must ensure that the program will be culturally and linguistically competent, accessible, and responsive to agencies, consumers and families. Older adult is defined in this specific section as individuals over the age of 55 years and with a psychiatric diagnosis. The older adult mental health service system in New Jersey does not discriminate with regard to diverse racial, ethnic and sexual /gender minorities. It is also contracted to provide nine regional trainings and one annual conference. Staffing includes a Clinical Administrator, Program Director, Masters Level Clinicians, an Advance Practice Nurse and the services of a Gero-Psychiatrist. The SMHA Older Adult Workgroup carefully monitors the performance of the program.

Deaf and Hard of Hearing. New Jersey has an array of services throughout the state for individuals who have mental health issues who are also deaf or hard of hearing.

ACCESS at St. Joseph's Medical Center in Paterson is contracted to provide on-site outpatient services at several outpatient locations throughout the state with Master's level clinicians trained in American Sign Language (ASL). They also provide 24/7 statewide consultation for psychiatric emergency services (available onsite during business hours and by phone/TTY in the evening). Consultation is also available to inpatient settings, and outpatient programs. TTY capacity to ACCESS staff is also available. ACCESS staff participates in the New Jersey training for Certified Psychiatric Screeners so that they are able to understand and explain the state's screening process. ACCESS also provides onsite clinical consultation and liaison services to New Jersey's STCF 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 consumers who are deaf and hard of hearing with a mental health diagnosis living in the community.

New Jersey has a Statewide Specialized Inpatient (SSIP) Deaf Program at Greystone Park Psychiatric Hospital. The SSIP consists of a 25 bed capacity inpatient unit in the main hospital

building and an eight bed capacity to less restrictive residential cottage to prepare individuals for discharge. The SSIP staff are trained in ASL and deaf culture on all shifts.

Two additional community programs located in the Northern Region of the state provide services to the deaf and hard of hearing population with mental health issues. The Integrated Case Management Services program in Paterson provides a staff member to work with this specialty population and the Partial Care program in Paterson has a specialty track for consumers who are 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.

LGTBQ. The SSA provides prevention services to Gay, Lesbian, Bisexual, Transgendered, and Questioning (GLBTQ) youth. The SSA awarded funding to the North Jersey Community Research Initiative to expand their existing programs for high-risk GLBTQ 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.

Consumers < 350% Federal Poverty Level (FPL). The SSA has established a guideline of 350% 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.

In contrast, the SMHA does not means test its clients. In preparation for the arrival of an ASO, an Income Eligibility/SMI survey was developed. The web-based survey was launched June 1, 2013 and is being administered to all mental health programs, with the exception of emergency services, and some other services that will not fall under the purview of the ASO, to determine the FPLs of mental health consumers entering the public mental health system in New Jersey. In addition, the definition of SMI that was developed by the DMHAS Clinical Work Group, will be tested and the correlation between FPL and SMI will be analyzed. This information will be used to help determine the eligibility criteria to be used with the MBHO/ASO.

VIII. 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. 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.

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.

Based upon its National Evaluation Data Systems (NEDS) sponsored research on the proportion of treatment recipients with co-occurring disorders (2001), as well as its Center for Substance Abuse Treatment (CSAT) sponsored special population surveys of drug using behaviors of persons in outpatient mental health treatment, driving-under-the-influence programs, homeless shelters, the state's Temporary Assistance for Needy Families (TANF) program, pre-natal care, middle and high school, as well as the needs of veterans returned from foreign wars, the SSA has the planning data to design policies and programs that address the needs of diverse racial, ethnic, sexual, and transgendered minorities. The SSA attends to the needs of the gay, lesbian, bisexual, trans-gendered and questioning youth in the design of its prevention programs. Also, in the course of its planning efforts, the SSA has examined the demographic characteristics of substance abusing persons accessing and not accessing treatment to identify treatment outcomes over a three-year period by age, gender and race as measured by mortality rates, treatment goal achievement scores, and future hospital costs. Finally, the SSA has provided SAMHSA with valid and reliable data necessary to file the treatment needs assessment tables by age, sex, and race on each of its previous SAPT Block Grant applications.

The SSA provides prevention services to GLBTQ youth. The odds of substance use for GLBTQ youth are on average 190 percent higher than for heterosexual youth, according to a study by University of Pittsburgh researchers published in the April 2008 issue of *Addiction.* For some sub-populations of GLBTQ youth, researchers found the odds were substantially higher, including 340 percent for bisexual youth and 400 percent for lesbians. The SSA awarded funding to the North Jersey Community Research Initiative to expand their existing programs for high-risk GLBTQ 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.

The SMHA provides services to a diverse population of consumers. 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 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 is 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 that addresses special populations, including gender identity, sexual orientation, gender and trauma informed care, racial, ethnic and the hearing impaired.

Multicultural and sensitivity training is mandatory for staff (per DMHAS regulations) upon hire to SH 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.

SEd and SE are provided to a rich mix of diverse consumers: male and female as well as individuals of Caucasian, African American, Hispanic, Asian and Asian Indian backgrounds and from many different countries.

IX. Olmstead

Over the last few years, the SMHA has been successful in its delivery of services to its consumers. 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 have been found to no longer meet commitment standards, but for whom no appropriate placement is available. The official term for the status assigned is Conditional Extension Pending Placement (CEPP). The SMHA issued its Olmstead Plan known as the Home to Recovery CEPP Plan in January 2008, which can be viewed at http://www.state.nj.us/humanservices/dmhs/olmstead/CEPP_Plan_1_23_08_FINAL.pdf.
Although the Olmstead Settlement agreement was a result of a lawsuit initiated in 2005, this Settlement has resulted in an investment in the mental health system in needed community residential and other services. The Olmstead Settlement agreement can be viewed at http://www.state.nj.us/humanservices/dmhs/olmstead/olmstead_settlement_agreement.pdf.

From June 2006 to June 2012 the state hospital census (excluding Anne Klein Forensic Center (AKFC)) has decreased from 2,109 to 1,459, a reduction of 650 or 30.82%. From June 2009 to June 2012, the state hospital census (excluding AKFC) has decreased from 1,724 to 1,459, a reduction of 265, or 15.37%. On July 29, 2009, DHS and DRNJ came to a settlement in the Olmstead litigation that began in New Jersey in 2005. The SMHA has been working toward fulfilling the requirements of the settlement agreement and its Home to Recovery - CEPP Plan. Some of the items listed below are the SMHA's accomplishments since the signing of that agreement.

The settlement called for the creation of 95 beds expressly for the community placement of consumers on CEPP status in the hospitals and 50 beds to be created for consumers who are already in the community and at high-risk for hospitalization and/or homelessness, for a total of 145 placements to be created in FY 2012. The SMHA has met and exceeded this goal for FY 2012 by creating 135 placements for consumers on CEPP status and 107 placements for consumers at risk, for a total of 242 placements created during the fiscal year. Targets were exceeded in 2011 as well, with the creation of 171 placements for CEPP consumers, and 82 placements created for consumers at risk of hospitalization. In 2010, with the Olmstead housing expansion, the SMHA created an additional 196 placements for consumers who were on CEPP status and awaiting discharge and 50 placements for consumers who were in the community and at risk of hospitalization or homelessness. In addition, from 2006 to 2009, the SMHA created 1,424 community placements. Therefore, since 2006, the SMHA has created 2,165 new placement opportunities. The SMHA is currently in the process of rolling out placements geared toward meeting the 2013 targets of 125 placements for CEPP consumers and 100 placements for consumers at risk of hospitalization.

In addition to the accomplishments listed above, a decision was made in July 2011 to close a state psychiatric hospital. The SMHA had been closing several units at its state hospitals prior to the announcement of the closure. Planning efforts began around the closure of a state hospital including statewide hearings that were held and a Stakeholder Task Force that was convened. Hagedorn Psychiatric Hospital, a 288 bed state hospital located in the northern region was closed on June 14, 2012. Admissions to the hospital stopped on October 3, 2011. As of June 30, 2011, the census was 1,554, excluding AKFC and on June 30, 2012, the census, excluding AKFC was 1,459. The SMHA was able to close one of its state hospitals primarily due to its Olmstead Initiative. Some of the activities leading to the decrease in census and closure of the state hospital are listed below:

1. Enhancement of community infrastructure via the development of community placements including SH, enhanced SH for consumers with behavioral or co-occurring service needs, medically enhanced SH, and enhancement of PACT services;
2. Continued use of the Individualized Needs for Discharge Assessment (INDA). Introduced shortly after admission to the hospital, the INDA serves as an assessment tool geared toward evaluating needs or barriers that the consumer may face upon discharge. Through regular review and updating of this assessment, the goal is to anticipate and address any barriers that may hinder or preclude placement within the community, thus decreasing the likelihood of readmission to the hospital. The INDA also contains information from the Housing Preference Interview (HPI) regarding consumer preferences for housing placement type and county.
3. Continued utilization of the Intensive Case Review Committee (ICRC). Consumers are referred to this committee if they a.) have been on CEPP status for two months; b.) are determined, prior to two months on CEPP, to have significant barriers to discharge; or c.) are refusing placement. The cases that are referred are reviewed to ensure that referrals for discharge are being made in a timely manner, barriers to discharge are being addressed, systemic issues are addressed, and compliance with length of stay targets are maintained.

Efforts to enhance community residential placements and the continued reduction in census at New Jersey state hospital, enabled the SMHA to close one of its state hospitals. As the Olmstead efforts continue and the SMHA develops more opportunities for individuals living in the community, the SMHA will continue to evaluate and manage the hospital resources in an efficient and clinically appropriate manner.

In addition to its network of state psychiatric hospitals DMHAS also supports county operated psychiatric facilities which operate as part of the continuum of services. These county hospitals receive most of their funding from the SMHA. In August of 2012, the sale of Buttonwood County Hospital in Burlington County was finalized and the license was conferred to the new owners, a private vendor. After the sale of Buttonwood, there are now five county hospitals remaining in the state. In addition, one other hospital is slated to be sold and privatized by the beginning of Calendar Year 2014.

X. Legislation: Intensive Outpatient Commitment (IOC)

This law is an amendment to the civil commitment law creating the option to commit to outpatient treatment persons in need of involuntary commitment to treatment. The outpatient commitment law is intended to provide a treatment option in the community for a class of consumers who are not willing to receive treatment voluntarily and will become, in the foreseeable future, dangerous enough because of a mental illness to require supervision, but who are not so imminently dangerous that they need to be physically confined in an inpatient program.

The legislation became effective on August 11, 2010, and required phase in to seven counties each year, over a three year period, and included no appropriation. Due to the lack of sufficient funding in SFY 2011, implementation of the law was delayed by invoking "General Provision" #72 on page E-7 of the FY 11 Appropriations Handbook. A Request for Information (RFI) was issued January 26, 2011 to stakeholders to inform the development of a future, competitive RFP and to help estimate the amount of additional resources necessary to implement the law.

An IOC Advisory Committee on Implementation was established to provide input as to how NJ can best implement IOC in a manner which comports with the law and is also responsive to the needs of families, consumers and citizens. The first meeting was held in April 2011. This committee was comprised of representatives from consumer and family organizations, providers, the court system and DMHAS staff. Members of the IOC Advisory Committee on Implementation also participated in two subcommittees that were convened: the Screening Subcommittee and the Court Procedures Subcommittee. Meetings were held in April, May, June and July and the IOC Advisory Committee and the two subcommittees concluded deliberations in July 2011.

On January 13, 2012, DMHAS issued a RFP for the implementation of IOC in up to seven counties using the $2 million that was appropriated in the FY 2012 budget. DMHAS funded five programs in response to this RFP at approximately $1.7 million annually. These programs were operational August 1, 2012. As of February 21, 2013, there were 69 individuals served by and 46 individuals actively enrolled in the five operational IOC programs. DMHAS used the

remaining resource of approximately $294,000 to issue a statewide RFP for one additional IOC program (excluding the awarded counties). The RFP was issued on August 1, 2012 and the sixth IOC program was awarded in November 2012. The sixth program became operational in the Spring of 2013. In addition, by the end of Calendar Year 2013, DMHAS will issue a report to the legislature describing how we will roll out IOC statewide.

XI. Promoting Health and Behavioral Health

The SMHA contracts with community service agencies to work collaboratively to treat the physical and emotional needs of consumers. Initiatives to promote a better understanding of the role of mental health to overall health include: Smoking Cessation; Illness Management and Recovery (IMR), and the Advanced Practice Nurse (APN) Program.

Smoking Cessation: On April 7, 2008, the state legislature passed a law banning smoking on state hospital grounds with the provision that a smoking cessation program shall be offered to patients one full year in advance of the ban. On July 8, 2009, Ancora Psychiatric Hospital and Greystone Park Psychiatric Hospital became tobacco free as a result of this legislation. Both Trenton and Hagedorn Psychiatric Hospitals became smoke free in the fall of 2009. The smoking cessation program is a SMHA funded university-based program targeted towards educating staff and patients in state hospitals and provider agencies about cardiac risk factors associated with smoking. The goal is to have a smoke-free environment for consumers and staff.

Illness Management and Recovery (IMR): The IMR program initiated in the community and state hospital programs is on-going. Training of staff started in our central region with five to ten staff in each agency being trained. This initiative is specifically geared toward helping mental health consumers acquire the information and skills needed to collaborate effectively with others in the development of their treatment plan. The goal of the IMR program is to help the consumer learn about mental illness and strategies for treatment; decrease symptoms; reduce relapses and hospitalizations; and make progress towards personal goals through recovery. The SMHA, in partnership with UMDNJ's School for Health Related Professions, provides training in this model which consists of ten modules to targeted staff in five state psychiatric hospitals and 102 partial care programs/partial hospitals. IMR is provided to a diverse population of consumers; male and female as well as individuals of Caucasian, African American, Hispanic, Asian and Asian Indian backgrounds and from many different countries.

Advanced Practice Nurse (APN) Program: Through the APN Program, comprehensive health and mental health assessments of acute and chronic conditions are completed; medication is prescribed under joint protocols; and APNs participate in the development, implementation, and evaluation of treatment plans. Consumers are referred to APNs from a variety of sources, including state and county hospitals, emergency rooms, short-term care facilities, family members, self-referrals and community providers. APNs are accessible on site at the hospitals, some community programs, and in homeless shelters. The SMHA funds approximately 68 APN positions. The state hospitals are responsible to ensure that consumers receive all necessary medical treatment (including mammography, dental care, etc.). Some of the state and county hospitals have dental offices within their facilities.

In addition to these efforts, the SMHA will continue its health promotion and wellness activities in the state hospitals and in the community. Recently, the state psychiatric hospitals have begun recording and tracking patients' metabolic indices and other relevant health data. Each facility has a wellness committee that supports and monitors health promotion activities and programs (walking and exercise, nutritional and wellness education, smoking cessation, etc.). All state hospitals are smoke-free and offer smoking cessation programming that is specially tailored to individuals with serious mental illness through the Learning about Healthy Living manual, which was developed in collaboration with the UMDNJ. Most hospitals have a peer support specialist who is involved with these activities, and the facilities are also connected to the consumer organizations that also offer support for consumers and for wellness programs in the facilities. Dr. Margaret Swarbrick of the Wellness Institute of CSPNJ, the state's largest consumer organization, provided a presentation to the hospital wellness committee in December 2010.

In regard to community initiatives, the CSPNJ and UMDNJ had joined with the SMHA on a federal grant that had funded training for peer wellness coaches, who serve in a variety of community settings. The SMHA also helps support the Consumers Helping Others to Increase their Chances of Ending Smoking (CHOICES) program, which is an award-winning peer-to-peer program to raise awareness about the harms of smoking and motivates consumers to quit. The SMHA has had a several year contract with UMDNJ to develop educational materials and tools that promote health and wellness and then provide training and technical assistance on these to hospitals and community agencies. In addition to the smoking cessation manual, UMDNJ has conducted a statewide survey to assess access and barriers to health and wellness services, and it has more recently been working on educational tools to promote shared decision-making and consumer awareness about psychotropic medications and the metabolic syndrome.

Medical and Dental. The SMHA recognizes that ensuring consumers' medical and dental needs are met is essential to overall wellness and recovery. There is clearly an expectation that agencies will follow up to ensure that consumers receive necessary medical treatment. There are numerous SMHA regulations that mandate mental health service providers take consumers' primary health into account. Examples include N.J.A.C. 10:37 whereby consumers who receive inpatient or any contracted mental health service have the right to prompt and adequate medical treatment and N.J.A.C. 10:37 which indicates that if an individual is in inpatient treatment, is discharged, de-compensates, and is re-admitted to the unit, then that the unit is responsible to identify if there was a breakdown in the individual's support system for a physical condition. Contracted providers of residential services require healthcare monitoring and oversight services. Providers of outpatient services, partial care services, PACT, and residential services are required to incorporate previous and current physical problems into consumers' comprehensive service plan.

Bi-Directional Integration of Behavioral Health and Primary Care Services. The state is well positioned to take advantage of the Patient Protection and Affordable Care Act (PPACA) and move forward with a number of related initiatives that will promote medical homes, reform its Medicaid program, and further promote illness self-management for individuals with SMI, in order to address the major health disparities in this population. New Jersey has been fortunate to have several Health Homes initiatives that have developed at the grass roots level. Two New Jersey providers are implementing SAMSHA-funded Behavioral Health Home (BHH) Pilots. In

addition, the Nicholson Foundation, through a public-private partnership, has provided funding to two FQHCs to implement health homes providing integrated behavioral health care. DMHAS and the DMAHS (Medicaid) have been at the table to help these efforts overcome obstacles created by the current regulatory and funding mechanisms.

New Jersey's Medicaid Comprehensive Waiver includes under Section 2703 of the ACA, Health Homes as part of its Medicaid state plan, thereby becoming eligible to receive additional federal funds (90/10 match) for health home services in the first two years after implementation. This component of the waiver includes provisions for BHHs for people who are This component of the waiver includes provisions for Behavioral Health Homes (BHHs) for people with SMI.

Upon approval from Centers for Medicare and Medicaid Services (CMS), care coordination services in the health home model, consistent with federal CMS guidelines under Section 2703 of the ACA, will be reimbursed as a new service at an enhanced rate for up to two years. The provider will be permitted to retain the funds for service expansion and/or investment into health information technology, such as a certified electronic health record, if certain outcomes are achieved. DMHAS has received technical assistance from SAMHSA on financing models and is exploring strategies to build system readiness and capacity throughout the state before starting the two-year enhanced funding clock.

In addition to the waiver regarding BHHs, DMAHS and DMHAS are partnering to assist the HMOs that manage the primary care for Medicaid clients to develop Health Homes services that include bidirectional behavioral health and primary care screening, identification, referral to, and linkage for consumers. The partnership between the two divisions is critical to the full integration of services and both divisions are committed to work together toward that goal.

The county Mental Health Administrators have been involved in the efforts to promote integration and wellness activities of agencies in their counties, as are stakeholders at every level. The behavioral health community has expressed considerable interest in these issues and is motivated to learn about opportunities to coordinate, collaborate or integrate behavioral health and primary care services. The New Jersey Association of Mental Health and Addiction Agencies (NJAMHAA), which is the provider organization for New Jersey behavioral health agencies, has issued a white paper entitled "Integrating Physical Health and Behavioral Health Care" in which it presented several recommendations for integration, and they have formed a task force and have held meetings on these issues, most of which have involved members of the DMHAS Work Group on Integration. Several new community behavioral health agencies have received SAMHSA grants for pilot projects; these include CarePlus-NJ, which received a Primary and Behavioral Health Care Integration grant to provide primary care clinic services for consumers onsite, and also a consortium of four mental health agencies led by Catholic Charities-Trenton, which received a SAMHSA grant for coordination of primary care services with local FQHCs.

The New Jersey Primary Care Association (NJPCA), the trade association representing FQHCs in New Jersey, is also working with DMHAS in regard to the bi-directional integration of physical and behavioral health services. With the help of a foundation grant, the NJPCA has a pilot program in which two FQHCs are screening patients for depression and anxiety and then treating them or referring them to an affiliated behavioral health agency. The state has a very

active and strong consumer movement, and these organizations have been instrumental in these efforts, including Dr. Swarbrick, who also works on a national level with the SAMHSA "10 X 10" wellness campaign. The state has a number of peer specialists working as wellness coaches in a variety of settings, and the consumer-run Self Help Centers that are funded by the SMHA are providing a number of wellness activities.

In July 2012, SAMHSA awarded the DMHAS a five-year $7.5 million cooperative agreement for Screening, Brief Intervention and Referral to Treatment (SBIRT) services. Entitled NJ SBIRT, the project is a partnership between the DMHAS and the Henry J. Austin Health Center (HJA), a FQHC serving the capitol city of Trenton. The NJ SBIRT project seeks to expand and enhance the existing continuum of care by integrating evidence-based services, proven effective in reducing substance use and associated negative health consequences, in primary care and community health settings. The project goals are to: 1) reduce alcohol and drug consumption and its negative health impact; 2) increase abstinence; 3) reduce costly health care utilization among Trenton residents accessing primary care services through an FQHC and hospital outpatient clinics; and 4) promote policy and systems change that identify and overcome barriers to consumers accessing and engaging in treatment.

The HJA will implement SBIRT services in a total of five project sites located throughout the city of Trenton. The array of services to be provided includes universal screening of adult patients for the identification of substance use risk, and clinically appropriate brief intervention, brief treatment, referral to specialty treatment and care coordination services for those identified in need. Approximately 44,000 screens will be conducted over the course of the five-year project period.

The Delivery System Reform Incentive Payment (DSRIP) Program is one component of New Jersey's Comprehensive Medicaid Waiver as approved by CMS in October 2012. DSRIP seeks to result in better care for individuals (including access to care, quality of care, health outcomes), better health for the population, and lower cost through improvement by transitioning funding from the current Hospital Relief Subsidy Fund (HRSF) to a model where payment is contingent on achieving health improvement goals by hospitals. Hospitals designated as DSRIP participating hospitals will receive 2013 HRSF Transition Payments in demonstration year one. The DSRIP Pool is available in demonstration years two through five for the development of a project which includes activities that support the hospitals' efforts to enhance access to health care, the quality of care, and the health of the patients and families they serve. Projects that are eligible related to behavioral health include the following:

1) Utilize an Electronic Self-Assessment Decision Support Tool to Improve Mental Health Consultations and Treatment: The objective of this project is for the hospital to work with outpatient facilities to implement an electronic self-assessment decision support tool to improve the continuum of care treatment provided to mental health patients by improving the efficiency and effectiveness of treatment planning, adherence and communication between the patient and the mental health provider.

2) Integrated Health Home for the SMI: The objective of this project is to fully integrate behavioral health and physical health services for those with a SMI diagnosis in order to provide evidence-based whole-person care.

3) Hospital-wide Screening for Alcohol Withdrawal: The objective of this project is to ensure the utilization of hospital-wide screening tools to detect alcohol or substance withdrawal for all patients admitted to the hospital regardless of the admitting diagnosis or event in order to effectively manage these symptoms. Upon screening, precautionary or treatment algorithms will be initiated as needed.

4) Hospital Partners with Residential Treatment Facility to Offer Alternative Setting to Intoxicated Patients: The purpose of this project is to offer an alternative treatment setting for acute alcohol intoxicated patients in order to lower the emergency department length of stay and offer immediate access to treatment.

Managed Behavioral Health Care. DHS convened a formal Stakeholder Steering Committee in January 2012 to inform the DHS' values and vision regarding the design and implementation of the ASO/MBHO; elicit broad stakeholder input regarding the design and development of the various components of the ASO/MBHO; initiate a small group process to inform at a more detailed level the components of the ASO/MBHO; and identify and leverage opportunities under Health Care Reform to support a transformed system. The group met regularly from January to March of 2012 and presented their final report to Commissioner Velez in June 2012. Four Work Groups were formed to address key aspects of the design and development of the MBHO: access, clinical, fiscal, and outcomes. The Work Groups were asked to embrace a consumer-centered, wellness and recovery orientation and to keep key consumer-level and systems level considerations in mind as they engaged in their work. Each Work Group was asked to prepare a report that identified key issues for consideration, challenges and opportunities, and recommendations for the Steering Committee within their respective areas of focus. In addition, the Steering Committee formulated guiding principles for the development of a managed behavioral health care system and identified characteristics an ASO/MBHO should possess in order to reflect the values of New Jersey's behavioral health system. A full copy of the report, including an executive summary and the Work Group specific recommendations, can be accessed at http://www.state.nj.us/humanservices/dmhs/home/mbho/Stakeholder_final_report_june15_2012.pdf.

Overview of the New Jersey Department of Children and Families' Division of Children's System of Care

New Jersey's children's mental health System of Care began in November 1999 when the New Jersey DHS won a System of Care grant award from SAMHSA of the federal Department of Health and Human Services. Beginning in the year 2000 the Department led a major reform initiative, formerly known as the Children's System of Care Initiative (CSOCI). This initiative began to restructure the system for delivering services to children with emotional and behavioral challenges and their families into a single System of Care, coordinated and integrated at the local level, focused on improved outcomes for children and their families.

The CSOCI concept operated on the following abiding principles:

- The system of care for children must be restructured and expanded;
- There should be a single point of entry into the behavioral healthcare system and a common screening tool;
- Greater emphasis must be placed on providing services to children in the most natural setting, at home or in their communities, if possible;
- Families must play a more active role in planning for their children; and
- Non-risk based care and utilization management methodologies must be used to coordinate financing and delivery of services.

Between 1999 and 2004, CSOCI and its successor, Partnership for Children, underwent several expansions and changes. In 2004, legislation was enacted creating the Office of Children's Services within the DHS. This Office acted as a single umbrella over three Divisions most concerned with children's welfare: the Division of Youth and Family Services (DYFS - the state's child welfare agency) and two new Divisions, the Division of Child Behavioral Health Services (DCBHS) and the Division of Prevention and Community Partnerships (DPCP). An Office of Training was also created as a vital component of the Office of Children's Services.

On December 31, 2005, New Jersey closed the Arthur Brisbane Child Treatment Center, the single remaining state operated inpatient facility for youth. This necessitated the development of a variety of intensive and specialized residential services, along with additional intermediate care inpatient services, to provide the most appropriate clinical interventions in community-based settings. In addition to tow new Intermediate Units base in community hospitals, DCBHS developed five Intensive Residential Treatment Services (IRTS) to serve youth who have been stabilized in a hospital but who need longer-term intensive treatment.

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 new, freestanding Department included the DYFS, the DCBHS, the DPCP, the Office of Education, the Office of Adolescent Practice and Permanency and the New Jersey Child Welfare Training Academy.

On June 29, 2012, Governor Chris Christie signed a bill that 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 will 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 transition of these services to DCF from DHS began January 1, 2013.

The bill also establishes and renames four divisions within DCF:

- 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.

- DPCP is now the Division of Family and Community Partnerships (DFCP) and serves as DCF's grant-making and best practices team committed to strengthening New Jersey's families. DFCP is committed to provide the resources and technical assistance needed to grow a robust network of public/private partnerships and programs.

- The Division on Women has been transferred to DCF from the Department of Community Affairs. The Office of Adolescent Services, the DCF Office of Education, and the New Jersey Child Welfare Training Academy remain under the auspices of DCF.

- DCBHS is now the Division of Children's System of Care (DCSOC) 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. On January 1, 2013, DCSOC began coordinating services for youth with developmental disabilities and their families. Coordination of services for youth with substance use disorders and their families began on July 1, 2013.

DCSOC is the single state agency that provides contracted services to children, youth and young adults with emotional and behavioral health care challenges and their families across multiple child-serving systems. DCSOC was created to coordinate and expand existing services and to develop new community services to help youth and their families recognize their strengths and plan services to meet their needs. DCSOC is committed to providing services based on the needs of the child, youth or young adult and their family in community-based, family-centered environment. DCSOC services are coordinated through the Child/Family Team and are based on a single, strength-based individual service plans (ISP). Children, youth and young adults and their families are viewed as full partners in the development of their ISP and in assessing progress toward their own outcomes.

DCSOC provides funds and/or contracts for the following services for children and adolescents with serious emotional and behavioral disturbances and their families: diagnostic and evaluation; alternatives to inpatient care; outpatient services; group and family counseling services; professional consultation; the review and management of medication; case management; screening/emergency services, 24 hours a day, 7 days a week, including mobile response and stabilization services; intensive in-community and home-based services, including behavioral assistance; intensive day treatment and partial care services; treatment homes, residential treatment; therapeutic group homes; and parent-run family support.

DCSOC developed the following system partners for its system of care:

- A statewide **Contracted Systems Administrator (CSA)** to support utilization management, care coordination, quality management, and information management for the statewide system of care. The CSA provides DCSOC, the care management entities and other system partners with the information needed to manage the ISP process toward child and family satisfaction, quality outcomes and cost effectiveness. The CSA provides data to DCSOC. The CSA creates a virtual single point of processing that registers all enrollees, authorizes services, is a single electronic record, tracks and coordinates care for all New Jersey children who are screened into the system at any level. The CSA acts as an agent of state government

contracted by and accountable to DCSOC to manage services. The CSA is not risk based and has no incentive to restrict care.

- **Care Management Organizations (CMOs)** are non-profit community-based organizations that combine advocacy, service planning and delivery, and care coordination into a single, integrated, cross-system process, in order to assess, design, implement and manage child-centered and family-focused ISPs for children, youth and young adults whose needs require either intensive or moderate care management techniques that cross multiple service systems. Community-based services and informal resources are organized and coordinated through face-to-face care management at the local level. CMOs work with Child/Family Teams to develop ISPs. The CMOs' goals are to keep children in their homes, their schools and their communities. The CMOs are fully operational in all 15 vicinages covering all 21 counties in New Jersey.

- **Family Support Organizations (FSOs)** provide direct peer support and assistance to children and families by family members of children with current system involvement. FSOs paralleled the development of CMOs. FSOs are a parent run organization that provides assistance to families through peer mentorship, education and advocacy, information, referral and the hosting of parent and peer support groups. FSOs act as a guide for professionals and provide direct peer support to families whose children are enrolled in DCSOC services. The FSOs are fully operational in all 15 vicinages covering all 21 counties in New Jersey.

- **Mobile Response and Stabilization Services (MRSS)** provide face-to-face intervention to children who are experiencing escalating emotional and/or behavioral issues. The goal is to prevent the disruption of children's living situation and to help maintain children in their current living environment. Staff responds within one hour of the initial call and provides de-escalation, assessment and crisis planning and may initiate stabilization services for up to eight weeks. This service is available 24 hours per day, seven days per week. MRSS are fully operational in all 15 vicinages covering all 21 counties in New Jersey.

The children's system of care also includes but is not limited to the following service components including the traditional children's mental health services:

- **Intensive In-Community (IIC) and Behavioral Assistance (BA) Services** IIC/BA services developed as a needed component of the new system of care and are flexible, multi-purpose, in home community rehabilitative services for parents/ caregivers/ guardians and children/youth with behavioral and emotional needs. Intervention is geared toward strengthening the family and preserving the family constellation within the community setting. Services include, but are not limited to, group, individual or family therapy, clinical consultation/evaluation, instruction in anger management, parenting skills and problem solving behavioral management and psycho-social education. **IIC** are services to strengthen the family, provide family stability and to preserve the family constellation in the community setting. Services are flexible as to where and when they are provided based on the family's needs. Interventions may be provided as a component of Mobile Response and Stabilization or as a longer-term treatment intervention. This family-driven treatment is based on targeted needs as identified in the ISP. The ISP also includes specific interventions with target dates

for accomplishments of goals that focus on the restorative functioning of the child/youth and family. Also developed as part of an ISP, **BA** provides specific, outcome-oriented interventions that are components of a detailed plan of care prepared by a licensed clinical behavioral healthcare practitioner. BA is a dynamic process of intervention and ongoing evaluation resulting in effective modification of specific identified behaviors. BA services involve applying positive behavioral principles within the community using culturally based norms to foster behaviors that are rehabilitative and restorative in nature. The model is flexible allowing for some interventions to be provided in small (no more than 3) group setting. These services are available statewide.

- **Evidence-Based Programs (EBPs).** DCSOC contracts for two types of EBPs for delinquent and at-risk youth; Functional Family Therapy (FFT) and Multisystemic Therapy (MST). These therapies, which last four months on average, treat the entire family, not just the youth referred for treatment. FFT and MST both support DCSOC core principles of keeping youth at home (with their families and not in out-of-home settings), in school (in their regular school in their district), and out of trouble (not involved with the juvenile justice system or at risk of detention or incarceration).

  DCSOC contracts for 157 Therapeutic Nursery beds for children between the ages of 2½ and 7. Therapeutic Nurseries provide intensive outpatient, behavioral health services to young children who evidence unusually challenging behavioral patterns that interfere with their ability to adaptively function at home and in the community. These programs help children develop problem solving skills, interpersonal skills, self-esteem, anger management skills, and internal controls to regulate impulses and emotions, and a foundation for lifelong healthy attachments. In addition, Therapeutic Nurseries provide family interventions and related training and support services to parents and caregivers.

  DCSOC currently contracts for 729 Treatment Home beds. Treatment Homes are New Jersey's approach to Therapeutic Foster Care. This level of care is for children who require more intensive treatment and supervision than is found in a traditional or kinship foster care placement. Children reside in the safe environment of a private home setting, licensed as a treatment home and the treating parents have received specialized training in the care of children with emotional and behavioral problems. Treatment Homes are designed for children with behavioral and functional disturbances who have the capability to engage in community-based activities in a family setting. Community resources are used in a planned, purposeful and therapeutic manner that encourages residents' autonomy appropriate to their level of functioning and safety and as indicated in their ISP. Services provided in this setting may include mentoring, counseling, behavioral management and crisis intervention. A Treatment Home parent participates as part of the Child Family Team and ensures that the youngster receives needed psychiatric and psychological services, medical care and education. Treatment Home parents receive supervision and are supported by the staff and programs of the Treatment Home agency. This level of care is transitional, typically considered for children who have been recently discharged or are being diverted from a more intensive level of care. It is intended to maintain the child in the community while preparing for permanency - return to family of origin, adoption, permanent foster care, kinship care or independent living.

- **Screening/Emergency Services.** These services are available 24-hours a day, seven days a week for children and youth who are experiencing a psychiatric crisis and need to access inpatient hospitalization. Screening/emergency services are typically located within community hospitals' emergency service departments.

- **Children's Crisis Intervention Services (CCIS).** Located in community hospitals, CCIS are acute inpatient units that provide screening, stabilization, assessment and short-term intensive treatment. The Department of Health, following designation by the DCF DCSOC, licenses these units.

- **Intermediate Inpatient Unit (IIU) Treatment Services.** Sub-acute inpatient psychiatric units licensed as closed child/adolescent inpatient facilities by the Department of Health and located in community hospitals. These units serve youth who require additional inpatient treatment following stabilization in a CCIS with a typical length of stay of up to 60 days.

- **Intensive Residential Treatment Services (IRTS).** Non-inpatient secure treatment provided to youth who require 24/7 care in a safe, secure environment with constant line-of-sight supervision, medication management and a concentrated individualized treatment protocol. Services are provided to youth with a wide range of serious emotional and behavioral needs. The typical length of stay is in excess of 60 days.

- **Residential Treatment Centers (RTC).** RTCs provide intensive treatment services for 13 or more children on a 24-hour a day basis. This includes facilities providing educational services on or off grounds as well as programs that provide adventure-based treatment. This also includes facilities certified to provide voluntary inpatient psychiatric care. RTCs are located both in the State of New Jersey and outside of the state.

- **Group Home treatment.** Group homes are licensed by DCF to provide board, lodging, care and treatment on a 24-hour basis for generally 12 or fewer children in a community based setting. The intensity of the mental health treatment and the average length of stay may vary depending on the program design.

- **Detention Alternative Programs (DAP).** DCSOC has developed three Detention Alternative Programs (DAP) with a total of 15 beds. The priority population is youth in DCP&P custody awaiting DCF placement once their charges have been disposed. These DAP beds ensure DCF is in compliance with the child welfare Modified Settlement Agreement (MSA). The DCSOC liaison also refers youth in detention centers with mental health needs.

- **Partial Care Programs.** Generally provided in after-school or half day settings, Partial Care programs are intensive, non-residential day treatment services that can include counseling, psychiatric assessment, medication, behavior management, rehabilitation and recreation components.

- **Partial Hospital Programs.** Partial hospitalization is an intensive, nonresidential, therapeutic treatment program that may or may not be hospital-based. The program provides clinical treatment services in a stable environment on a level equal to an inpatient program, but on less than a 24-hour basis. These services are outcome oriented for children and youth experiencing acute symptoms or decompensating clinical conditions that impede their ability to function on a day-to-day basis, and who may be at risk of inpatient care without daily programming. The course of treatment will be based on targeted needs as stipulated in either the ISP. Treatment may include therapeutic milieu; nursing, psychiatric evaluation, medication management/education, group/individual/family therapy, supervised clinically appropriate leisure time and/or vocational programming. Provision of a Partial Hospital program is used as a time limited response to stabilize acute symptoms. It can be used as a step-down from inpatient services, residential treatment or to stabilize a deteriorating condition and avert hospitalization.

- **Outpatient Treatment Programs.** Available in a variety of community agencies and settings, outpatient services include individual group and family therapy, medication management, and therapeutic recreation.

- **Flexible Wraparound Funds for Non-Traditional Supports.** These funds ensure that non-traditional supports are available to children and families served by Mobile Response and Stabilization Services, CMOs and the CSA.

- **County Inter-Agency Coordinating Councils (CIACCs).** Located within each county, CIACCs were created by statute to serve as the mechanism in each county to develop and maintain a responsive, accessible, and integrated system of care for children with emotional and behavioral challenges and their families, through the involvement of parents, consumers, youth and child serving agencies as partners. The CIACCs provide a forum where the system of services for children with emotional and behavioral challenges is developed, reviewed, revised and/or redirected, through collaborative decision-making process with DCF to promote optimal services provided in the least-restrictive, but most appropriate setting possible. Each CIACC completes an annual county needs assessment to determine how DCSOC community development funds should be allocated within that county.

DCBHS Initiatives, Collaborations, Services and Supports

Collaboration with DYFS on Behavioral Health Service Planning for Child Welfare Service Recipients

Clinical Consultants report to DCP&P Area Offices four days per week and serve as liaisons, joined from the wraparound perspective, who 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 CMO Clinical Consultant is a jointly owned and administered position between the CMO and DCP&P. Clinical Consultants translate clinical information into user-friendly language, 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 CSA 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.

DCF Transitions for Youth (TFY) Initiative

Transitions for Youth (TFY) is a multifaceted statewide initiative that utilizes a positive youth development framework to address the complex needs of youth transitioning to adulthood, particularly those who are aging out of foster care or who were involved with New Jersey's juvenile justice or behavioral health systems. TFY's goal is to ensure that youth develop essential skills and competencies in education, employment, daily living, decision-making, and interpersonal communication. TFY is funded primarily through the DCF's Office of Adolescent Services (OAS) and is coordinated by the Center for Nonprofit Management and Governance, The School of Social Work at Rutgers, The State University of New Jersey.

All TFY programs are rooted in best practices and integrate Positive Youth Development, a model for improving outcomes for youth by addressing the following domains: housing stability; improved academic functioning; job-readiness skills; financial literacy; emotional regulation and physical wellness; and peer, adult and community partnerships. TFY services for Special Populations include: gay, lesbian, bisexual, transgender, questioning and intersex youth (GLBTQI); parenting youth; youth living with HIV/AIDS and youth with juvenile justice involvement/ mental health concerns.

A complete description of the programs and supports available through TFY can be accessed at: http://socialwork.rutgers.edu/CentersandPrograms/TFY.aspx

DCF Division of Family and Community Partnerships (DFCP)

DFCP serves as DCF's grant-making and best practices team committed to strengthening New Jersey's families. DFCP is committed to provide the resources and technical assistance needed to grow a robust network of public/private partnerships and programs. Schools and community-based organizations are two prime locations for prevention and intervention services. DFCP's goal is to build a continuum of child abuse prevention and intervention programs that are culturally competent, strength based and family-centered, with a strong emphasis on primary child abuse prevention.

New Jersey Juvenile Justice Commission (JJC)

DCF and its Divisions have established cooperative relationships with the JJC. In December 2004, the Department and the JJC signed a Memorandum of Understanding that outlines a distinct process by which youth in the JJC can be referred directly into the children's system of care before being discharged from a JJC facility. Representation from both DCP&P and DCSOC 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 process and in case review process.

The JJC 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, provide treatment for sex offenders, increase disposition options, and provide aftercare to youth and their families.

Collaboration with Juvenile Detention Centers

When a court-involved child who is being held in a county juvenile detention facility is ordered by a family court judge into an out-of-home treatment residential facility, that child should be transitioned from the juvenile detention center as quickly as possible. To effectively accomplish this, it is critical that children for whom a congregate care placement is contemplated be identified as early in the court involvement as possible. DCSOC has implemented an easily accessed clinical assessment process for any youth in a county juvenile detention center who may have behavioral and/or mental health issues. The detention social services staff can request one of these evaluations which a have a turn-around time of five business days. To accomplish this, DCSOC developed a tracking system for children in county detention centers for whom a congregate care placement is being considered. The contracted system administrator's management information system was modified to incorporate information about detention status for system-involved children. The information in the contracted system administrator's management information identifies children for whom proactive placement is initiated.

DCSOC developed three Detention Alternative Programs (DAP) with a total of 15 beds. The priority population is youth in DCP&P custody awaiting DCF placement once their charges have been disposed. These DAP beds ensure DCF is in compliance with the child welfare Modified Settlement Agreement (MSA). The DCSOC liaison also refers youth in detention centers with mental health needs.

Developmental Disabilities/Mental Illness (DD/MI) Dual Diagnosis Task Force

The DHS Dual Diagnosis Task Force released its report *Collaborating to Provide Services and Supports for Children and Adults with Co-Occurring Developmental Disabilities and Mental Health/Behavior Disorders* on October 10, 2008. Task Force membership is comprised of individuals with developmental disabilities, family members, advocates, service providers, professionals, state officials and representatives. Leadership from DDD, DMHAS and DCSOC respectively pledged their support and expressed their commitment to bring about change to efficiently and effectively serve the dually diagnosed population. The Task Force made recommendations for system and service change which are cognizant of the difficult economic climate and its impact on implementation, focusing on identifying opportunities to maximize existing resources to make incremental changes. An Executive Oversight Board was convened to manage the implementation plan to ensure that the vision for system change is achieved. The

Task Force re-convened in SFY 2010 to continue its work and is now creating a plan for implementing the most important recommendations outlined in the report, which include:

- Developing collaborative, county-based planning for individuals who have a dual diagnosis;
- Training direct-care and professional staff working with people with dual diagnoses;
- Developing a continuum of crisis-response services to both prevent the need for crisis intervention and allow individuals to gain access to crisis-response services when needed;
- Increasing family and other caregiver education and support through professional, as well as family and peer organizations, in order to teach individuals with dual diagnoses, families and caregivers effective behavioral management; and
- Developing Outpatient Service Centers with the capacity to provide comprehensive assessment and evaluation, medical and dental care, integrated mental health treatment and behavior management, guidance on providing behavioral support at-home and training for the workforce.

As of January 1, 2013, DCSOC became the single point of access for service coordination and provision for children, youth and young adults with developmental disabilities.

Transition of Aging Out Youth to the Adult Mental Health System

DCSOC developed "The Tool" to assist care managers and case workers in documenting actions involving children and young adults who are receiving out of home (OOH) services. The Tool has three parts: Treatment, which includes questions for the program/treatment team; Discharge Planning, which covers discharge questions, care manager responsibilities, and developmental disabilities information; and Protocol for Youth Transition Planning, which is used for the young adults transitioning between DCSOC and the adult mental health system. The Protocol for Transition Planning is for young adults aged 17- 21 who require transitioning from DCSOC to the adult mental health system. The Tool is completed at the transition planning meetings by the care manager or case worker. When completed, The Tool will contain information regarding transition plans, identifying what the young adults' needs are, what is already in place and what needs to be put in place to make the transition to the adult system as smooth as possible. Additional information regarding The Tool can be accessed at: http://www.nj.gov/dcf/documents/behavioral/providers/TransitionPlanning.pdf

Cooperation with the New Jersey Department of Education (DOE)

Recognizing the importance of the educational community in a youth's life, the Department has undertaken several strategies to coordinate services for troubled youth with the state DOE. As part of the restructuring of the New Jersey child welfare system, DCF has targeted several areas of cooperation with DOE to improve the lives and access to education for youth in the child welfare system. These activities have been expanded to include all youth who are accessing mental health services through DCSOC.

DCF Activities Related to the Individuals with Disabilities Act (IDEA) for Children

The DOE Office of Special Education Programs, ensures compliance with the statutory requirements of the IDEA for all New Jersey students with disabilities, from age three to twenty-one, who receives educational services in the state. The DOE guarantees that a free and appropriate education is provided to youth with disabilities, including youth with serious emotional and behavioral disturbances.

The DCF Office of Education serves children who are clients of one of the Divisions of DCF, either in the institutions in which they reside or at one of 18 Regional Schools staffed by specially trained administrators, teachers and aides.

DCSOC Services to Homeless Youth

DCSOC provides behavioral health services to all "homeless" youth in New Jersey through its mandated access procedures. It also provides additional services for sheltered youth, including MRSS for crisis intervention, assessment and stabilization, mobile outreach for regular group and individual therapies delivered on site, and case management services.

DCSOC participates in joint efforts with other Divisions in the DCF and Department of Community Affairs for state and local planning and the delivery of shelter and support services to homeless youth and their families. Screening/Emergency Services, mobile outreach teams, CCIS, and case managers provide services to homeless children and adolescents. The Department of Health's Certificate of Need requirements mandate hospitals to have affiliation agreements with DCF for placement assistance of homeless youth. DCSOC, which designates CCIS, encourages inpatient units to establish agreements with youth shelters in their service areas.

DCSOC Services to Rural Youth

DCSOC defines a county as "rural" if, according to US Census figures, 25 percent or more of its population live in rural areas. Using this definition, six New Jersey counties are considered rural, three on the state's southwestern border, and three along the northwestern border. This configuration, along the Delaware River, places rural counties in each region – in the north, Warren and Sussex; in the Central Region, Hunterdon; and in the South, Cape May, Cumberland and Salem. One of the six rural counties is among New Jersey's highest per capita income counties and one is the lowest, illustrating the diverse resources and needs of even this small subset of our 21 counties.

As part of New Jersey's System of Care, a full array of children's mental health services is available to all rural counties. These services include but are not limited to Care Management Organizations, Family Support Organizations, MRSS, Children's Partial Care, Outpatient Services, and out of home treatment. DCSOC monitors the adequacy and effectiveness of the acute care system in each region.

In-State Specialty Beds

Reducing DCSOC reliance on out-of-state providers to treat New Jersey's children, youth and young adults has resulted in keeping children in treatment close to their families, a clinically desirable goal. Relying on New Jersey providers to treat New Jersey's children is also a key policy goal incorporated into the Child Welfare Settlement Agreement. DCSOC developed clinical profiles of children in out-of-home, out-of-state treatment settings. The information derived from these profiles helped us clearly define the type of treatment needs that New Jersey providers were not able to provide. In SFY 2011-2013, DCSOC has contracted for out of home treatment services at the following level of intensity: Group Home, Specialty Services, Residential Treatment Center, and Psychiatric Community Home. Populations served include youth with MI/DD challenges; youth who are pregnant or parenting; and, youth diagnosed as deaf or hard of hearing.

Gay, Lesbian, Bisexual, Transgender, Questioning and Intersex Youth (GLBTQI)

Resources for GLBTQI can be accessed at http://www.nj.gov/dcf/adolescent/lgbtqi/.

Strengths of the Service System

- The consolidation of youth services under one Department, the DCF.

- DCSOC maintained full implementation of and expanded the children's system of care, which includes CMO, FSO, and MRSS in every county/vicinage in New Jersey and 234 contracts with 515 service components. The SFY 2013 DCSOC appropriated budget is $434,122,000.

- DCSOC implemented the unified CMO model state-wide. These organizations combine advocacy, service planning and delivery, and care coordination into a single, integrated, cross-system process, in order to assess, design, implement and manage child-centered and family-focused ISPs for children, youth and young adults whose needs require either intensive or moderate care management techniques that cross multiple service systems. Families no longer have to change agencies or care managers when changing levels of care. Youth outcomes are positive. There is no longer a cap on the number of youth who can receive care management. Siblings at different levels of care can be served in the same agency. The unified CMO pilot has shown to be fiscally advantageous; peer support for families has been extended to families of moderate need level youth and fidelity to the Wraparound model of care has been maintained.

- The DCSOC Youth Development Council Guiding Document serves as DCSOC's plan to ensure youth are decision-makers in their own care, empowered as self-advocates and supported as community advocates with a distinct voice.

- The inclusion of families in planning and implementing system change and the focus on the importance of family participation in treatment decision. DCSOC recognizes of the importance of the role of parents and caregivers in determining the most appropriate services for their children is central to New Jersey's new service system. Parent input in

policy and service development has become the accepted standard throughout the children's system of care.

- DCSOC, with input from the NJ Youth Suicide Prevention Council developed the New Jersey Youth Suicide Prevention Plan, which serves as the guiding document for suicide prevention and intervention throughout the state.

- In July 2012, the U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration awarded a $1.4 million Garrett Lee Smith Youth Suicide Prevention Grant to UBHC in partnership with DCF DCSOC. Through the grant, new suicide prevention programming will be added in the state for individuals who work with youth and young adults from 10 to 24 years of age. The "New Jersey Youth Suicide Prevention Project" will target six pilot counties in a three-year period: Camden, Monmouth, Passaic, Hudson, Middlesex and Bergen Counties. The grant allows UBHC to focus on best practice and evidence-based suicide prevention and intervention training programs for gatekeepers (non-mental health staff working with youth and young adults in schools and community programs), mental health clinicians, primary care physicians, other health care professionals and youth peer leaders. The project includes a mental health and suicide screening component and an innovative social media project that employs various social media properties to engage youth and young adults in suicide prevention activities, while connecting them with prevention resources across the state. The project began in August 2012.

- DCSOC successfully transitioned to a new CSA, PerformCare.

- DCSOC continues to support the implementation of evidence-based programs including MST, FFT, Therapeutic Nurseries and Treatment Homes (Therapeutic Foster Care).

- The number of youth receiving behavioral healthcare services in out-of-state treatment settings was reduced from over 300 in October 2006 to 145 in August 2008. In July 2009, the number was reduced to 67. In July 2010, the number of youth receiving treatment in out of state treatment settings was 22. In July 2012, the number was reduced to five. Currently four youth continue to receive services out of state. In March 2013, a grant was awarded to Saint Joseph's Hospital and Medical Center to develop a RTC for Deaf and Hard of Hearing youth. When this RTC is operational, no youth currently receiving behavioral health services from DCSOC will remain out of state for treatment. DCSOC's continued success is due to the Division's focus on managing new authorizations to out of state care, a year-long case planning initiative focusing on returning youth from out of state care, and continuing efforts to develop appropriate in-state resources for these youth.

- The implementation of New Jersey's Child Welfare Reform Plan coincides with and is integrated with the children's system of care. Clinical Consultants report to DCP&P area offices four days per week and serve as liaisons, joined from the wraparound perspective, who 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.

- County Inter-Agency Coordinating Councils (CIACCs) exist in each county in New Jersey and provide a forum where the system of services for children with emotional and behavioral challenges is developed, reviewed, revised and/or redirected, through collaborative decision-making process with DCF to promote optimal services provided in the least-restrictive, but most appropriate setting possible.

- DCSOC development and implementation of uniform assessment tools and processes for all individuals referred for services.

- The inclusion of youth involved with juvenile justice in the children's system of care.

- The creation of new pathways to services to increase access for underserved populations.

- The provision of specialized statewide and local training and retraining on a host of topics.

SUBSTANCE ABUSE TREATMENT SERVICES

Counseling/Therapy Services

Individual Counseling Session:

Counseling provided on an individual basis to clients with a substance abuse or dependence diagnosis which includes therapeutic and supportive interventions designed to: motivate the client for recovery from addictive disease, facilitate skills for the development and maintenance of that recovery, improve problems solving and coping skills, and develop relapse prevention skills. Session content and structure are designed in accordance with client's treatment. Individual counseling can be delivered by a CADC, an alcohol and drug counselor intern or credentialed intern under the supervision of a qualified clinical supervisor per N.J.A.C. 13:34C-6.2, or by a New Jersey licensed behavioral health professional who is also credentialed to provide therapy in accordance with the DAS Service Descriptions. 1 hour = 1 unit

Individual Therapy Session:

The treatment of an emotional disorder, including a substance abuse disorder, as identified in the DSM through the use of established psychological techniques and within the framework of accepted model of therapeutic interventions such as psychodynamic therapy, behavioral therapy, gestalt therapy and other accepted therapeutic models. These techniques are designed to increase insight and awareness into problems and behavior with the goal being relief of symptoms, and changes in behavior that lead to improved social and vocational functioning, and personality growth. Individual Therapy must be provided by: Licensed Clinical Psychologist, Certified Nurse Practitioner-Psychiatric and Mental Health (CNP-PMH), Advanced Practical Nurse-Psychiatric and Mental Health (APN-PMH), Licensed Clinical Social Worker (LCSW), Licensed Professional Counselor (LPC), or Licensed Marriage and Family Therapist (LMFT). 1 hour = 1 unit.

Group Counseling:

Counseling provided on a group basis to clients which uses group processes and supports to: motivate the client for recovery from addictive disease, facilitate skills for the development and maintenance of that recovery, improve problems solving and coping skills, improve intra and inter personal development and functioning, and develop relapse prevention skills. Session content and structure are designed in accordance with client's treatment plan. Group counseling can be delivered by a CADC, an alcohol and drug counselor intern or credentialed intern under the supervision of a qualified clinical supervisor per N.J.A.C. 13:34C-6.2, or by a New Jersey licensed behavioral health professional who is also credentialed to provide therapy in accordance with the DAS Service Descriptions. 1 hour= 1 unit

Family Counseling:
Counseling provided to the family unit, with or without the client present, to impart education about the disease of addiction, elicit family support for the client's treatment, encourage family members to seek their own treatment and self-help, assess the clients environment during or after treatment and to assess the client's functioning outside of the treatment environment. Family counseling can be delivered by a CADC, an alcohol and drug counselor intern or credentialed intern under the supervision of a qualified clinical supervisor per N.J.A.C. 13:34C-6.2, or by a New Jersey licensed behavioral health professional who is also credentialed to provide therapy in accordance with the DAS Service Descriptions. 1 hour =1 unit

Family Therapy:
Treatment provided to a family utilizing appropriate therapeutic methods to enable families to resolve problems or situational stress related to or caused by a family member's addictive illness. In this service, the family system is the identified client and interventions are targeted to system change. Family and Individual Therapy must be provided by: Licensed Clinical Psychologist, Certified Nurse Practitioner-Psychiatric and Mental Health (CNP-PMH), Advanced Practical Nurse-Psychiatric and Mental Health (APN-PMH), Licensed Clinical Social Worker (LCSW), Licensed Professional Counselor (LPC), or Licensed Marriage and Family Therapist (LMFT). 1 hour = 1 unit.

Psychoeducation
Psychoeducation is the education of a client in way that supports and serves the goals of treatment.

Didactic Session:
Group session that involves teaching people about the disease of addiction, how to treat it, and how to recognize signs of relapse so that they can get necessary treatment and support services. 1 hour = 1 unit

Family Education and Information:
Family Education and Information is the education of the family in a way that services the goals of the identified client. Family Education and Information involves teaching family members of identified clients about the disease of addiction, how the disease affects the family, how to support the client's recovery and how to find services and treatment for the family members. 1 hour = 1 unit

OUTPATIENT SUBSTANCE ABUSE TREATMENT
Level 1

Definition: Outpatient Substance Abuse Treatment is provided in a DAS licensed outpatient facility which provides regularly scheduled individual, group and family counseling services for less than nine (9) hours per week. Services may be provided to patients discharged from a more intensive level of care, but are not necessarily limited to this population. Twelve (12) Step Meetings or other Self-Help Meetings cannot be counted as billable Counseling Services. This care approximates ASAM PPC-2R Level 1 care.

Counseling/Therapy Services:

- Individual: in a full session, this includes face-to-face for one (1) hour.
- Individual: in a half-session, this includes face-to-face for thirty (30) minutes.
- Group: minimum sixty (60) minutes of face to face contact.
- Family: in a full session for one (1) hour or a half-session for thirty (30) minutes. To be included during course of treatment as clinically indicated.

Psychoeducation:

- Didactic sessions.
- Family education and information sessions as clinically indicated.

INTENSIVE OUTPATIENT SUBSTANCE ABUSE TREATMENT
Level II.I

Definition: Intensive Outpatient (IOP) Substance Abuse Treatment is provided in a licensed IOP facility which provides a broad range of highly intensive clinical interventions. Services are provided in a structured environment for no less than nine (9) hours per week. Request for more than twelve (12) hours per week of services must be pre-approved by initiative case manager or DAS staff. **A minimum of three (3) hours of treatment services must be provided on each billable day to include one individual counseling session per week.** IOP treatment will generally includes intensive, moderate and step-down components. Twelve (12) Step Meetings or other Self-Help Meetings cannot be counted as billable services. This care approximates ASAM PPC-2 Level II.I care.

Counseling/Therapy Services:

- Individual: One hour per week minimum.
- Group: Six (6) hours per week minimum.
- Family: To be included during course of treatment as clinically indicated.

Psychoeducation:

- Didactic sessions: 2 hours/week minimum.
- Family education and information sessions as clinically indicated.

PARTIAL CARE SUBSTANCE ABUSE TREATMENT
Level II.5

Definition: Partial Care Substance Abuse Treatment is provided in a licensed Partial Care facility which provides a broad range of highly clinically intensive interventions. Services are provided in a structured environment for no less than 20 hours per week. **A minimum of four (4) hours of treatment services must be provided on each billable day to include one individual counseling session per week.** Lunch is not a billable hour. Twelve (12) Step Meetings or other Self-Help Meetings cannot be counted as billable services. Programs have ready access to psychiatric, medical and laboratory services. This care approximates ASAM PPC-2 Level II.5 care.

Counseling/Therapy Services:

- Individual: 1 hour/week minimum.
- Group: 8 hours/week minimum.
- Family: To be included during course of treatment as clinically indicated.

Psychoeducation:

- Didactic sessions: 3 hours/week minimum.
- Family education and information sessions as clinically indicated.

CLINICALLY MANAGED LOW-INTENSITY RESIDENTIAL TREATMENT
HALFWAY HOUSE SUBSTANCE ABUSE TREATMENT
Level III.1

Definition: Halfway House Substance Abuse Treatment is provided in a licensed residential facility which provides room, board, and services designed to apply recovery skills, prevent relapse, improve emotional functioning, promote personal responsibility and reintegrate the individual into work, education and family life. Halfway house services must be physically separated from short term and long term program. In addition, clinical services must be separate from short term and long term residential services. **This modality includes no less than 5 hours per week of counseling services.** A minimum of 7 hours per day of structured activities must be provided on each billable day. (Note: Self-help meetings may be included as part of structured activities. This care approximates ASAM PPC-2 Level III.1 care.

Medical Services: Must be provided as per licensing requirements.

Counseling/Therapy Services:

- Individual: 1 hour/week minimum.
- Group: 3 hours/week minimum.
- Family: To be included during course of treatment as clinically indicated.

Psychoeducation:

- Didactic sessions: 1 hours/week minimum.
- Family education and information sessions as clinically indicated.

Structured Activities: 7 hours a day required. Example of activities:

a. Counseling Services
b. Psycho Education
c. Employment
d. Vocational Training
e. Recovery Support Services
f. Recreation

CLINICALLY MANAGED HIGH-INTENSITY RESIDENTIAL TREATMENT
LONG TERM RESIDENTIAL SUBSTANCE ABUSE TREATMENT
Level III.5

Definition: Long Term Residential Substance Abuse Treatment or Therapeutic Community is provided in a licensed long term residential facility which provides a structured recovery environment, combined with professional clinical services, designed to address addiction and living skills problems for persons with substance abuse diagnosis who require longer treatment stays to support and promote recovery. (Note: Self-help meetings may be included as part of structured activities.) Long Term Residential includes **no less than 8 hours per week of counseling services on at least five (5) separate occasions.** A minimum of 7 hours per day of structured activities must be provided on each billable day. Intervention focuses on reintegration into the greater community with particular emphasis on education and vocational development. This care approximates ASAM PPC-2 Level III.5 care.

Medical Services: Must be provided as per licensing requirements.

Counseling/Therapy Services:

- Individual: 1 hour/week minimum.
- Group: 5 hour week minimum.
- Family: To be included during course of treatment as clinically indicated.

Psychoeducation:

- Didactic sessions: 3 hours/week minimum.
- Family Education and Information sessions as clinically indicated.

Structured Activities: 7 hours a day required. Example of activities:

a. Counseling Services
b. Psychoeducation
c. Vocational Training
d. Recovery Support Services
e. Recreation

MEDICALLY MONITORED INTENSIVE INPATIENT TREATMENT
SHORT TERM RESIDENTIAL SUBSTANCE ABUSE TREATMENT
Level III.7

Definition: Short Term Residential Substance Abuse Treatment is provided in a licensed short term residential facility which provides a highly structured recovery environment, combined with a commensurate level of professional clinical services, designed to address specific addiction and living skills problems for persons who are deemed amenable to intervention through short-term residential treatment. **Short Term Residential treatment must include no less than 12 hours per week of counseling services on at least 6 separate occasions.** A minimum of 7 hours of structured programming must be provided on a billable day. (Note: Self-help meetings may be included as part of structured activities.) This care approximates ASAM PPC-2 Level III.7 care.

Medical Services: Must be provided as per licensing requirements.

Counseling/Therapy Services:

- Individual: 2 hour/week minimum.
- Group: 10 hours/week minimum (4 sessions).
- Family: To be included during course of treatment as clinically indicated.

Psychoeducation:

- Didactic sessions: 8 hours/week minimum.
- Family Education and Information sessions as clinically indicated.

Structured Activities: 7 hours a day required. Example of activities:

a. Counseling Services
b. Psychoeducation
c. Vocational Training
d. Recovery Support Services
e. Recreation

MEDICALLY MONITORED INPATIENT DETOXIFICATION
Level III.7D

Definition: Medically Monitored Inpatient Detoxification is an organized service delivered by medical and nursing professionals, which provides 24-hour medically supervised evaluation and withdrawal management in a permanent facility with inpatient beds. Services are delivered under a defined set of physician-approved policies and physician monitored procedures for clinical protocols. This level provides care to patients whose withdrawal signs and symptoms are sufficiently severe to require 24-hour medical monitoring care**. Detoxification includes 2 hours per week of counseling services.** (Note: Self-help meetings may be included as part of daily activities) This care approximates ASAM PPC-2 Level III.7D care.

Medical Services: Must be provided in the facility under the supervision of a Medical Director. All other licensing requirements for medical services must be followed.

Counseling/Therapy Services:

- Individual: 1 hour/week minimum.
- Group: 1 hour/week.

Psychoeducation:

- Minimum of two hours per detox episode.

MEDICALLY MONITORED INPATIENT DETOXIFICATION ENHANCED
111.7D Enhanced

Description: Medically Monitored Inpatient Detoxification Enhanced is an organized service delivered by medical and nursing professionals, which provides 24-hour medically supervised evaluation and withdrawal management in a permanent facility with inpatient beds. Services are delivered under a defined set of physician-approved policies and physician-monitored procedures for clinical protocols. This level provides care to patients whose withdrawal signs and symptoms are sufficiently severe enough to require 24-hour medically monitored care. **Detoxification includes substance abuse assessment, medication monitoring and two (2) hours per week of counseling services**. (Note: Self-help meetings may be included as a part of daily activities)

This care approximates ASAM PPC-2 Level III.7D care but enhances that level to include the ability to treat the following: 1) individuals with co-occurring disorders; 2) pregnant women; 3) poly-addicted persons, including those addicted to benzodiazepines; 4) individuals who may or may not be on opiate replacement therapy; and 5) clients with non–life-threatening medical condition(s) that do not require the services of an acute care hospital.

In order to accommodate this increased acuity in patients being treated in this service, the facility must have an affiliation agreement and procedures in place with an acute care hospital that ensures the seamless transfer of the patient to the acute care setting, if clinically necessary.

Required Staff: Must be provided in the facility under the supervision of a Medical Director. All other licensing requirements for medical services and co-occurring services must be followed.

Required Medical Services:

- Full medical assessment.
- Ongoing medical services including medication monitoring.
- Pregnancy test for all women.
- 24 hour nursing services.
- 24 hour access to physician.

Counseling Services:

- Individual counseling: 1 hours/week minimum.
- Group Sessions: 1 hour/week.

Psychoeducation:

- Minimum of two hours per week.

Co-occurring Services included as part of this service:

- Case Management.
- Medication Monitoring.

SUBSTANCE ABUSE TREATMENT SERVICES
CO-OCCURRING SERVICE ENHANCEMENTS

Substance Abuse Treatment Co-occurring Service Enhancements strive to advance the integration of mental health services into client's substance abuse treatment. This initiative provides reimbursement for an array of co-occurring services to be provided as an enhancement to substance abuse treatment services for consumers with a co-occurring mental health diagnosis. Specific services are delivered based on individual need.

Psychiatric Evaluation

Description:
Psychiatric evaluations are meetings between a psychiatrist and a child, adolescent or adult in which the professional tries to glean information necessary to diagnose an emotional disorder. During this interview the psychiatrist collects enough data about the patient, through input from the substance abuse and/or co-occurring evaluation, previous treatment records and consultation with the treatment team, to develop an initial psychiatric diagnosis and treatment plan, including pharmacotherapy.

Who Can Provide the Service?
Psychiatric Evaluation is provided by: MD or DO Certified in Addiction Psychiatry; Board Certified Psychiatrist who is a member of ASAM or experienced with addiction; Board Eligible and ASAM Certified Psychiatrist; MD or DO Board Eligible for Psychiatry with 5 years of addiction experience and ASAM membership; ASAM Certified MD or DO with 5 years of co-occurring mental health disorders experience; Certified Nurse Practitioner-Psychiatric and Mental Health (CNP-PMH), Advanced Practical Nurse-Psychiatric and Mental Health (APN-PMH), and Physician's Assistant (PA) w/Psychiatric and Mental Health certification.

Comprehensive Intake Evaluation

Description:
The Comprehensive Intake Evaluation includes; a full mental status evaluation, a detailed history of psychiatric symptoms, a review & if necessary expansion of the information collected during the ASI, collection and review of previous treatment records, & the completion of relevant assessment tools such as the Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS) are helpful to clinicians making LOC decisions for the COD client

Who Can Provide the Service?
The Comprehensive Evaluation is provided by: Licensed Clinical Psychologist, Licensed Clinical Social Worker (LCSW), Licensed Professional Counselor (LPC), Licensed Marriage and Family Therapist (LMFT).

Medication Monitoring

Description:
Medication monitoring is the ongoing assessment, monitoring and review of the effects of a prescribed medication (Medication Assisted Therapy) upon a client. It is as a result of these visits that medications are adjusted, medical tests are ordered, and the client's response to treatment is evaluated. All Addictions and COD treatment facilities must allow for Medication Assisted Therapy for appropriate clients. These clients may be receiving medication(s) prescribed by the primary treatment facility, or by another provider.

Who Can Provide the Service?
Provided by: Licensed MD or DO, Certified Nurse Practitioner-(CNP), Advanced Practical Nurse-(APN) Physician's Assistant- (PA).

Clinical Consultation

Description:
The Consultant meets with an agency's clinical staff in order to advise, counsel or educates those clinicians regarding the diagnosis, treatment, and management of clients in the care of that organization.

Who Can Provide the Service?
A psychiatrist is the preferred consultant in this role. Psychiatrists or clinicians from other disciplines who provide clinical consultation must be licensed or certified to practice as health care professionals, and authorized to render diagnoses according to the DSM for both mental health and substance use disorders. (e.g.: psychiatrist, licensed clinical psychologist, licensed clinical social worker, licensed psychiatric nurse, licensed professional counselor, etc.). A minimum of 5 years' experience in mental health or co-occurring treatment is required.

Case Management

Description:
Case Management is the provision of direct and comprehensive assistance to clients in order for those individuals to gain access to all necessary treatment and rehabilitative services. The clinical case manager (CCM) facilitates optimal coordination and integration of these services on behalf of the client. In addition to connecting clients to these resources, the CCM monitors their client's progress in treatment. The goal of this intervention is to reduce psychiatric and addiction symptoms, and to support the clients' continuing stability and recovery.

Who Can Provide the Service?
Clinical case management services can be provided by the client's primary counselor, or by a staff member designated as CCM for a number of clients. CCM services can be

provided by a health care professional with experience and expertise in service systems, including social service systems, the addictions treatment system, and services for mental health disorders. A minimum of Bachelor's Degree in one of the helping professions, such as social work, psychology, and counseling or LCADC or CADC.

Family Therapy

Description:
Treatment provided to a family utilizing appropriate therapeutic methods to enable families to resolve problems or situational stress related to or caused by a family member's addictive illness.

Who Can Provide the Service?
Family and Individual Therapy must be provided by: Licensed Clinical Psychologist, Certified Nurse Practitioner-Psychiatric and Mental Health (CNP-PMH), Advanced Practical Nurse-Psychiatric and Mental Health (APN-PMH), Licensed Clinical Social Worker (LCSW), Licensed Professional Counselor (LPC), or Licensed Marriage and Family Therapist (LMFT).

Individual Therapy

Description:
The treatment of an emotional disorder as identified in the DSM through the use of established psychological techniques and within the framework of accepted model of therapeutic interventions such as psychodynamic therapy, behavioral therapy, gestalt therapy and other accepted therapeutic models. These techniques are designed to increase insight and awareness into problems and behavior with the goal being relief of symptoms, and changes in behavior that lead to improved social and vocational functioning, and personality growth.

Who Can Provide this Service?
Family and Individual Therapy must be provided by: Licensed Clinical Psychologist, Certified Nurse Practitioner-Psychiatric and Mental Health (CNP-PMH), Advanced Practical Nurse-Psychiatric and Mental Health (APN-PMH), Licensed Clinical Social Worker (LCSW), Licensed Professional Counselor (LPC), or Licensed Marriage and Family Therapist (LMFT).

Individual Therapy - Crisis Intervention

Description
The provision of emergency psychological care to a client who is experiencing extreme stress. In order for a difficult situation to constitute a crisis, the stressor(s) must be experienced as threatening, and of an intensity/magnitude that can not be managed by the client's normal coping capacities. The determination that a client is experiencing a

crisis must be made by a licensed clinician. This initial assessment, where clinically indicated, includes evaluation of the individual's potential for suicide, homicide, or other violent/extremely problematic behaviors. In COD treatment settings, the client's potential for relapse and/or decompensation must be determined. The goals of crisis intervention are:(1) Stabilization, i.e. to reduce or relieve mounting distress; (2) Mitigation of acute signs and symptoms of distress; (3) Restoration of the pre-crisis (hopefully adaptive and independent) level of functioning; (4) Prevention (or reduction of the probability) of the development of maladaptive post-crisis behavior (e.g.: relapse and/or decompensation), or of post-traumatic stress disorder (PTSD).

Who Can Provide the Service?

Provided by: MD or DO, Licensed Clinical Psychologist, Certified Nurse Practitioner-Psychiatric and Mental Health (CNP-PMH), Advanced Practical Nurse-Psychiatric and Mental Health (APN-PMH), Licensed Clinical Social Worker (LCSW), Licensed Professional Counselor (LPC), or Licensed Marriage and Family Therapist (LMFT), Physician's Assistant (PA) , Advance Practice Nurse (APN) ,Certified Nurse Practitioner (CNP)

SUBSTANCE ABUSE TREATMENT SERVICES
MEDICATION ASSISTED TREATMENT SERVICE ENHANCEMENTS

Methadone Treatment

Description: Methadone is a synthetic opioid used medically as an analgesic, and as an anti-addictive medication for use in patients who meet criteria for opioid dependence. Methadone, used for maintenance and/or detoxification is a medication that is provided in combination with substance abuse counseling in a licensed substance abuse treatment facility that is; accredited by a recognized accreditation body, approved by SAMHSA, complies with all rules enforced by the Drug Enforcement Administration (DEA) and is licensed by the Division of Addiction Services.

Required Staff: When prescribed in a substance abuse treatment facility, the following requirements apply:

Medical Director: Licensed in the State of New Jersey as a physician, certification in Addiction Medicine (ASAM, Addiction Psychiatry, or American Osteopathic Association) is preferred. Membership in ASAM is required.

Nursing Director: Registered Nurse (RN) currently licensed in New Jersey with one year of experience in Addictions treatment.

Only physicians, registered nurses, licensed practical nurses or pharmacists may dispense or administer medication in a facility providing opioid treatment services.

Required Medical Services for Methadone Maintenance:

- Full assessment with physical examination at admission and annually thereafter;
- Regular urine drug screens; pregnancy screen at intake for women of child-bearing age; and
- Regular review of medication by physician and prescription adjustments as medically determined.

Required Medical Services for Methadone Detoxification: All physicians are referred to the federal guidelines established through the Center for Substance Abuse Treatment (CSAT) for the minimum requirements:

- During methadone detoxification, medical care and consultation should be available on a 24-hour basis. This care and consultation should be supervised by the physician performing the detoxification protocol;
- Pregnancy testing must be conducted at intake for women of child-bearing age;
- Opioid dependent pregnant clients must receive proper education for the risks of methadone detoxification; and
- Clients must have 24 hour access to a nurse on call.

Counseling Services: At minimum, methadone treatment delivered in a Licensed Methadone Treatment program must adhere to the counseling standards outlined in DAS licensure standards, 10:161B-11, which includes number and frequency of counseling sessions based on the criteria of the Phase System.

- Phase I- At least one counseling session per week
- Phase II- At least one counseling session every two weeks
- Phase III- At least one counseling session per month
- Phase IV- At least one counseling session every three months

Methadone can be administered in conjunction with other clinical services across all levels of care provided by a DAS licensed Substance Abuse treatment program. All counseling requirements must be in accordance with the licensing requirements for that level of care.

Buprenorphine Treatment

Description:
Buprenorphine, in the form of Subutex (buprenorphine hydrochloride) and Suboxone tablets (buprenorphine hydrochloride and naloxone hydrochloride), is used medically for the treatment of opioid dependence.

Detoxification:
Buprenorphine can be used for the medically supervised withdrawal of clients from both self-administered opioids and from opioid agonist treatment with methadone, providing a transition from the state of physical dependence on opioids to an opioid-free state, while minimizing withdrawal symptoms and avoiding side effects of suboxone. The goal of the service is to achieve a safe and comfortable withdrawal from mood-altering drugs and to effectively facilitate the client's entry into ongoing treatment and recovery.

Induction:
Buprenorphine induction (usual duration approximately one week) involves helping a client begin the process of using buprenorphine to manage his or her opioid dependence. The goal of the induction phase is to find the minimum dose of medication at which the client discontinues or markedly diminishes use of other opioids and experiences no withdrawal symptoms, minimal or no side effects, and has no uncontrollable cravings for drugs of abuse, and is stabilized.

Maintenance:
Buprenorphine maintenance, following induction and stabilization, requires maintaining buprenorphine at stable dosage levels for a period in excess of 21 days.

Counseling Services: Suboxone treatment should be administered in conjunction with other clinical services across all levels of care provided by a DAS licensed Substance Abuse treatment program. All counseling requirements must be in accordance with the licensing requirements for that level of care.

Required Staff:
Must be provided by a certified physician in Addiction Medicine who has satisfied qualifications set-forth by the provisions of the Drug Addiction Treatment Act of 2000 (DATA 2000) and the Office of National Drug Control Policy Reauthorization Act of 2006 (ONDCPRA).

When prescribed in a substance abuse treatment facility, the following requirements apply:

Medical Director: Licensed in the State of New Jersey as a physician, certification in Addiction Medicine (ASAM, Addiction Psychiatry, or American Osteopathic Association) is preferred. Membership in ASAM is required. DATA 2000 waiver and appropriate Drug Enforcement Agency (DEA) registration are required.

Nursing Director: Registered Nurse (RN) currently licensed in New Jersey with one year of experience in Addictions treatment.

Only physicians, registered nurses, licensed practical nurses or pharmacists may dispense or administer medication in a facility providing opioid treatment services.

Required Medical Services:

- All physicians are referred to the federal guidelines established through the Center for Substance Abuse Treatment (CSAT) for the minimum requirements;
- A full assessment with physical examination must be conducted at admission and annually thereafter;
- Pregnancy testing must be provided at assessment for women of child-bearing age;
- Opioid dependent pregnant clients must receive proper education regarding the risks of buprenorphine treatment;
- During buprenorphine detoxification, induction and stabilization, medical care and consultation should be available on a 24-hour basis supervised by the physician performing the detoxification or induction and stabilization protocol.
- During buprenorphine detoxification, clients must have 24 hour access to a nurse on call;
- During detoxification, the client must be seen each day for, at minimum, a medical assessment.
- Clients must be instructed to abstain from the use of any opioids for twelve hours prior to the induction phase of buprenorphine treatment; and
- Regular urine drug screens should be performed for all clients.

Naltrexone Treatment

Description:
Naltrexone, in the form of Vivitrol (injectable naltrexone) is a medication administered to support relapse prevention in conjunction with substance abuse treatment and social

supports to consumers with a diagnosis of alcohol abuse or dependence or opioid dependence Vivitrol is an extended-release formulation of naltrexone, an opiate antagonist. Patients should not be actively drinking at the time of the initial nalterxone administration. Naltrexone is indicated for the prevention of relapse to opioid dependence following opioid detoxification.

Induction:
Naltrexone induction involves an initial intramuscular injection administered by appropriate medical personnel (either a Medical Director, Nurse Practitioner, Physician Assistant, Registered Nurse). Liver Functioning Tests (LFT) should be performed as per medical need identified by physician.

Maintenance:
Typical duration of services is a once a month intramuscular injection for 3-6 months.

Counseling Services: Naltrexone treatment should be administered in conjunction with other clinical services across appropriate levels of care provided by a DAS licensed Substance Abuse treatment program. All counseling services must be provided in accordance with the licensing requirements for that level of care.

Required Staff:
When prescribed in a substance abuse treatment facility, the following requirements apply:

Medical Director: Licensed in the State of New Jersey as a physician, certification in Addiction Medicine (ASAM, Addiction Psychiatry, or American Osteopathic Association) is preferred.

Nurse Practitioner: Nurse Practitioner (NP) currently licensed in New Jersey.

Physician Assistant: Physician Assistant (PA) currently licensed in New Jersey.

Registered Nurse: Registered Nurse (RN) currently licensed in New Jersey.

Required Medical Services:

- A full assessment with physical examination must be conducted prior to induction and annually thereafter;
- Pregnancy testing must be provided at assessment for women of child-bearing age;
- LFTs as medically indicated.

SUBSTANCE ABUSE TREATMENT SERVICES
MEDICAL, CLINICAL, AND RECOVERY SUPPORT
SERVICE ENHANCEMENTS

Medical Services

Physician Visit: Reimbursement for physician office visit, new or established patient.

Urine Drug Screen: Reimbursement for process to collect urine to screen for drugs of abuse.

Oral Swab Drug Screen: Reimbursement for process to collect oral fluids to screen for drugs of abuse.

Comprehensive Assessment

A bio-psycho-social assessment of patients entering treatment or transferring to a different contractee. This assessment includes completion of an ASI, completion of an American Society of Addiction Medicine (ASAM) placement criteria, a co-occurring screening, and completion of the NJ-SAMS admission. Members of the patients family and/or significant others may also be involved, *if indicated and authorized by the patient.* The assessment must result in a DSM IV Diagnosis and Level of Care determination, to be used in the client treatment placement and treatment planning. The assessment must produce a written document which is placed in the patient's clinical record. It identifies problems which must be addressed in a written treatment plan, also to be placed in the patient's clinical record.

Continuing Care Assessment

Continuing Care Assessment is a treatment activity that can take place with or without the client present. The primary clinician, working with their clinical supervisor or preferably, the agency interdisciplinary team, reviews client treatment progress and current functioning. During the review a LOCI continuing care evaluation is completed, a treatment plan review is completed and a new plan for the client is developed. All participating members of the team and participating clients must sign a note or treatment plan indicating the review took place and that they participated. This must be in client chart and available for review.

Case Management

The provision of direct and comprehensive assistance to clients in order for those individuals to gain access to all necessary treatment and rehabilitative services. The clinical case manager (CCM) facilitates optimal coordination and integration of these services on behalf of the client. In addition to connecting clients to these resources, the

CCM monitors their client's progress in treatment. The goal of this intervention is to reduce psychiatric and addiction symptoms, and to support the clients' continuing stability and recovery.

Court Liaison

Substance abuse treatment agency staff accompany client to court for required hearing.

Recovery Mentor

A service designed to support the clients' treatment engagement and retention and transition the client from structured treatment to long-term recovery in the community. The Mentor provides emotional support and concrete assistance to enable the client to access and utilize social, medical, legal and other support services. The Mentor coordinates with the treatment contractee and provides outreach, advocacy, and coordination of services. Primarily through role modeling, he/she educates the client about recovery process and how to live a sober lifestyle.

Transportation

A transportation voucher is issued to DAS client for the following allowable trips:

- To and from assessment
- To and from detoxification
- To and from initial meeting with treatment contractee
- To court from treatment facility for scheduled court date

Women with Dependent Children Services

Services including room, board, and childcare designed to support a family-centered approach to care for women whose dependent children accompany them in treatment. May be provided in an ambulatory or residential setting.

II: Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system.

Narrative Question:

This step should identify the data sources used to identify the needs and gaps of the populations relevant to each Block Grant within the State's behavioral health care system, especially for those required populations described in this document and other populations identified by the State as a priority.

The State's priorities and goals must be supported by a data driven process. This could include data and information that are available through the State's unique data system (including community level data) as well as SAMHSA's data set including, but not limited to, the National Survey on Drug Use and Health, the Treatment Episode Data Set, and the National Facilities Surveys on Drug Abuse and Mental Health Services. Those States that have a State Epidemiological Outcomes Workgroup (SEOW) must describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with serious mental illness and children with serious emotional disturbances that have been historically reported. States should use the prevalence estimates, epidemiological analyses and profiles to establish substance abuse prevention, mental health promotion, and substance abuse treatment goals at the State level. In addition, States should obtain and include in their data sources information from other State agencies that provide or purchase behavioral health services. This will allow States to have a more comprehensive approach to identifying the number of individuals that are receiving behavioral health services and the services they are receiving.

In addition to in-state data, SAMHSA has identified several other data sets that are available by State through various Federal agencies such as the Center for Medicaid and Medicare Services or the Agency for Health Research and Quality. States should use these data when developing their needs assessment. If the State needs assistance with data sources or other planning information, please contact planningdata@samhsa.hhs.gov.

Footnotes:

Planning Step 2: Identify the Unmet Service Needs and Critical Gaps within the Current System

Data Sources Used To Identify Needs and Gaps

The SSA and SMHA use 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:

DMHAS Information Systems

- New Jersey Substance Abuse Monitoring System (NJ-SAMS)
- Prevention Outcomes Management System (POMS)
- Block Grant Support System (BSS)
- Contract Information Management System (CIMS)
- Intoxicated Driving Program (IDP) Data System
- Unified Services Transaction Form (USTF)
- Quarterly Contract Monitoring Report (QCMR)

DMHAS Surveys

- NJ Household Survey on Drug Use and Health (2003, 2009)
- NJ High School Risk & Protective Factor Survey (2008)
- NJ Middle School Risk & Protective Factor Survey (2007, 2010, 2012)
- Co-Occurring Survey (2008)
- Survey of Older Adults (2012)

Other DMHAS Data Sources

- NJ Epidemiological Profile for Substance Abuse (2008)
- County and Municipal Social Indicator Chartbooks (2005,2013)
- NJ Substance Abuse Provider Performance Reports
- NJ Substance Abuse Overviews
- NJ Intoxicated Driving Reports

Other State Data Sources

- NJ DHSS Uniform Billing (UB-04)
- Uniform Crime Reports
- NJ Department of Education Student Health Survey (2009, 2011)
- Pregnancy Risk Assessment Monitoring System (PRAMS)
- Youth Risk Behavior Survey
- Behavioral Risk Factor Surveillance System (BRFSS)

Federal Data Sources

- National Survey of Drug Use and Health
- Treatment Episode Data System (TEDS)
- State Epidemiological Data system (SEDS)
- National Survey of Substance Abuse Treatment Services (N-SSATS)

Single State Authority on Substance Abuse (SSA)

Data Driven Planning Process

Over the years, the SSA has performed regular statewide needs assessments for substance abuse prevention and treatment. The merged SSA/SMHA is looking forward to a joint, statewide and comprehensive behavioral needs assessment—inclusive of both substance abuse and mental illness, to be conducted within the grant period.

Information from general and special populations surveys combined with treatment utilization data from the New Jersey Substance Abuse Monitoring System (NJ-SAMS), as well as the application of Geographic Information Systems (GIS) methodology for visual data presentations, provides the SSA with valid and reliable data to assess both service needs and delivery capacities which drive its SAPT Block Grant Application, its statewide strategic planning, and its multi-year county comprehensive planning.

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 alcoholism 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 household survey is of sufficient sample size to present use data and other general findings at the county level within an acceptable standard error (+ or – 3.8%). 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 behavioral health care.

Needs Assessment: Treatment

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. For example, in 1993, 500 in-person interviews of adults were completed in each of six regional health planning areas (N= 3,000) as well as an in-person survey of 1,000 inmates from a sample of jails across the state yielding estimates of treatment need both statewide and by region among adults living in both residential and county holding facilities.

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 SAPT Block Grant funding. The SSA is now planning a fifth "family of studies" needs assessment program for FFY 2013 and FFY 2014 again using the SAPT Block Grant.

For its New Jersey Household Survey of Drug Use and Health (NJ-HSDUH), the SSA uses a questionnaire developed by CSAT during the STNAP that is nearly identical to the questionnaire employed by NIDA for the National Survey of Drug Use and Health (NSDUH). The primary focus is the population distribution of substance use. It employs DSM diagnostic criteria of abuse and dependence in combination with "past 12 month" alcohol use to obtain alcohol treatment need estimates. The questionnaire also asks those with a treatment need about their treatment histories and obtains an estimate of unmet treatment demand which was .47% in 2003 and .46% in 2009.

Beyond these core elements, the SSA's questionnaire regularly includes sections on tobacco use and gambling behavior. Typically, one or more special topics are also included, such as in 1993 and 1998, the needs of pregnant women; in 2003, persons impacted by the 9/11 attacks in NYC, and in 2009, both substance use among New Jersey Veterans and obstacles to treatment access among persons who need but do not get care. The questionnaire fielded in 2013-2014 will include a new section on mental health.

Surveys of sub-populations not found in the telephone sampling frame have included: tri-annually since 1993, middle school students; in 1998, Medicaid eligible clients in managed behavioral health care, Temporary Assistance for Needy Families (TANF) recipients, adults and youth in the criminal justice system, convicted intoxicated drivers, residents of homeless shelters, women receiving pre-natal care; in 2003, outpatient mental health patients, in 2008, high school students, in 2009, persons relying on mobile cell phones to the exclusion of landlines in their homes and in 2012, a statewide survey of prescription drug misuse and abuse by senior citizens aged 65 or older.

For the 2003 STNAP contract, the SSA employed techniques of administrative database linkage to evaluate long-term treatment utilization patterns, recidivism, mental health, mortality, hospital discharge histories and access to care. Longitudinal database linkage studies are also planned for the FFY 2013-2014 program which will include the findings from a four-year evaluation of treatment outcomes and social cost/benefit ratios for injecting heroin users receiving medically assisted treatment (methadone and buprenorphine), a newly launched study of alcohol dependent persons participating in the SSA's Driving Under the Influence Initiative (DUII) who will be treated with Vivitrol, as well as an updated, social indicators chart book that presents secondary source data, including those from the 2010 census, related to prevention and treatment admissions over multiple years.

Another keystone source of information for need assessment and gap analysis for addiction services is the NJSAMS, which is described more fully in Section *Q. Data and Information Technology*. The SSA is able to establish the number of persons receiving substance abuse 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. Used in combination with other methodologies, e.g., capture-recapture, NJ Household Survey, etc., the SSA can determine the need for drug treatment and the met and unmet demand for treatment.

Finally, 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 applying state needs assessment data and supplementing state-provided data 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 most recent county planning cycle, 2010-2014, a wide range of service gaps were identified in the county plans beyond the fundamental shortfall in the supply of services at all levels of care. Often access to existing services is hampered by: lack of transportation, particularly in the more rural areas of the state; limits to personal financial capability; struggles with private insurance plans to obtain coverage for short term residential treatment; social stigma associated with seeking treatment; lack of post-acute care recovery services, such as housing, employment, health care, day care, sober recreation, post-traumatic stress care, or case management for persons with little or no recovery capital of their own; waiting lists consequent to the aforementioned shortfall in supply of acute care services; language and cultural differences between providers of care and clients seeking treatment.

Gaps in services exist for: adolescent care, residential services for specialized populations, co-occurring treatment, women, medically-assisted service slots, services for pregnant women, access to psychiatric services, and re-entry services for the criminal offender.

A variety of system level changes were also implemented in the county plans in response to these identified gaps. These included: improving case management and care coordination services; developing gender specific treatment; expanding recovery support for youth; seamless transition from detoxification services to rehabilitative services and linking clients to the self help community.

The SSA also 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 substance abusing residents with mental health issues. 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, which was in fact accomplished. The SSA is currently receiving technical assistance from CSAT on improving adolescent treatment services and is participating in an In Depth Technical Assistance (IDTA) effort concerning its women’s programs.

Estimation of the Population in Need of Treatment - The estimated size of New Jersey’s 2012 resident adult population in need of treatment for *alcohol* abuse or dependence is 585,930 persons. It is found by applying the proportion in need identified by the 2009 NJ-HSDUH to the U.S. Census Bureau’s estimate of New Jersey’s resident adult population for 2012. The size of the 2012 adult population needing treatment for *drug* abuse or dependence in New Jersey is 398,657 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 2010 and 2012 as reported in the NJ-SAMS. 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 2012 New Jersey total substance abuse treatment need or 984,587 persons. Results by county are presented in Table 1.

Table 1

Estimate of Treatment Need for Alcohol and Drug Addiction, New Jersey, 2012					
County	Adult Population 2012	% in Need of Alcohol Treatment	% in Need of Drug Treatment	Total Need for Alcohol and Drug Treatment	Total Need as % of Adult County Population
Atlantic	210,698	11.3	8.0	40,596	19.3
Bergen	711,219	9.0	3.5	88,649	12.5
Burlington	345,723	6.9	5.4	42,301	12.2
Camden	387,208	7.8	8.0	61,356	15.8
Cape May	77,910	8.7	10.2	14,674	18.8
Cumberland	119,601	8.9	7.6	19,788	16.5
Essex	590,808	7.8	7.0	87,489	14.8
Gloucester	218,348	9.3	7.7	36,978	16.9
Hudson	516,623	6.3	4.5	55,888	10.8
Hunterdon	96,685	9.7	11.0	20,022	20.7
Mercer	284,330	13.2	5.7	53,722	18.9
Middlesex	633,742	6.7	4.4	70,389	11.1
Monmouth	477,702	12.3	8.9	101,279	21.2
Morris	377,981	11.8	4.1	60,026	15.9
Ocean	444,640	8.8	6.1	65,994	14.8
Passaic	377,667	5.7	4.5	38,621	10.2
Salem	50,186	7.9	8.9	8,402	16.7
Somerset	245,453	8.5	4.8	32,484	13.2
Sussex	111,466	11.2	7.6	21,006	18.8
Union	410,702	7.5	5.0	51,372	12.5
Warren	81,924	8.3	8.3	13,552	16.5
Total	**6,770,616**	**8.7**	**5.9**	**984,587**	**14.5**

Note: The percentages have been rounded up to the nearest tenth and will not reproduce the numbers given in the text.

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 87,140 individuals who wanted substance abuse treatment, 55,995 received it. This resulted in an unmet demand of 31,145 or a gap of 35.7%.

Met and Unmet Demand in 2012

County	2012 Adult Population[1]	Met Demand[2]	Unmet Demand[3]	Total Demand	Unmet Demand As Percent of Total Demand
Atlantic	210,698	3,207	969	4,176	23.2
Bergen	711,219	2,554	3,272	5,826	56.2
Burlington	345,723	2,270	1,590	3,860	41.2
Camden	387,208	4,700	1,781	6,481	27.5
Cape May	77,910	1,603	358	1,961	18.3
Cumberland	119,601	1,606	550	2,156	25.5
Essex	590,808	5,162	2,718	7,880	34.5
Gloucester	218,348	2,789	1,004	3,793	26.5
Hudson	516,623	3,194	2,376	5,570	42.7
Hunterdon	96,685	713	445	1,158	38.4
Mercer	284,330	2,136	1,308	3,444	38.0
Middlesex	633,742	3,947	2,915	6,862	42.5
Monmouth	477,702	5,521	2,197	7,718	28.5
Morris	377,981	2,132	1,739	3,871	44.9
Ocean	444,640	4,955	2,045	7,000	29.2
Passaic	377,667	2,752	1,737	4,489	38.7
Salem	50,186	499	231	730	31.6
Somerset	245,453	1,520	1,129	2,649	42.6
Sussex	111,466	1,010	513	1,523	33.7
Union	410,702	2,921	1,889	4,810	39.3
Warren	81,924	804	377	1,181	31.9
New Jersey	**6,770,616**	**55,995**	**31,145**	**87,140**	**35.7**

[1]Source: U.S. Census Bureau, 2010 Census, Table DP-1: Demographic Profile of General Population and Housing Characteristics.

[2] Met demand: number of adults admitted to treatment in 2012 according to NJSAMS.

[3] Unmet demand: Percent of 2009 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 (0.46 %) times the 2012 adult resident population.

Special Treatment Capacity Assessment Initiatives

Geographic Information Systems (GIS) - In 2007, using its licensure database, the SSA mapped the spatial distribution of treatment services across all counties and modalities of care and used this information in it county comprehensive planning. Since that time the SSA routinely uses GIS to map its treatment services in order to guide its planning of services in underserved areas.

Dual Diagnosis Capacity - In FFY 2008, the SSA conducted a web-based survey of licensed substance abuse treatment providers to assess provider capacity to serve New Jersey's dually-diagnosed treatment population. The survey was adapted from the Dual Diagnosis Capability in Addiction Treatment (DDCAT) tool. It was found that among 120 agencies responding, 76.7% did NOT qualify as Dual Diagnosis Capable. NJSAMS data indicate that approximately 40% of New Jersey's substance abuse clients also have a mental health issue, but with 76.7% of substance abuse treatment agencies lacking dual-diagnosis capability, there is clearly a need to develop dual-diagnostic capability among substance abuse treatment providers in order to increase both their referrals to and their acceptance of referrals from mental health treatment providers. In FFY 2011, the SSA converted the survey questionnaire for use among community mental health treatment providers.

The DDCAT survey results were used in the planning and development of the SSA's co-occurring services network (COSN) as well as a statewide, co-occurring learning collaborative that helps individual provider agencies to develop co-occurring capabilities. Presently, the SSA is working with the SMHA to develop a co-occurring learning collaborative for community-based, mental health care providers, and will be offering the opportunity for agencies to participate in this effort. The strategy of the learning collaborative is to assist participating substance abuse and mental health provider agencies develop a work plan specific to co-occurring service integration that fosters affiliation agreements and cross-training between substance abuse and mental health agencies at all levels of the treatment continuum of care.

Workforce Development. - The SSA has developed two workforce development initiatives with the Rutgers University School of Social Work, one with the Rutgers Center for Alcohol Studies to address the workforce gap currently existing in SSA licensed addiction treatment programs throughout the state, and one with the Division of Continuing Education to provide county behavioral health planners with a Certificate in Community-based Planning.

A. Coursework with the Rutgers Center for Alcohol Studies targets the needs of licensed treatment agencies with less than 50% credentialed staff by recruiting program candidates from their current staff. Current regulations require at least 50% of staff have credentials. Rutgers offers Master's level addiction courses leading to credentialing as a Licensed Alcohol and Drug Counselor (LCADC), internship placement, and oversight for alcohol and drug counseling interns in accordance with the New Jersey Office of the Attorney General, Division of Consumer Affairs, State Board of Marriage and Family Therapy Examiners', Alcohol and Drug Counselor Committee Statues and Regulations for licensure, N.J.C.A.13:34C-6.2. Upon completion of the program, candidates will meet the licensing requirements to become dually licensed as a LCADC and other clinical licensed professional (social worker, counselor, psychologist, etc). DMHAS will benefit

from this initiative in two key ways: 1) students will perform field work at licensed substance abuse treatment agencies which helps to serve more individuals at provider agencies without additional expense during the field placement periods; and 2) students who go through the curriculum are required to work at a licensed substance abuse treatment agency for two years post-credentialing or they must re-pay the state for their course work. This initiative will produce 400 dually licensed clinicians for the field.

B. The School of Social Work, Division of Continuing Education Certificate in Community-based Planning addresses the needs of County Alcoholism and Drug Abuse Directors as well as county Mental Health Administrators (MHAs) to develop professional skills in health care systems planning. Traditionally, counties have played an ancillary role in the purchase and provision of mainly treatment services for their residents. With the implementation of both the federal PPACA Affordable Care Act and the New Jersey Medicaid Waiver plan for managed behavioral health care, county comprehensive plans will have to reflect the impacts of these reforms.

   The *Education, Training and Technical Assistance* (ETTA) project is an innovative program developed and designed by DMHAS and the Continuing Education Department of the Graduate School of Social Work at Rutgers University for the purpose of advancing the planning education and training of today's county comprehensive planner. It also provides the planner with technical assistance to apply the training in the course of the 2015-2018 county comprehensive planning process that takes place during 2013 and 2014. Coursework began in June 2013. The curriculum consists of five day long training sessions, coupled with on-line instruction and results in a Certification in Community-Based Planning from Rutgers University. There will be three waves of this education and training, with the first wave involving all 21 County Alcohol and Drug Directors, plus 9 of 21 county Mental Health Administrators.

Medication Assisted Treatment - Data from NJSAMS for Calendar Year 2011 indicates that only 10% of Methadone is planned in treatment for clients, yet heroin and other opiates are the primary drugs of admission for 42% of clients entering New Jersey's addiction treatment system. The development of the MATI is an attempt to help reduce this gap by providing more access to medication assisted treatment for opiate addicted individuals by offering methadone, as well as suboxone, to clients.

The SSA has implemented a pilot program for the alcohol or opioid dependent, Driving Under the Influence (DUI) offender that includes medication-assisted therapy using the FDA approved medication Vivitrol (an injectable form of Naltrexone). A comprehensive research protocol was developed and numerous client outcomes are being assessed. The pilot was launched in September 2011. Clients receive the medication for up to six months. There is a follow-up survey six months after the client's last injection. There are currently 70 clients in the pilot.

Based on the promising results for this pilot program, the DMHAS is planning to fund a third medication-assisted treatment option for the opioid dependent patient in New Jersey: Detoxification and Stabilization, including Vivitrol, delivered to high risk consumers in a residential setting, followed by up to five additional injections in an outpatient setting.

Acknowledging that addiction is a medical disorder that postulates client-centered treatment, the purpose of this funding is an additional medication treatment alternative for the opioid dependent patient. This treatment package is an enhanced service for opioid dependent persons who are in need of opioid detoxification and want to remain abstinent without maintenance medications, or for patients seeking medically supervised withdrawal from maintenance medications. The addition of the Stabilization Period in care is to assist the opioid dependent with acute withdrawal during the ten-day, opioid-free period required prior to the first injection of the medication. The patient will then be referred to outpatient treatment for additional injections, treatment, and all the appropriate bio-psychosocial interventions to decrease the likelihood of relapse and assist the person to long-term recovery.

Also, the Division has mandated trainings on medication assisted treatment for treatment providers, incorporated language requiring acceptance of clients on medication assisted treatment into contract requirements, and has provided training for systems partners in Drug Court and Child Welfare on medication assisted treatment. Most significantly, the SSA has incorporated course work requirements in the workforce development initiative described above.

Needs Assessment: Prevention

In December 1993, the SSA was awarded a three-year contract with the Center for Substance Abuse Prevention (CSAP) to conduct a family of 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 consisted of 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 SAPT Block Grant Application process beginning in FFY 1998.

Due to the perceived 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 second Middle School Survey in 1998, a third survey in SFY 2001, a fourth survey in 2003 and a fifth survey in 2007. The sixth Middle School Survey was conducted during the 2011-2012 school year and a final report has been prepared. This year, county level reports are being prepared which provide trend information for key indicators.

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. The SSA has also been collaborating with the NJ Department of Education (DOE) on its Student Health (High School) Survey and has provided financial assistance for the 2010-2011 survey and is providing assistance for its 2013 survey. 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.

Through data obtained in all the prevention studies, the SSA identified risk and protective factors for substance abuse and ranked communities by risk scores. These school surveys have allowed the SSA to establish substance abuse risk and protective factors at the community level and to identify trends in factor scores over the past 18 years. However, one of the state's challenges is that active parental consent is required for students to participate in these surveys, which impacts response rates. The SSA would support a change in the legislation to require passive parental consent instead.

The SSA also developed the Relative Needs Assessment Scale (RNAS) for alcohol and drug prevention planning in 1995 and updated it in both 2008 and 2013. 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 last RFP process for awarding three-year prevention contracts utilizing SAPT Block Grant funding. In FFY 2012 and FFY 2013, the SSA will provide RNAS indexes down to the municipal level for use in the county comprehensive planning process for 2014 to 2017.

Addictions Prevention Strategic Plan - In 2010, the SSA began an addictions strategic prevention planning process for the use of primarily environmental management strategies. The planning method relied on the full range of DMHAS' available quantitative data for the purpose of identifying 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. The Plan aligns stakeholder group prevention efforts and resources with the identified priority areas and will guide prevention decision-making and policy development at the tate, county, and provider levels for all DMHAS-funded prevention services over the next five years. A draft Addictions Prevention Strategic Plan was distributed to Planning Committee members in August, 2011.

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. Seventeen coalitions were awarded contracts.

State Epidemiological Outcomes Workgroup (SEOW) - The SSA was awarded a Strategic Prevention Framework State Incentive Grant (SPF-SIG) by SAMHSA in October 2006 to prevent the onset and reduce the progression of substance abuse, including childhood and underage drinking. In addition, it was intended 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 conducting 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 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 has been meeting regularly to discuss ways to prevent the onset and reduce the progression of substance abuse disease in New Jersey.

The SSA continues to actively recruit for new members of the SEOW. This past year has seen the addition of members from the NY/NJ High Intensity Drug Trafficking Area (HIDTA), the Department of Health's Division of Family Health, Department of Military and Veterans Affairs, the NJ Poison Information and Education System (NJPIES), the New Jersey Hospital Association Behavioral Health Group, and the Prescription Drug Monitoring Program which became operational in September 2011.

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 a State Epidemiological Profile which it submitted to SAMHSA in April 2007.
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 Substance Use Survey (MSSUS)
6. The Treatment Episode Data Set (TEDS)
7. The Uniform Crime Report (UCR)
8. The New Jersey Uniform Crime Reporting (UCR) Program
9. The Youth Risk Behavior Survey (YRBS)
10. New Jersey Student Health Survey (NJSHS)
11. 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 Division of Youth and Family Services (DYFS)
2. The National Highway Traffic Safety Administration (NHTSA)
3. The Intoxicated Driver Program (IDP)
4. The New Jersey Center for Health Statistics (NJCHS)
5. The New Jersey Department of Health: Division of HIV/AIDS Services (NJDHSS)
6. 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)

The profile served as the basis for recommending prevention priorities to be addressed through the SPF-SIG grant. The SEOW conducted an extensive review of data describing substance use and its consequences available from a multitude of sources. 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 dependence of 18-25 year olds in the past year", "drug dependence of 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 tailored for the 18-25 year old population. In 2008, the SSA awarded eleven community contracts to implement this prevention priority. As the projects have been implemented, most are focused on the harmful consequences of alcohol consumption and in particular, motor vehicle crashes.

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 dependence of 18-25 year-olds in the past year; 2) Binge drinking by college students; 3) Use of illicit drugs by persons 12-17/18-25 in the past 30 days; 4) Drug dependence of persons 12-17 years old in past year; and 5) Use of alcohol by high school students in the last 30 days.

The Division was awarded a SEOW grant from SAMHSA for $180,000. Funding from the SEOW grant will enable DMHAS to update the state Epidemiological Profile and develop county-level profiles as well. The SEOW, through its Planning Committee, will prepare a Powerpoint Epidemiological Profile training module to be presented onsite to assist county staff on Profile creation and educate on data collection, analysis and reporting. Additionally, regular reports posted on the Division website and shared electronically will be prepared with data from the following sources: the recent NJ Older Adult Survey, prescription drug use reports in collaboration with the NJ Prescription Monitoring Program Administrator (and SEOW member), and mental health and substance abuse issues regarding Veterans. Finally, SEOW funding will make possible the development of a Social Network Analysis Project (analysis of linkages between/among the disparate prevention organizations in New Jersey).

Prevention Outcomes Management System - In August 2009, the SSA implemented its Prevention Outcomes Management System (POMS) which replaced the Minimum Data Set (MDS). The POMS is used to collect basic demographic and process information (similar to MDS) as well as outcome information recommended in CSAP's core measures. All agencies that receive prevention contracts from the SSA, which are funded with SAPT Block Grant funds, are required to use the system. The long-range objective is for the SSA to achieve a working, integrated system based on empirical data that informs both its policy decisions and its SAPT Block Grant Application.

Two new modules have been developed for POMS during FY 2013: Strategic Prevention Framework (SPF) and Environmental. Training on the SPF module occurred in March 2013 and is now being utilized by the 17 Regional Coalitions. Modifications are being made to the Environmental module, and training will occur in August 2013.

County Planning for Treatment and Prevention

The SSA collaborates with the County Alcohol and Drug Abuse Directors in the administration of the aforementioned AEREF program. In SFY 2012, the AEREF program distributed

$9,065,796 to the states' 21 counties, based on county population size, per capita income and estimated treatment need. The SSA supplemented these awards with an additional $6,908,396 for a total investment of $15,974,165 by the state in county provision of services.

Further, 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."[1]..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 develop and present to the County Board of Freeholders 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. Thus, the next CCP will govern the four-year period beginning 2015 and ending 2018.

[1] Chapter 51, Laws of 1989, paragraph 14 incorporating Section 4 of P.L.1983, c.531 (C.26:2b-33 as amended).

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, and outcomes for prevention, early intervention, treatment, and recovery services; 4) one system-level change to enhance the local continuum-of-care; 5) a 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 a 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 lead to 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 data from: a) the Household Survey findings and social indicator data from the county and municipal chart books, b) the SSA's NJ-SAMS and facility licensure data, and c) other relevant state department data. The planning process also incorporates local perceptions of substance abuse issues and treatment system capacity by means of county focus groups and other encouragements to citizen participation. As previously mentioned, the SSA also provides planning education, training, and technical assistance to the county directors.

Future Developments in the State-County Collaborative Planning Process – During the next cycle of Unification Planning, the SSA, in collaboration with the GCADA, intends to: 1) help counties identify and implement a greater number of evidence-based prevention programs and 2) support counties to establish environmental approaches to prevention planning at the county and municipal levels using training by the National Community Anti-Drug Coalitions of America (CADCA) in New Jersey. CADCA trains counties and their GCADA municipal alliances to develop coalitions that focus on problem "spots" or "types" that harm quality of life at the community level. Planning will consist of data-driven problem assessments, community mobilization strategies, and partnership development with affected communities to better regulate identified problems and improve or restore quality-of-life standards damaged by problem drinking and drug use. The SSA will support this effort by providing County Alcohol and Drug Abuse Directors with specialized data sources, analyses, planning education, continued training and technical assistance.

Planned System Enhancements: Prevention

SPE Grant - In May 2011, the SSA submitted a Strategic Prevention Enhancement (SPE) grant to SAMHSA. New Jersey's SPE Project will serve six high-need counties: Bergen, Camden, Essex, Hudson, Middlesex, and Monmouth. The SPE grant will provide 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. The SSA computed county estimates of need for prevention of alcohol and other drugs. 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 are far more prevalent than in other counties throughout the state. Additionally, these counties' alcohol and drug-related problems are significantly higher relative to other New Jersey counties.

In addition to serving these high-need communities, New Jersey proposes to utilize 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 POMS, the SSA's prevention management information system, to collect data on environmental strategies and programs, creating a Social Indicator Database, updating the *New Jersey State Epidemiological Profile for Substance Abuse,* updating 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, and creating a database of all prevention services and programs being delivered throughout the state.

The training and services that New Jersey will provide to high-need communities as well as the enhancements to its prevention infrastructure will better enable New Jersey to support more strategic, comprehensive systems of community-oriented care and will allow us to deliver services and programs that are simultaneously consistent in their application throughout the state yet able to identify and address problems and needs on a local level.

Regional Coalitions - A second enhancement is the RFP that was issued by the SSA to fund "Regional Coalitions to Utilize Environmental Strategies to Achieve Population-Level Change." Environmental strategies are cost effective given the potential magnitude of change. Community mobilization is central to creating population level change. In August of 2010, the SSA convened a Prevention Strategic Planning Committee for the purpose of developing a five-year addictions prevention strategic plan. The purpose of the Addictions Prevention Strategic Plan is to focus statewide prevention efforts on specific data-driven priorities for which measurable change can be achieved at the state and community levels. The planning committee formed needs assessment, capacity, and planning sub-committees to analyze existing data on addictions in the state population and current prevention resources. These data provided the foundation for identifying and selecting the following prevention priorities that are also the focus of the RFP:

- 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 seventeen 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, 2008." 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.

Effective January 1, 2012, the regional substance abuse prevention coalitions were funded 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 SAMHSA's Eight Strategic Initiatives.

The coalitions will intensively collaborate with Municipal Alliances in their region, which are funded and overseen by the GCADA. Coalitions will also coordinate their efforts with those of the nine 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.

Partnership for Success Grant - In May 2013, the SSA submitted a Partnership for Success (PFS) grant to SAMHSA. This grant will target underage drinking and the misuse of prescription medication among 12 to 25 year olds as per SAMHSA requirements. New Jersey has also added an additional priority focused on the misuse of prescription medication among older adults (60 years and above). The grant will also include components related to smoking cessation and addressing the needs of returning military.

Planned System Enhancements: Treatment

DUI Vivitrol Pilot - The SSA's goal is to develop a system of care that offers high risk clients the means to enter and sustain recovery. In this effort, the SSA has implemented a pilot program for the alcohol or opioid dependent, DUI offender that includes medication-assisted therapy using the FDA approved medication Vivitrol. A comprehensive research protocol was developed and numerous client outcomes are being assessed. The pilot was launched in September 2011; clients receive the medication for up to six months. There is a follow-up survey six months after the client's last injection. There are currently 70 clients in the pilot. Since results have been promising, plans are currently underway to incorporate Vivitrol as an enhancement in its Fee for Service Initiatives, moving it into general practice, rather than pilot status.

Adolescents - The SSA has received technical assistance from CSAT as a result of its 2009 Core Technical Review to improve adolescent service demand and appropriateness and ensure that clinical decisions regarding adolescent placement and services are clinically sound. Discussions have centered on: 1) developing a statewide adolescent services menu, 2) marijuana specific treatment, 3) identifying leading national evidence-supported assessment, placement, continued

stay and outcome measurement instruments, 4) addressing adolescent engagement, retention and utilization issues and practices, and 5) outlining a strategy and action steps to shift the service delivery system toward community- and family-based recovery-oriented care utilizing more flexible outpatient and home-based services. As noted earlier in this plan, adolescent services were transitioned to the DCF in July 2013, where there will be additional opportunities for adolescent treatment.

Client-centered Treatment Planning - The SSA received technical assistance from CSAT to help design a treatment plan that is client-centered and recovery-oriented, moving away from the traditional pathology/symptom based approach. This project reflects the SSA's strong commitment to client-centered care. This new approach builds on client strengths and actively involves clients in their treatment planning. A key element is the use of concurrent documentation that involves both the client and clinician in writing the progress note. Two agencies (one residential, one outpatient) piloted this approach. The SSA will consider the next steps.

Pay for Performance - In 2009, the SSA implemented its first pay-for performance project with Drug Court providers that provide long-term residential care. Using a statistical technique known as survival analysis, key retention points of 21, 45 and 91 days were identified where 25%, 50% and 75% of the clients dropped out of treatment, respectively. Data were examined for the percentage of clients who completed treatment at those points in order to set benchmarks. The SSA decided to "raise the bar" and set 95%, 90% and 80% client retention rates for those three intervals, respectively, in order for agencies to receive an incentive. The incentive structure was $1,000, $500 and $500, respectively, so an agency could earn up to $2,000 per month. A 95% utilization requirement was also instituted to ensure contract beds were not left vacant. The results for the first quarter of FY 2010 (7/1/09 - 9/30/09), when this incentive was implemented, indicated that for the six agencies participating, all received an incentive which ranged from $1,000 to $5,000; the maximum that could be attained for the quarter was $6,000. However, since this was the first time the incentive was paid, the 95% utilization requirement was waived. Results for the most current data available (the fourth quarter of FY 2012 (4/1/12 – 69/30/12)) indicated that four agencies received an incentive ranging from $500 to $2,500. For the two agencies that received no incentive, one did not meet the utilization criteria and one received no admissions during the quarter.

Payment for Episode of Care - The SSA has explored financing strategies involving payment for an episode of care. Since the SSA has a fee-for-service billing system for several of its treatment initiatives, it has the data available to conduct this analysis. Preliminary work has begun by examining the episode costs for the different initiatives by the level of care initially entered. 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.

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 RFPs and contract efforts (e.g., Outpatient Services, Supportive Housing), and is in the early stages of conducting a comprehensive statewide needs assessment, using a myriad of sources (e.g., US Census Bureau, New Jersey Department of Labor and Workforce Development, SMHA consumer satisfaction survey data) 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, numbers of minority owned firms, median household income, screening center admissions, and crime rates.

The merged SSA/SMHA is better positioned to conduct a joint, statewide and comprehensive behavioral health needs assessment—inclusive of both substance abuse and mental illness within the grant period. One promising data source that has integrated substance abuse and mental health instruments is NJ HSDUH to be collected in 2013-2014. Mental Health indicators have been included in the questionnaires of this survey.

Mental Health Promotion, Needs Assessment and Goals

A major initiative currently underway is the development and implementation of a web-based client registry and tracking system to support DMHAS' transformation into a recovery oriented service organization. The new system will provide the ability to more easily create unduplicated statistics on consumers served, as well as to identify service utilization across the mental health system.

Functionally separate and distinct from other SMHA reporting measures, the Quarterly Contract Monitoring Report (QCMR) database provides the SMHA with information regarding aggregate utilization and costs for each contracted community agency and corresponding program elements. All agencies funded by the SMHA contractually agree to provide specified types of services for a pre-determined number of consumers as well as to submit data to the SMHA via QCMR protocols. This database thereby gives the SMHA the capacity to monitor compliance with contractual agreements.

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:

- Annual Demographic Profiles summarized by New Jersey Department of Labor and Workforce Development based upon Census 2010, 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 and 2013).
- Mental Health Consumer Satisfaction Survey (MHISP), Mental Health Statistics Improvement Program.
- New Jersey DOH Uniform Billing from which we can derive prevention quality indicators (using the algorithm provided by AHRQ) to calculate preventive hospitalizations.

Needs Assessment - The SMHA has identified the following gaps in service delivery: minority populations, transgender, lesbian and gay populations, persons with dual disorders, consumers with co-occurring medical conditions, persons in dual recovery from substance abuse and mental health disorders as well as those who have past criminal involvement. Due to the high prevalence rate of dual disorders, DMHAS sponsors and funds a small program to provide specialized approaches to starting and running dual recovery groups at self-help centers. Nine self-help centers participate in the initiative. Due to the early mortality and medical co-morbidity of the mental health consumer population, self-help centers have begun to offer free health screenings for cardio-metabolic syndrome by measuring blood glucose levels, weight, blood pressure, and body mass indicator.

Client Level Database - With the development and implementation of the web-based client level database, as well as with the other databases and datasets described above, the SMHA will be able to significantly enhance its planning efforts and capacity for data informed decision making. The SMHA will be able to prepare a comprehensive need assessment inclusive of county based needs, barriers, critical gaps, and reporting on target populations. To enhance this, the SMHA has recently acquired GIS technology (ArcView[2]) which will allow for sophisticated statewide analyses of need to be conducted on a county-by-county basis. Such technology allows the SMHA to conduct geographically-informed queries using existing tabular datasets (e.g., US Census data, SMHA client utilization information, etc.).

New Jersey Statute 30:4-177.63 - became effective March 2010 which required the Commissioners of Human Services and Children and Families to: a) establish a mechanism to inventory all county-based public and private inpatient, outpatient and behavioral health services and make the information available to the public, b) establish and implement a methodology, based on nationally recognized criteria, to quantify the usage and need for inpatient, outpatient and residential behavioral health services throughout the state, taking into account projected patient care level needs, c) annually assess whether there are sufficient behavioral health services available, d) annually identify the funding for existing mental health programs; e) consult with various stakeholder groups to make recommendations, f) consult with various NJ hospital organizations and organizations that advocate for mental illness and their families and g) annually report on activities related to this act to the Governor and Senate and Assembly Health and Human Services Committees.

[2] http://www.esri.com/software/arcgis/index.html

To meet this legislative requirement a methodology was recently developed to determine mental health need for New Jersey utilizing nationally recognized criteria. There are three major approaches that are typically used in assessing the need for mental health services: 1) community surveys (e.g., direct survey, key informant), 2) demand or utilization based methods, and 3) social indicators. New Jersey has chosen to use social indicators, due to its demonstrated practicality, expediency, empirical support and cost effectiveness.

A key assumption with the social indicator approach is that the population at risk of mental illness can be estimated by using demographic data and can substitute for a direct survey of the mental health needs of individuals. A major advantage is that census data and other public data (suicides, divorce, crime statistics, etc.) are readily available. A review by Cagle (1984)[3] suggests that a small set of carefully chosen indicators can serve the purpose for determining need. The current approach is based on epidemiological literature to determine the social correlates of mental illness. Cagle reviewed this approach to assess need for acute psychiatric services in New York State. The New York Office of Mental Health was searching for a "rational" method to determine statewide need for acute psychiatric beds. Interestingly, Cagle's review of the research suggested that there may not be much difference in correlations between social indicators and the need for long term- vs. acute-care services.

The epidemiological evidence was grouped into three categories: low socioeconomic status, marital status indicators and other social factors. The social indicators and their definitions that were used to produce the need assessment for mental health in New Jersey are presented in Table 1 and are partially based on Cagle's work.

Table 1
Definition of Social Indicators Used in the RNAS Model to Calculate Mental Health Risk Index for New Jersey Counties

Low socioeconomic status	
• Poverty [A]	Poor families below the poverty level
• No high school education [B]	Number of people age 25 years & over, with no high school diploma, 2010
Marital status	
• Divorced families [B]	Adults 15 and over in 2010 who were separated or divorced.
• Female householder [B]	Female householder, no husband present with own children less than 18 years, 2010.
• Living alone, 2010 [B]	Nonfamily householder living alone, 2010.
Environmental and Other Social Factors	
• Unemployment [B]	Population 16 and over unemployed in 2010
• Housing tenure [B]	Ratio of occupied housing which are renter occupied, 2010

[3] Cagle "Using Social Indicators to Assess Mental Health Needs", Evaluation Review, 1984, 8 (3), 389- 412.

• Population density [A]	County population per square mile, 2010
• Suicide [C]	Death with suicide as underlying cause. Suicide is defined as death resulting from the intentional use of force against oneself.

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

The methodology utilized was the Relative Needs Assessment Scale (RNAS) developed by the DMHAS research team, which has been used for determination of substance abuse treatment and prevention need and has been described in the above section. RNAS provides a single value of the severity of mental health problems for each county with its magnitude demonstrating its relative standing among the rest. This work attempts to standardize the relative occurrence of mental health problems into a scale that segments population counts into proportional shares.

As the research team refines this need assessment methodology, an opportunity to enhance the determination of mental health need will become available with the NJ HSDUH scheduled to be deployed in 2013-2014. Since the Divisions are now merged, there will be a special section added to the survey for mental health, utilizing questions on this topic. This will allow us to develop a coefficient for mental health need that can be applied to estimating the need and demand for mental health treatment in New Jersey. Due to the large sample size of the NJ household survey, it will be possible to assess mental health need at the county level, as is currently done for alcohol and drug need. This additional methodology will supplement the current RNAS that was developed for mental health. Also the synthetic estimation technique of "capture-recapture" will be explored to assess its utility for improving estimates of mental health need.

The next step will also be to do a gap analysis for mental health as has been done for substance abuse. The gap analysis examines the difference between the "demand" for mental health treatment, which can be derived from the household survey, and the actual number of individuals who are able to receive treatment.

Data Driven Planning

Consumer Operated Service - Self Help Outcomes and Utilization Tracking (SHOUT) is an outcome-based measurement system based on the CSP-sponsored consumer operated self-help centers (SHC) model. It is utilized by CSP in evaluating performance and fidelity to the SHC model. The SHOUT system provides CSP with information on Self Help Center operations, activities, and consumer participation.

Peer Recovery Warm Line - The Peer Wellness Warm Line (PRW) is a statewide toll free line operated by the Mental Health Association in New Jersey. Peer Specialists, who are trained in "Intentional Peer Support" and "The Wellness and Recovery Action Plan," staff the call line.

By establishing "mental health" as the common ground, the Peer Specialist supports the Caller in talking about their wellness and recovery using the key concepts within the Intentional Peer Support and Wellness and Recovery Models. The Warm Line was recognized nationally in 2012 as the winner of the Mental Health America Innovative Program of the Year Award. In 2012, the PRW answered a total of 12,265 calls.

In addition to tracking quantitative data, the Warm Line also tracks qualitative measure to assess the impact of services on Callers. One goal of the services is to provide Callers with the support and skills to avoid emergency room visits and other more restrictive interventions. Also in 2012, an average of 93% of callers identifying feeling they were in crisis and may need to go to an ER were able to make an alternate plan by the end of the PRW phone contact. Work on the "Dimensions of Wellness" is also tracked. Data consistently shows that all eight dimensions are being addressed with PRW Callers, with Emotional Wellness and Social Wellness being the most frequently discussed at 42% and 19%, respectively.

Supported Employment (SE) - Contract performance commitments (Annex A) and subsequent QCMRs provide the number of consumers to whom services are delivered and become employed.

Supported Education (SEd) - Contract performance commitments (Annex A) and subsequent QCMRs provide the number of successfully completed semesters consumers complete.

Justice Involved Services (JIS) - Contract performance commitments (Annex A) and subsequent QCMRs provide the number served by the Services.

Integrated Dual Diagnosis Treatment (IDDT) - The providers that have implemented this service are evaluated every year by the University Behavioral Health Care (UBHC), Rutgers.

Illness Management and Recovery (IMR) - SMHA provides IMR through existing DMHAS-funded partial care and PACT contracted community provider organizations. In addition, IMR has recently, been offered to supportive housing providers. IMR training and technical assistance is provided by UBHC under contract with SMHA. For purposes of Block Grant reporting (and general planning) IMR training data is provided to DMHAS by UBHC.

Veterans Services*:* Veteran's status data is collected by the SMHA via the USTF database. This dataset is far from definitive—as many provider agencies solicit veteran's status data from their consumers on an inconsistent basis. The upcoming web-based, client-specific consumer database will remedy this, with business rules and data validation tools that will enhance the collection of veteran status data—with particular emphasis on identifying consumers who were veterans of recent conflicts (e.g., Operation Enduring Freedom and Operation Iraqi Freedom).

Supportive Housing (SH) - The SMHA contracts with approximately 52 SH providers and Supervised Residential providers in all 21 counties. These services range from being completely consumer-driven in the consumer's leased-based housing to supervised settings with 24/7 staffing. In addition, the state funds Residential Intensive Support Teams (RIST) in 17 of the 21 counties. In FY 2012, a total of 145 placements were targeted to be created (with 95 set aside for

individuals on Conditional Extension Pending Placement (CEPP) Status) and 50 set aside to prevent homelessness and/or institutionalization. The Division created a total of 242 placements with SFY 2012 Olmstead funding. 135 placements were created for consumers designated CEPP and 107 placements were created for consumers at Risk of Hospitalization. In 2013, the targeted number of placements increases to 225 (125 set aside for CEPP designees, and 100 set aside to prevent homelessness and/or institutionalization). The SMHA shapes its SH efforts based on: 1. the aforementioned Olmstead settlement agreement and 2. service gaps identified through the states' Homeless Management Information System (HMIS), which tracks homeless adults with SMI. This data is used to generate RFPs in order to develop SH initiatives for the "At Risk" population.

Treatment teams currently collect data on the discharge needs of every consumer in the state hospital using the Individual Needs for Discharge Assessment (INDA). The data that is collected is essential in planning at the individual client level, the local level, regional and statewide. The INDA provides key clinical information with regards to discharge planning such as barriers to discharge and consumers' needs upon discharge. This data is used to develop SH initiatives for consumers being discharged from the state psychiatric hospital system. In addition, each hospital maintains a Housing Preference Interview (HPI) for each consumer.

A new Provider Performance Report for Supportive Housing (PPR SH) is in the final stages of development. The PPR SH contains 17 data elements organized among three domains: program volume indicators, program terminations, and linkages made to other programs. This dashboard report collects annual data for each SH agency and benchmarks it alongside of statewide and regional averages. A draft iteration of the PPR SH is expected to be released to the SH providers in 2013.

Homeless Adults/Housing First/PATH - 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. Data from the PATH program is collected using the HMIS. This web-based software application stores client-specific information (demographics, needs) of homeless populations. HMIS data is accessed at the SMHA by the program coordinator for Homeless Services.

Acute Care Services - The SMHA uses multiple data sources in monitoring acute care system trends. The QCMR system provides data on basic volume measures (with relation to contract specifications) such as service episodes, numbers of persons served and units of service delivery. The USTF provides data on demographic factors, system use, service needs and diagnosis. By regulation, Systems Review Committee (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.

In early 2013 the SMHA convened a meeting of the Designated Screening Center (DSC) coordinators to present the first Provider Performance Report for Designated Screening Centers (PPR DSC). These provider-specific, dashboard-style reports contain 17 separate data elements drawn from the SRC, QCMR and Annex A data sources. The data elements on this PPR are organized by volume indicators, quality measures (e.g., recidivism, frequency transfer delays) and operational costs. These reports also provide aggregate statewide and regional data to allow providers to compare their results across the state and its regions.

Programs for Assertive Community Treatment (PACT) - The SMHA collects data for all New Jersey PACT teams on a monthly and quarterly basis. The quarterly data is submitted via the QCMR. The QCMR collects program/provider specific data for programs contracted by the SMHA. See http://nj.gov/humanservices/dmhs/info/csc/qcmr/index.html for more details. Seventeen program elements submit their quarterly aggregate data in this manner. The QCMR data is augmented annually by the submission of Annex A data which provides the SMHA with data on expected service levels, and mutually-agreed upon deliverables.

By regulation, all New Jersey PACT teams are required to have staff with expertise in the treatment of substance abuse disorders and thus, PACT teams shall provide highly individualized dual disorder services for enrollees who have co-occurring mental health and substance abuse disorders. DMHAS anticipates continued targeting of dedicated funding to expand the state's Program of Assertive Community Treatment (PACT). SFY 2013 is the fourth consecutive year in which the statewide PACT capacity has been expanded. In total, since SFY 2010, eleven New Jersey PACT teams have been expanded, with the targeted (maximum) capacity of the program going from 2,002 to the current capacity of 2,082

Anti-Stigma - The Governor's Council on Mental Health Stigma relies on both qualitative and statistical data provided by community partners to identify needs and then craft strategies that address those needs. The Governor's Council on Mental Health Stigma partnered with the state psychiatric hospital staff to celebrate hope, recovery and wellness in recognition of Mental Illness Awareness Week October 7 – 15, 2012. Participants heard speeches on wellness and recovery from families and consumers, were able to tour the treatment malls and see programs, and viewed displays of artwork. For 2013, creative arts festivals will be held at the state hospitals. Community agencies will be invited to attend along with families and consumers.

The Council posted training videos relating to stigma awareness and messages of hope and recovery on its website. It continues to work with DMHAS, the Mental Health Planning Council, and additional stakeholder groups to publicize the suicide prevention lifelines (e.g., 1.800.273.TALK) and the accessible community-based mental health services that can help consumers deal with symptoms leading to suicidality. In addition, the Stigma Council has partnerships with federal and state military and veterans 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.

Intensive Family Support Programs (IFSS)*:* Data regarding the usage of IFSS by minority families has been obtained via individual program monitoring visits, mental health licensing site

reviews, IFSS Workgroup meetings and QCMR from NAMI NJ which document the number of referrals to IFSS. In the third quarter of Fiscal Year 2013, a survey was conducted by the SMHA among the 21 IFSS programs in order to determine the volume of minority families being served. The response rate was 100% of the 21 programs surveyed. The total number of families served statewide was 1,665. The results revealed that 1,301 (78.12%) are White, 160 (9.61%) are Black or African American, 125 (7.51%) are Hispanic or Latino, 43 (2.58%) are Asian, 22 (1.32%) are Other or Not Reported, 13 (.78%) are Native Hawaiian or Other Pacific Islander and finally 1 (.06%) is American Indian or Alaska Native. The effort to attract minority families is definitely not lacking although remaining a challenge. Monitoring the efforts of IFSS with regard to minority families shall continue to occur on a regular basis via monitoring visits, Office of Mental Health Licensing Site Reviews and IFSS Workgroup Quarterly Meetings. The SMHA will conduct the next survey of minority families in the third quarter of Fiscal Year 2014.

Older Adults - According to the United States Census Bureau, the New Jersey population age 65 and older is projected to be 19.07% of New Jersey total adult population by 2015[4]. The specialized needs of older adults is well known (e.g., medical fragility, ambulatory considerations, increased risks of falls, increased prevalence of depression and social isolation), yet the necessary resources still must be marshaled on an appropriate scale. It is evident that housing opportunities (appropriate for older adults) must be expanded throughout the state.

Workforce Development - As the SMHA and the SSA continue to merge their workforce development offices, their respective training and prevention staff will be able to look system-wide at resources and develop a joint plan to utilize the staff to address training, prevention, HIV, LGBTQ, early intervention, etc.

Consumer Perception of Care Survey - The SMHA Consumer Perception of Care Survey will be distributed in the summers of 2013 and 2014 to a representative sample of adult consumers of all community-based, non-acute programs. The survey results will be reported in the 2014 and 2015 CMHSBG Implementation Reports. An unmodified version of the Mental Health Statistics Improvement Program (MHSIP) Adult Survey[5] will be 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 that is administered by an agency by the SMHA, will serve as a sampling stratum. Agency program coordinators will be 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 expected to be studied and used to guide the SMHA's planning efforts for future initiatives and resource allocation.

Use of 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

[4] United States Census Bureau,http://lwd.dol.state.nj.us/labor/lpa/dmograph/lfproj/lfproj_index.html
[5] See http://www.mhsip.org/Survey/MHSIP%20Adult%20Survey%202006%20URS.pdf
[6] See http://www.cdc.gov/brfss/questionnaires/pdf-ques/2011brfss.pdf

mental health services) for new community services and RFPs. Additional statewide and county-specific data is obtained from the US Census Bureau (e.g. http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml) 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 New Jersey Department of Labor and Workforce Development also generates important economic and employment data (http://lwd.dol.state.nj.us/labor/lpa/content/njsdc_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 http://www.state.nj.us/njsp/info/stats.html) 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 URS data tables, and state level detail reports provide useful information in this regard (http://www.samhsa.gov/dataOutcomes/). 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 wide mental health data (http://www.nri-inc.org/reports_pubs/). The SMHA regularly receives and reviews the findings of both inter-state and regional mental health reports distributed by The Bristol Observatory and the University of Vermont (http://www.thebristolobservatory.com/pubsformultistaterp.html).

The state's priorities and goals are supported through a mix of data-driven processes, political mandates, and legal obligations. Initiatives such as the Involuntary Outpatient Commitment (IOC) Program are mandated (and legislated into being) by state government. The myriad of Olmstead-related activities are conducted under the aegis of the Olmstead settlement agreement. The *existence* of such programs is determined by legal/legislative processes, but the *execution and implementation* are based on data and quantitative analysis. Local data identifies the need, statewide data determines the presence of existing relevant resources, national inference provide guidance on the shape such programming might take, and program data evaluates the degree to which such interventions are successful.

Prevalence for Adults with SMI and Children with SED

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%.

According to figures released by the United States Census Bureau[7], the 2010 adult population of New Jersey was 6,726,680. The size of the New Jersey child population was 2,065,214. Using the same estimates (3.7% lower, 5.4% middle, and 7.1% upper), the estimates of adult SMI in New Jersey in 2010 was 248,887 (lower), 363,241 (middle) and 477,594 (upper). In 2011, the estimated total New Jersey adult population was 6,778,345. The estimate of adults with SMI in New Jersey in 2011 ranged between 250,799 (lower estimate), 366,031 (middle estimate) and

[7] Population Estimates by Single-Year of Age and Sex: April 2010 to July 1, 2011 (Excel) Source: Population Division, US Census Bureau, May 17, 2012 downloaded from http://lwd.dol.state.nj.us/labor/lpa/dmograph/est/est_index.html#state. .

481,262 (upper estimate). The projected size of the total New Jersey adult population for year 2015 is 6,987,264[8] - an increase of 3.1% relative to 2011. The projected estimate of adults with SMI in New Jersey for 2015 ranges between 258,529 (lower estimate), 377,312 (middle estimate) and 496,096 (upper estimate).

The demand for SMHA-funded community programs for people aged 65 and older has continued to grow in New Jersey. Rising enrollments are consistent with a general increase in the population size of older adult state residents. In 2010, New Jersey had 1,185,993 residents who were 65 years of age or older. In 2011, this population increased to 1,208,360, as reported by the US Census. This represents an increase of 22,367from 2010 to 2011 (an increase of 1.9%). The US Census projection for 2015 is 1,332,800 New Jersey adults aged 65 and older, a projected increase of 10.3% relative to 2011.

In accordance with nationally-accepted definitions, New Jersey currently uses the Federal definition that stipulates that adults with a SMI are persons:

> "Age 18 and over, who currently, or at any time during the past year, have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within (DSM IV), that has resulted in functional impairment which substantially interferes with or limits one or more major life activities" (Federal Register, Vol. 58, No. 96, May 20, 1993, p. 29425)."

However, we are in the process of developing our own independent definition of SMI which will be piloted with agencies in Calendar Year 2014 prior to full implementation across the system. With the implementation of the Home to Recovery CEPP Plan and the expansion of community capacity, the number and types of community mental health services has grown and diversified in order to meet the needs of the New Jersey's mental health consumers. According to the USTF database, SMHA has served 285,217 unduplicated consumers in community settings—including county hospitals and STCFs in SFY 2011. Although complete FY 2012 USTF data is unavailable at the time of writing, the number of unduplicated consumers served in community agencies, county hospitals and short-term care facilities in the first three quarters of SFY 2012 (spanning the time period between July 1, 2011 and March 31, 2012) is 286,885.

When county hospitals are excluded from tabulation, the SMHA served 276,676 unduplicated adult consumers in community settings (excluding county hospitals), in FY 2011- which was a 2.1% increase from 2010 (270,948).

US Census Bureau Estimates (2010 and 2011) and 2015 Projection of New Jersey								
Year	**Fed %**	**Total Adults**	**Total Adult SMI**	**Fed%**	**Total Children**	**Total Children SED**	**Total**	**Source**
2010	0.054	6,726,680	363,241	0.08	2,065,214	165,217	8,791,894	http://lwd.dol.state.nj.us/labor/lpa/dmograph/est/est_index.html#state

[8] Projections of Population by Age and Sex: New Jersey, 2010 to 2030 (Excel) downloaded from http://lwd.dol.state.nj.us/labor/lpa/dmograph/lfproj/lfproj_index.html.

2011	0.054	6,778,345	366,031	0.08	2,042,810	163,425	8,821,155	http://lwd.dol.state.nj.us/labor/lpa/dmograph/est/est_index.html#state
2015	0.054	6,987,264	377,312	0.08	2,036,736	162,939	9,024,000	http://lwd.dol.state.nj.us/labor/lpa/dmograph/lfproj/lfproj_index.html

Quantitative Targets - According to the USTF data (which includes all contracted community agencies and short-term care facilities) the number of adults served in non-emergency settings has steadily increased from 2010 to 2012. At the time of writing, the relevant data from the 4th Quarter of FY 2012 has not been submitted by the providers to the SMHA, thereby limiting analysis. However, the number and percent served in non-emergency settings has continued to increase at this point in time.

Unduplicated Adults Served - When reporting the number of consumers served across the system and including those served in county hospitals, there are 106,522 unduplicated seriously mentally ill (SMI) consumers that were served in non-emergency settings in the first three quarters of FY 2012. This represents 87.1% of the total SMI population served. Using this same dataset, 102,385 unduplicated SMI consumers were served in non-emergency settings, or 83.3% of the total served in FY 2011. In FY 2010, 98,822 unduplicated SMI consumers were served in non-emergency settings, or 82.2% of the total served when county hospitals were included. Looking at these same variables between FY 2010 – FY 2012, when those consumers served in county hospitals have been excluded from the data set, we see similar overall trends. In the first three quarters of FY 2012 there were 98,541 unduplicated SMI adult consumers served in non-emergency settings, (86.2% of total adults served). In FY 2011, there were 94,653 unduplicated SMI adult consumers served in non-emergency settings (82.2% of total adults served), and in FY 2010, there were 90,906 unduplicated SMI adult consumers served in non-emergency settings (81.0% of all adult consumers served) when the county hospitals were excluded from the data set.

Including consumers served in the county hospitals, in the first three quarters of FY 2012 (the fourth quarter's data has not been submitted to the SMHA at the time of writing) 55,753 adult ethnic minorities with SMI were served by the SMHA. This value represents 45.6% of all adult SMI consumers served. In FY 2011, 56,293 adult ethnic minorities were served, or 45.8% of the total SMI population served. In FY 2010, there were 53,964 ethnic minorities that were served, 44.9% of the population. If consumers in the county hospitals were not included in the data set above, 53,024 adult ethnic minorities with SMI were served in the first three quarters of FY 2012 or 46.4% served. In FY 2011, there were 53,663 adult SMI ethnic minority consumers served, or 46.6%. There were 51,203 adult SMI consumers served, or 45.60%, who were ethnic minorities in FY 2010.

The SMHA is able to determine treated prevalence within the publicly funded mental health system through its management information system. The USTF database is a de-identified client registry for individuals seen in state and county psychiatric hospitals, short term care facilities and publicly-funded mental health programs in community mental health agencies. A USTF form is completed for every consumer upon admission, discharge and transfer from a public mental health service provider. The USTF was revised, effective July 1989, to be 100 percent

consistent with the MHSIP minimum data set. The USTF provides the state with information regarding treated prevalence within the public mental health system.

As has been done in previous years, the SMHA defines SMI as those individuals who score 5 or less on the Global Level of Functioning (GLOF) scale (Carter and Newman (1976). The GLOF scale has 10 levels that provide an overall score integrating separate judgments of consumer functioning on four dimensions: personal self-care; social and interpersonal functioning; vocational and/or educational productivity; and emotional stability and stress tolerance. As noted in previous years, the SMHA's use of this measure to determine the proportion of persons with SMI served might slightly under-represent the numbers served as operationally defined by the Federal methodology, however in order to maintain consistency with previous years' results, this definition of SMI is still in use.

The Division of Children's System of Care (DCSOC)

A summary of the DCSOC strengths, as well as unmet service needs and gaps within the current system of care, is based on the following sources of information:

- DCSOC "10 Years of System of Care Implementation: *Letting the Data Tell the Story*", NJ Department of Children and Families, 2011.
- DCSOC Child and Youth Behavioral Electronic Record (CYBER) Data Collection and Reports SFY 2010-2011.
- DCSOC Internal Data Collection and Reports SYF 2010-2011.
- DCSOC Youth Services Survey for Families, NJ DCF, November 2010.
- Independent Assessment of New Jersey's Children's Behavioral Health Care System, *Louis de la Parte*, Florida Mental Health Institute, October 2006.
- DCBHS Strategic Plan, 2007, NJ Department of Children and Families, September 2006.
- Traumatic Loss Coalitions for Youth Program Report 2008-10, University Behavioral Health Care Program, Behavioral Research and Training Institute, May 2010.
- New Jersey Kids Count 2011 – The State of Our Children, Advocates for Children of New Jersey, March 2011.
- The New Jersey Violent Death Reporting System (NJVDRS), Center for Health Statistics and the Violence Institute of New Jersey at the University of Medicine and Dentistry of New Jersey.
- New Jersey Student Health Survey, NJ Department of Education, January 2010.

- County Inter-Agency Coordinating Council (CIACC) Annual Needs Assessment, NJ Department of Children and Families, SFY 2009 and. SFY 2010.

DCSOC is in the process of developing a new Strategic Plan. The following unmet needs and critical gaps in service delivery are among the key issues that will be addressed within that plan:

Access to Services - The need for child and youth behavioral health care services exceeds capacity. According to figures released by the US Census Bureau, the 2010 child population in New Jersey was 2,065,214. Between 7% and 9% of children and youth in the United States meet the criteria for serious emotional disturbance (SED) indicating the presence of a psychiatric disorder that seriously interferes with functioning at home, in school and/or in the community. This translates to an estimated 165,217 children and youth with SED in New Jersey. During SFY 2011, the number of active enrollees in the DCSOC System of Care was 40,000. Of this number, 27,500 met the criteria for SED.

Community-based, and In State Out of Home Treatment Services for Children, Youth and Young Adults with Specialty Needs - The availability of community based services and supports and in-state, out-of-home treatment options for youth who are deaf or hard of hearing, youth with co-occurring mental illness and developmental disabilities (especially those individuals who function in the lower ranges of developmental disability), youth with chronic medical issues (for example, diabetes), and services for pregnant and parenting teens continues to be a challenge.

In SFY 2010, DCSOC developed 12 in-state beds for children, youth and young adults with MI/DD; 18 in-state beds for pregnant and parenting teens; and a six bed group home for male youth with diabetes. In SFY 2011, DCSOC developed six additional beds for pregnant and parenting teens and an additional ten beds for youth with MI/DD.

DCSOC will continue to fund the position of Team Leader, MI/DD to serve as the DCSOC Liaison to the Division of Developmental Disabilities (DDD) and assist in resolving issues regarding service provision and treatment for youth receiving services from DCSOC and DDD and their families. Additionally, DCSOC will continue to fund the comprehensive DD/MI training curriculum and technical assistance program in coordination with University Behavioral Health Care that provides that assists DCSOC, system partners, DDD, community providers, and other stakeholders in working effectively with the dually diagnosed population.

In SFY 2012, DCSOC will continue to decrease the number of children, youth, and young adults receiving treatment for specialized needs out-of-state. At the close of SFY 2011 on June 30, 2011, nine youth continued to receive services in an out-of-state treatment setting. Five youth require treatment services for deaf/hard of hearing; two youth require services from the DDD; and two youth await child welfare permanency plans.

Youth and Young Adult Suicide - In SFY 2010, suicide remained the 4th leading cause of death in New Jersey among individuals age 24 years and younger (NJVDRS). New Jersey's lead state agency for youth suicide prevention is the DCF. In response to a gradual but steady increase in the incidence of suicide among the youth and young adult population in New Jersey, the following strategies have been implemented by DCF/DCSOC:

- In March 2011, DCF released the New Jersey Youth Suicide Prevention Plan 2011-2014. This New Jersey Youth Suicide Prevention Plan seeks to build on the existing efforts in New Jersey by remaining focused on the risk and protective factors associated with the prevention of suicide in children, youth, and young adults. The plan outlines goals, rationale, and objectives for increasing the prevention effort throughout the state. The plan presents the overall goals for the prevention of suicide and is broken down into ten sections and within each section are specific objectives. The plan was modeled in content and in form after the 2001 National Strategy for Suicide Prevention and the joint Suicide Prevention Resource Center and SPAN USA 2010 Progress Review of the National Strategy.

  New Jersey's Youth Suicide Prevention Plan Goals

  1. Improve and expand surveillance systems;
  2. Promote awareness that suicide is a preventable public health problem;
  3. Develop broad-based support for youth suicide prevention;
  4. Develop and implement strategies to reduce the stigma associated with needing and receiving mental health, substance abuse, and suicide prevention services;
  5. Strengthen and expand community-based suicide prevention and postvention programs;
  6. Implement professional training programs for those who are in regular contact with youth at-risk for self-injury or suicide;
  7. Develop and promote effective clinical practices to reduce suicide attempts and completions;
  8. Promote access to mental health and substance abuse services;
  9. Improve reporting and portrayals of suicide, mental illness, and substance use in the electronic and print media; and
  10. Promote and support research on youth suicide and suicide prevention, its dissemination and incorporation into clinical practice and public health efforts.

- $2^{NDFLOOR}$ was accredited as New Jersey's first statewide suicide hotline by the American Association of Suicidology.

- In February 2011, DCSOC supported the Traumatic Loss Coalition (TLC) for Youth Program in applying for the Garrett Lee Smith Suicide Prevention and Early Intervention Grant. At the time of writing this application the grant awardees had not yet been announced.

- DCF will continue to fund the New Jersey Youth Suicide Prevention Advisory Council (NJYSPAC), which was formed under legislation signed into law in January 2004. The 17 members of the Council meet monthly to examine existing needs and services and make recommendations to DCF for youth suicide reporting, prevention and intervention. The Council also advises DCF on the content of informational materials to be made available to persons who report attempted or completed suicides. DCSOC will work closely with the NJYSPAC to identify ways in which New Jersey can continue to improve our efforts to prevent youth suicides and implement the needed changes as outlined in the State Plan.

Improve Access to Outpatient Services for Children, Youth and Young Adults - Historically, capacity in outpatient treatment programs for children, youth and young adults has been limited. In SFY 2011, DCSOC began an initiative to improve access to outpatient services for children, youth and young adults and their families. DCSOC invested $250,000 in community development funding through the CMOs/UCMs to provide start up and expansion funding for Outpatient centers. This funding will continue in SFY 2012. Since January 2011, 16 newly opened outpatient sites have been licensed.

In addition to increasing resources, increasing awareness of these resources is also critical for DCSOC to develop a more proactive and preventative system of care. Where parents, caregivers, school personnel, and pediatricians are more aware of available resources and how to make referrals earlier, the need for more restrictive services such as hospitalization and out-of-home treatment should continue to decrease.

Communication - The leadership of DCSOC recognizes the importance of good communication. DCSOC's goal is to provide good communication through our actions and facilitate opportunities for good communication amongst system partners. The following are key specific actions that DCSOC will take to meet this strategic priority:

- Engage youth as recommended in the Youth Development Council's Guiding Document.
- Pilot a statewide system partner meeting.
- DCSOC leadership will attend the statewide CIACC meetings regularly as well as attending county CIACC meetings whenever possible.
- DCSOC will increase the sharing of data. Specifically, DCSOC will publish data about the system of care on a quarterly basis on the DCF website.
- Families and other stakeholders often are not aware of services that already exist. DCSOC needs to find ways to better communicate statewide about the services that exist.

Continued Assessment of Unified Care Management (UCM) Pilot - The pilot of UCM in Essex, Mercer, and Monmouth counties has demonstrated the following positive outcomes: families do not have to change agencies or care managers when changing levels of care; youth outcomes are positive; there is no longer a cap on the number of youth that can receive care management; siblings at different levels of care can be served within the same agency; UCM has shown to be fiscally advantageous; peer support for families has been extended to families of moderate need level youth; and, fidelity to the Wraparound model of care has been maintained. Additional assessment is needed to determine the feasibility of implementing the UCM model statewide.

Single Individual Service Plan (ISP) and Joint Care Review (JCR) - The current ISP and JCR documents are inadequate to meet the requirements of the standards set forth by the DCF Office of Licensing. In addition, the concept of "one youth, one plan" has been very difficult when a youth is receiving services in an out-of-home treatment setting and receiving CMO/UCM or YCM services. In SFY 2011, a cross-system service provider user group came together and developed specific recommendations to DCSOC for to address these issues. DCSOC has begun working with PerformCare to make the changes; however, the process is complicated and

presents technical challenges. Nevertheless, DCSOC anticipates that the new ISP/JCR format and associated processing procedures will be in place in late 2011.

Collaboratively Work with Medicaid to Implement the Comprehensive Medicaid Waiver - The Comprehensive Medicaid Waiver project that is currently underway will impact child behavioral health services. At the same time that significant changes are expected, the changes present many great opportunities to better coordinate behavioral health care for the children, youth and young adults of New Jersey as well as integrate medical and behavioral health care in a more meaningful way. DCSOC expects that these changes will begin to be implemented in SFY 2012.

Improve Collaboration with Other State Departments and Divisions - Collaboration with other divisions and departments and improved protocols and services for particular populations such as transitioning young adults, youth with Autism or developmental disabilities, youth with hearing impairments, and youth with visual impairments is a priority for DCSOC. There is no simple answer to better collaboration. Collaboration takes work and time. DCSOC will invest the time necessary to make more significant in-roads in improving collaboration with other state divisions and departments.

Over the next year, DCSOC will be working closely with the DHS to better integrate addiction services and services for developmentally disabled youth with behavioral health services. DCSOC has also begun an initiative to identify better services for the deaf and hearing impaired youth that access the behavioral health system of care.

In addition to working with other Departments, DCSOC seeks to continue to make improvements in collaborating with DCP&P, the child welfare agency. For children, youth and young adults simultaneously receiving services from DCP&P and DCSOC, delineation and clarification of each Division's roles and responsibilities is needed. DCSOC will continue to strive to be responsive to the unique needs of DCP&P, in particular in partnering to develop successful community plans and facilitating admissions to out-of-home treatment settings as efficiently as possible.

Evidence-Based Interventions in the System of Care - Over the last few years DCSOC has taken several steps to infuse evidence-based practices into the state's system of care. Functional Family Therapy (FFT) and Multi-Systemic Therapy (MST) programs are now being funded in key areas of the state. In addition, DCSOC provided funding through the county CIACC's to provide training on locally determined evidence-based interventions. These efforts need to continue and DCSOC will lead the way in brining more evidence-based approaches into the system of care.

II: Planning Steps

Table 1 Step 3,4: -Priority Area and Annual Performance Indicators

Priority #: 1

Priority Area: Pregnant Women/Women with Children

Priority Type: SAT

Population (s): PWWDC

Goal of the priority area:

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

Strategies to attain the goal:

• Quarterly Women's Steering Committee meetings with women's treatment providers to discuss issues related to best practices including retention, engagement, access and referrals, systems collaboration, and training needs.
• Continuing contract with the community-based provider in Mercer County for the outstation of substance abuse counselors in four Health Care Centers that provide substance abuse screenings using the 4 P's Plus, assessment, case management and referrals to treatment for pregnant women.
• Implemented service elements from the National Association of State Alcohol/Drug Abuse Directors (NASADAD) "Guidance to States: Treatment Standards for Women with Substance Use Disorders" that emphasize best practice and modified women's treatment provider contracts to include language from the document that addresses the full continuum of treatment services.
• Require programs to provide: Family-Centered Treatment, Evidence-Based Parenting programs, Trauma-Informed and Trauma-Responsive treatment using "Seeking Safety, Strengthening Families and complete 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."
• During 2014, DMHAS will be integrating the CHOICES program, an evidence based intervention designed for women about choosing healthy behaviors to avoid alcohol –exposed pregnancies for use in by licensed substance abuse treatment providers serving pregnant and parenting women.
• Awarded In-Depth Technical Assistance (IDTA) from 2008 through 2012 from NCSACW. New Jersey received a customized program of IDTA designed to identify and implement key policy and practice changes based on New Jersey's readiness to change and progression through the phases of IDTA. New Jersey is in discussion with the IDTA team on continuing to build on the foundation established in the prior NCSACW IDTA project by working collaboratively with a NCSACW consultant(s) in a targeted effort to strengthen identification and system response to

substance exposed infants (SEI), including those presenting with Neonatal Abstinence Syndrome (NAS) from maternal opioid use.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Increase number of pregnant women or women with children receiving substance abuse treatment
Baseline Measurement:	9816 estimated for FY 2013
First-year target/outcome measurement:	Increase number of pregnant women or women with children receiving substance abuse treatment in 2014 by 2%.
Second-year target/outcome measurement:	Increase number of pregnant women or women with children receiving substance abuse treatment by 5% by the end of 2015. The change in FY 2015 will be measured by calculating the percent difference from 2013 to 2015.

Data Source:

The number pregnant women and women with children in SFY 2014– 2015 (and beyond) 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 #: 2

Priority Area: Intravenous Drug Users

Priority Type: SAT

Population (s): IVDUs

Goal of the priority area:

To expand access to comprehensive treatment, including Medication Assisted Treatment (MAT), in combination with other treatment modalities, for opiate dependent individuals, including IVDUs, through mobile treatment units and other innovative approaches.

Strategies to attain the goal:

• Referral to specialty treatment from sterile syringe programs operating in New Jersey.
• Providing services in convenient locations, particularly the mobile medication vans, in order to reduce barriers and engage individuals in care as easily as possible.
• Promoting the use of medication assisted treatment (e.g., methadone, buprenorphine, Vivitrol) for opiate dependent individuals.
• Educating providers and clients about the benefits of MAT.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Increase the number of IVDUs who obtain MAT in combination with other treatment modalities
Baseline Measurement:	10,081 estimate for FY 2013
First-year target/outcome measurement:	Increase the number of IVDUs who obtain MAT in combination with other treatment modalities by 2%.
Second-year target/outcome measurement:	Increase the number of IVDUs who obtain MAT in combination with other treatment modalities by 5% by the end of 2015. The change in FY 2015 will be measured by calculating the percent difference from 2013 to 2015.

Data Source:

The number of IVDUs in SFY 2014 and 2015 will be tracked by the SSA's 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 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 opiate dependent individuals who obtain MAT in combination with other treatment modalities
Baseline Measurement:	17,798 estimate for FY 2013
First-year target/outcome measurement:	Increase the number of opiate dependent individuals who obtain MAT in combination with other treatment modalities by 2%.
Second-year target/outcome measurement:	Increase number of opiate dependent individuals who obtain MAT in combination with other treatment modalities by 5% by the end of 2015. The change in FY 2015 will be measured by calculating the percent difference from 2013 to 2015.

Data Source:

The number opiate dependent individuals in SFY 2014 and 2015 will be tracked by the SSA's 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 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:	Individuals with or at risk of HIV/AIDS who are in treatment for substance abuse
Priority Type:	SAT

Population (s): HIV EIS

Goal of the priority area:

To provide funding and increase capacity for the provision of HIV Early Intervention Services (EIS) at designated substance abuse treatment facilities.

Strategies to attain the goal:

• Expend 5% of the SAPTBG award for HIV Early Intervention Services.
• Continue MOA with the University of Medicine and Dentistry of New Jersey (UMDNJ) for Rapid HIV Testing.
• Provide funding to the DOH Public Health and Environmental laboratory (PHEL) for laboratory services.
• Conduct web-based survey of agencies to assess where HIV testing services are most needed and their interest in providing such services.
• Coordinate and provide trainings/conferences in regards to the provision of best practices in HIV testing and counseling services for DMHAS licensed agencies (e.g., motivational interviewing).
• Develop data sharing agreement with the Department of Health (DOH).
• Provide de-identified data to DOH to match against their HIV/AIDS database to determine the number of infected or at risk clients in substance abuse treatment.

Annual Performance Indicators to measure goal success

Indicator #:	3
Indicator:	Increase the number of agencies engaged in the Rapid HIV Testing Initiative in 2015
Baseline Measurement:	24 sites
First-year target/outcome measurement:	30 sites
Second-year target/outcome measurement:	34 sites

Data Source:

DOH HIV database, NJSAMS and UMDNJ agency listing

Description of Data:

Data on the number of SSA licensed agencies engaged in the Rapid HIV Testing initiative is provided by UMDNJ. The change in FY 2015 will be measured by calculating the percent difference from FY 2013 to FY 2015.

Data issues/caveats that affect outcome measures::

None

Priority #: 4

Priority Area: Supportive Housing

Priority Type: MHS

Population (s): SMI

Goal of the priority area:

Increase opportunities for community living among mental health consumers who currently reside in inpatient settings and for those consumers who are at-risk of being hospitalized and/or homeless.

Strategies to attain the goal:

The SMHA will announce additional RFPs for Supportive Housing Programs which are designed to develop and support community-based programs that promote: housing stability in community settings, engagement with mental health services, regular access to primary health services; community inclusion, and wellness & recovery.

Contracted providers of Supportive Housing will continue to supply the SMHA with data to ensure that desired service levels are achieved. SMHA staff will monitor the continued development of new Supportive Housing opportunities. Workforce development activities will expand the reach and efficacy of community-based services for consumers receiving Supportive Housing. Improvements in the SMHA's data infrastructure—particularly around supportive housing and residential services, 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).

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Increased number of individuals served by Supportive Housing
Baseline Measurement:	The number of consumers served by Supportive Housing in SFY 2013 is estimated to be approximately 4,792 (see footnote 1).
First-year target/outcome measurement:	The number of consumers served by Supportive Housing in SFY 2014 is estimated to be 4,900.
Second-year target/outcome	In SFY 2015 this number will be increased 2% to a total of 5,000 individuals served by

measurement:	Supportive Housing.

Data Source:

The number of consumers served by Supportive Housing in SFY 2014 – 2015 (and beyond) will be tracked by the SMHA's QCMR database.

Description of Data:

The QCMR Database collects quarterly, cumulative, program-specific data from each of the service providers contracted by DMHS. The current QCMR for Supportive Housing contains 50 data elements. The key data field relevant for this performance indicator is Item 4, "Ending Active Caseload (Last Day of Quarter)". Currently 46 agencies contracted by the SMHA provide QCMR data for Supportive Housing.

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 Supportive Housing will be monitored through contract negotiations and data will be maintained through the QCMR database.

Failure to reach the performance indicator may result in review of agency admission and discharge policies to ensure that the target population receives this service and to ensure that consumers are not discharged prematurely nor unreasonably. Failure to reach performance indicators may also result in contract contingencies or termination

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Indicator #:	2
Indicator:	Creation of additional community-based supportive housing beds
Baseline Measurement:	At the time of writing, 292 supportive housing beds were created in SFY 2013.
First-year target/outcome measurement:	In SFY 2014, the SMHA will develop no fewer than 250 community-based supportive housing beds.
Second-year target/outcome measurement:	Due to the exigencies of the court-mandated Olmstead Settlement that expires at the end of SFY 2014, the SMHA is not currently able to indicate the number of community-based supportive housing beds that will be created in SFY 2015.

Data Source:

The SMHA, in collaboration with the DHS Office of Licensing will continue to provide updates on the development of community-based supportive housing beds. Specifically, internal SMHA contracting data will be used for the baseline

measurement and for the first-year target outcomes. In the second year, this data will be buttressed by the SMHA's forthcoming Bed Enrollment Data System (BEDS) which is expected to be operational by early SFY 2014.

Description of Data:

Current internal SMHA contracting data indicates the state contracting awards to agencies whom create Supportive Housing Beds. Key data indicates the date and amount of the grant award, as well as the date that the housing unit was available to consumers (e.g., "came online").

Data issues/caveats that affect outcome measures::

These new housing opportunities will be specifically earmarked for: 1. those at risk for homelessness and/or inpatient psychiatric hospitalization, and 2. individuals on CEPP status (e.g. individuals who are medically and clinically permitted to be discharged from state/county inpatient psychiatric hospitals but whom are unable to be discharged due to a lack of permanent housing options). The total number of beds to be developed from SFY 2010 through SFY 2014 is targeted to be 1065 in accordance with the Olmstead Settlement Agreement.

Indicator #:	3
Indicator:	Increased technical assistance activities to be delivered to providers of Supportive Housing (SH). Overview- the SMHA is currently in negotiation with the University Behavioral Health Care (UBHC) School of Health-Related Professions (SHRP) to provide technical assistance for SH providers to facilitate better community integration of consumers of SH services. In SFY 2014, the SMHA will contract with SHRP to provide two separate tracks of Technical Assistance for SH providers. Track 1 is for SH supervisors, where they will receive TA on how to supervise their staff in their efforts to have SH consumers better integrated into their communities. Track 2 will be geared toward direct care providers and is to provide training in core competencies. Both tracks of TA will be conducted in a series of trainings to be conducted over the course of a year. In addition, the TA will attempt to facilitate training communities (peer networks of SH supervisors and direct care staff) in order to refine, deepen and expand the understanding of the concepts taught in the TA sessions themselves.
Baseline Measurement:	Not relevant. The Technical Assistance to Supportive Housing Programs will be a new initiative with no antecedents.
First-year target/outcome measurement:	To be determined. The SMHA plans to contract SHRP to provide TA to a specific number of either agencies, or personnel. (The exact number has yet to be determined through vendor contract negotiations).

Second-year target/outcome measurement: To be determined (See above).

Data Source:

The exact number of agencies (or personnel) trained by this TA effort will be reported to the SMHA by the training provider (UBHC-SHRP).

Description of Data:

The SMHA anticipates that the TA provider will submit quarterly training reports to the SMHA on a range of outcome indictors such as: number (and dates) of training, the number of agencies that have received the TA, number of personnel participating in training, and number of activities conducted by the TA training communities.

Data issues/caveats that affect outcome measures::

The manner at which the outcome measures are to be established, quantified and reported on have yet to be determined (contingent on direct negotiations between the SMHA and UBHC-SHRP to occur in mid-May 2013).

Priority #: 5

Priority Area: Suicide Prevention Hotline

Priority Type: MHP

Population (s): SMI

Goal of the priority area:

To reduce suicides among New Jersey's residents through the expansion and increased availability of a suicide prevention hotline designed to support New Jersey's residents experiencing mental health crises.

Strategies to attain the goal:

DMHAS issued an RFP for a Suicide Prevention Hotline on 12/13/12. In early 2013, this RFP was awarded to the University Behavioral Healthcare (UBHC) for the development of a NJ-based suicide hotline to be answered by a trained staff member or volunteer and to accept calls that are routed by the National Suicide Prevention Lifeline Network (NSPLN). The phone number was launched on o May 1, 2013 and is 855—NJHOPELINE (855-654-6735).

This "Hopeline" serves as suicide prevention hotline, similar to the NSPLN, but located in New Jersey, with 27/7 coverage, and it will have clinical

supervisors whom are familiar with the constellation of New Jersey behavioral health resources. In addition, the Hope Line will be a backup to the current active Lifeline Crisis Centers hotline and it will receive and answer calls that are transferred by Lifeline that cannot be answered by these entities during times of excess call volume or after the Lifeline Crisis Centers' operating hours. To better describe this in sequential terms, the NSPLN is the 'first line of defense'--the default for handling suicide-related phone calls from the community. The NJ Hopeline will receive additional calls which 'overflow" from NSPLN. In the event that additional call volume necessitates 'overflow' that cannot be expedited by the NJ Hopeline, then out-of-state Lifeline backup crisis centers will handle any remaining calls.

One of the reasons that the NJ Hopeline was created was to avoid the need for a third entity, (and one located outside of New Jersey) to handle excess suicide prevention calls.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Reduce the number of suicide prevention hotline calls originating within New Jersey that are answered by parties outside of New Jersey
Baseline Measurement:	Due to the start of the newly-operational NJ Hopeline, no baseline/SFY 2013 data will be available.
First-year target/outcome measurement:	The target/outcome measurement for SFY 2014 is for the newly-created, DMHAS-funded, "NJ Hopeline" suicide prevention hotline to answer 85% of the calls originating in New Jersey transferred by the National Suicide Prevention Lifeline Network (NSPLN) which can't be answered by the current active New Jersey Lifeline Crisis Centers (either due to excess call volume or after the Lifeline Crisis Centers' operating hours (see footnote 2)). NJ Hopeline is contracted to provide 25,194 calls for the year.
Second-year target/outcome measurement:	In year two of the grant award (SFY 2015) this benchmark will be increased to 90%.

Data Source:

In October 2013, the SMHA will receive the first call record dataset from NSPLN for the first quarter of SFY 2014. Every quarter subsequent to that, the SMHA will review the additional datasets provided by NSPLN. In addition, the SMHA will attempt to collect analogous call data from the NJ Hopeline.

Description of Data:

The National Suicide Prevention Lifeline Network maintains data that tracks all calls from their point of origin to the point of where they are ultimately answered. DMHAS will receive this data on a regular basis, and that dataset will form the basis for measuring this performance indicator. The SMHA is looking forward to receiving both raw and summary call data from both NSPLN and NJ Hopeline on a quarterly basis. It is anticipated that both datasets will include: dates of calls, lengths of calls, call

source data, dispositions, and frequencies of all diversion.

Data issues/caveats that affect outcome measures::

In the summer of 2013, DMHAS will begin reviewing NSPLN call record data to learn about the format and quality of the data. The New Jersey Hopeline began operations on May 1, 2013 so the SMHA anticipates the standard operational and data reporting challenges endemic to new institutions. The SMHA is prepared to make best use of whatever data is submitted by both sources.

Priority #: 6

Priority Area: Consumer Operated Services

Priority Type: MHS

Population (s): SMI

Goal of the priority area:

To promote wellness and recovery among individuals attending DMHAS sponsored peer-operated self-help centers (SHCs) throughout New Jersey.

Strategies to attain the goal:

Provide a wide range of peer delivered wellness and recovery activities at DMHAS sponsored self-help centers statewide. Encourage participation by publicizing planned activities in monthly activity calendars, discussing at center community meetings, networking with DMHAS self-help centers, and marketing self-help services with other community service providers.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase consumer participation in wellness and recovery activities.

Baseline Measurement: Not available. The SMHA has not recently performed comparable studies of these performance indicators.

First-year target/outcome measurement: In SFY 2014, 80% of individuals participating in Consumer Operated Services will participate in wellness/recovery activities (i.e. developing Wellness and Recovery Action Plans, which may include enrollment in groups such as Exercise Groups, Anxiety Support Groups, etc.).

Second-year target/outcome measurement: In SFY 2015, 83% of individuals participating in Consumer Operated Services will participate in wellness/recovery activities

Data Source:

This performance indicator will be measured through use of the Self-Help Outcome Utilization Tracking (SHOUT) data application. SHOUT is used by 30 DMHAS-funded and community-based, self-help centers to track member participation at SHCs through a unified, individual record system specifically designed for self-help centers.

Description of Data:

Reports are generated on a monthly and quarterly basis to assess performance against contract indicators. To meet the performance measurement objectives, self-help center staff will input and monitor self-help center member participation in wellness and recovery activities statewide through the use of SHOUT™. Electronic surveys will be administered annually with self-help center members and in combination with SHOUT utilization data which will be used to assess performance against the stated indicator.

Data issues/caveats that affect outcome measures::

Differential submission of SHOUT data by the SHCs may impact the timing of quarterly reports. Due to the independent nature of the Self-Help Centers themselves, the completeness and comprehensiveness of SHOUT data is expected to vary considerably from center to center.

Priority #: 7

Priority Area: Access to community-based services for children, youth and young adults with a dual diagnosis of DD/ID and behavioral health

Priority Type: MHS

Population (s): SED

Goal of the priority area:

Increase access to community-based services for children, youth and young adults with a dual diagnosis of DD/ID and behavioral health challenges.

Strategies to attain the goal:

DCSOC will continue to expand its community-based services throughout the State of New Jersey in SFY 2014 and 2015 in order to increase the

total number of children, youth and young adults and the number of children, youth, and young adults with SED provided services through DCSOC. Community based services include both in-home and out of home services.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: In SFY 2014, DCSOC will develop a baseline of the number of children, youth and young adults with DD/ID and behavioral health challenges served.

Baseline Measurement: The total number of children, youth and young adults enrolled by DCSOC during SFY 2012 was 35,859. The number of children, youth and young adults with SED receiving DCSOC services during SFY 2012 was 27,028. The transition of services for children, youth and young adults with developmental disabilities and/or intellectual disabilities and behavioral health challenges to the DCF began on January 1, 2013.

First-year target/outcome measurement: 5% increase in 2013 baseline of children, youth and young adults with DD/ID and behavioral challenges.

Second-year target/outcome measurement: 5% increase in 2014 number of children, youth and young adults served by DCSOC.

Data Source:

DCSOC will utilize the CYBER database to collect enrollment data.

Description of Data:

The total number of children, youth and young adults enrolled by DCSOC as well as the number of children, youth and young adults with SED served during SFY 2013 will be reported in the SFY 2013 Implementation Report. Additionally DCSOC will provide a 6-month baseline measurement of children, youth and young adults with DD/ID and behavioral health challenges.

Data issues/caveats that affect outcome measures::

Access to community-based services for children, youth and young adults with a dual diagnosis of substance abuse and behavioral health will be transitioned to DCSOC beginning July 1, 2013. At the close of SFY 2014 DCSOC will provide a baseline of the number of children, youth and young adults with substance abuse and behavioral health challenges served. The addition of this population to DCSOC services will impact the total number of children, youth and young adults served.

Priority #: 8

Priority Area: Provision of in-state, community-based specialty treatment services to children, youth and young adults with specialized treatment needs.

Priority Type: MHS

Population (s): SED

Goal of the priority area:

Provide in-state services to children, youth and young adults with specialized treatment needs.

Strategies to attain the goal:

Continue to identify gaps in service for children, youth and young adults with specialized treatment needs. Develop in-state services and supports to address the needs of children, youth and young adults with specialized treatment needs including, but not limited to: deaf/hard of hearing, mental illness/developmental disabilities and/or medical challenges.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: In SFY 2014, DCSOC will continue to decrease the number of children, youth, and young adults receiving treatment for specialized needs out of state.

Baseline Measurement: At the close of SFY 2012, four youth requiring services for deaf/heard of hearing continued to receive services in an out of state treatment setting.

First-year target/outcome measurement: SFY 2014 will use the same database to measure a specified percentage of change.

Second-year target/outcome measurement: SFY 2015 will use the same database to measure a specified percentage of change.

Data Source:

DCSOC will utilize reports generated by the CYBER database and the DCSOC Special Residential Treatment Unit (SRTU), which facilitates all referrals to out of state treatment settings.

Description of Data:

CYBER and SRTU reports will identify gaps in services and the array of services needed to develop in-state capacity.

Data issues/caveats that affect outcome measures::

DCSOC anticipates the transition of new populations (DD/ID and youth with substance abuse challenges) to increase the number of children, youth and young adults requiring specialized treatment services.

Priority #: 9

Priority Area: Youth Suicide

Priority Type: MHP

Population (s): SED

Goal of the priority area:

Decrease youth suicide attempts and completions.

Strategies to attain the goal:

The Traumatic Loss Coalition (TLC) for Youth Program at UBHC provides Suicide Awareness Training for Educators to fulfill the professional development requirement, in accordance with N.J.S.A. 18A:6-11. A team of clinicians experienced in the evaluation and treatment of children and adolescents with mental health disorders and suicidal behaviors provide this training. The content can be customized to meet the needs of a single school or an entire school district, as well as mental health and social agency staff. On-site school counselors or administrators are included in the presentation to talk about the specific protocols outlined in their school's crisis plan for referring at-risk youth for further evaluation and treatment.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: DCSOC/TLC will continue to increase the number of school personnel trained in Suicide Awareness Training for Educators.

Baseline Measurement: The number of school personnel trained during SFY 2013 will serve as baseline.

First-year target/outcome measurement: SFY 2014 will use the same database to measure a specified percentage of change.

Second-year target/outcome measurement: SFY 2015 will use the same database to measure a specified percentage of change.

Data Source:

DCSOC will utilize reports generated by the Traumatic Loss Coalition (UMDNJ).

Description of Data:

The number of school personnel trained during given SFY.

Data issues/caveats that affect outcome measures::

None.

Footnotes:

1) The estimate of 4,792 consumers served by SH in SFY 2013 is based on QCMR data available in early May 2013—a point in time at which four SH providers had submitted one quarter of data, 118 providers had submitted two quarters of data, and 16 providers had submitted three quarters of data. These data submissions from 142 providers indicated that 4,564 consumers were served. Due to a relatively low program turnover rate, it is estimated that with complete data-- the total number of consumers served in SFY 2013 will be about 5% larger (4,792).

2) By way of background, in calendar year 2011, 78% of general Lifeline calls originating in New Jersey were answered by out-of-state Lifeline backup crisis centers.

Table 2 State Agency Planned Expenditures [SA]

Planning Period - From 07/01/2013 to 06/30/2015

Activity (See instructions for using Row 1.)	A. Substance Abuse Block Grant	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
1. Substance Abuse Prevention* and Treatment	$29,035,234		$	$3,029,994	$223,840,476	$	$
a. Pregnant Women and Women with Dependent Children*	$ 6,915,805		$	$	$	$	$
b. All Other	$ 22,119,429		$	$ 3,029,994	$ 223,840,47	$	$
2. Substance Abuse Primary Prevention	$ 11,751,879		$	$	$ 6,220,666	$	$
3. Tuberculosis Services	$		$	$	$	$	$
4. HIV Early Intervention Services	$ 2,205,662		$	$	$	$	$
5. State Hospital							
6. Other 24 Hour Care							
7. Ambulatory/Community Non -24 Hour Care							
8. Mental Health Primary Prevention							
9. Mental Health Evidenced-based Prevention and Treatment (5% of total award)							
10. Administration (Excluding Program and Provider Level)	$ 1,120,477		$	$	$ 3,069,088	$	$
11. Total	$44,113,252	$	$	$3,029,994	$233,130,230	$	$

* Prevention other than primary prevention

Footnotes:
Please note that column A - Substance Abuse Block Grant expenditures reflects funding for one year. Columns C through G reflect the funding for the planning period 7/1/13 to 6/30/15 as per the Block Grant application guidance.

III: Use of Block Grant Dollars for Block Grant Activities

Table 2 State Agency Planned Expenditures [MH]

Planning Period - From 07/01/2013 to 06/30/2015

Activity (See instructions for using Row 1.)	A. Substance Abuse Block Grant	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
1. Substance Abuse Prevention* and Treatment							
a. Pregnant Women and Women with Dependent Children*							
b. All Other							
2. Substance Abuse Primary Prevention							
3. Tuberculosis Services							
4. HIV Early Intervention Services							
5. State Hospital			$	$	$	$	$
6. Other 24 Hour Care		$ 730,915	$ 146,988,91	$	$ 105,762,83	$	$
7. Ambulatory/Community Non -24 Hour Care		$ 9,407,286	$ 85,821,338	$ 2,108,160	$ 381,565,47	$	$
8. Mental Health Primary Prevention		$	$	$	$	$	$
9. Mental Health Evidenced-based Prevention and Treatment (5% of total award)		$ 584,030	$	$	$	$	$
10. Administration (Excluding Program and Provider Level)		$ 958,360	$ 1,009,000	$ 121,075	$ 18,573,000	$	$
11. Total	$	$11,680,591	$233,819,250	$2,229,235	$505,901,313	$	$

* Prevention other than primary prevention

Footnotes:
The table represents planned expenditures for FY 2014.
For Adult Behavioral Health services herein, Medical Assistance resources supporting these programs are not shown because they are not appropriated to the SMHA.
For Child Behavioral Health services herein, Medical Assistance funding is directly appropriated to DCSOC, as such, expenditures above inclusive of those resources.

III: Use of Block Grant Dollars for Block Grant Activities

Table 3 State Agency Planned Block Grant Expenditures by Service

Planning Period - From 07/01/2013 to SFY 06/30/2015

Service	Unduplicated Individuals	Units	SABG Expenditures	MHBG Expenditures
Healthcare Home/Physical Health			$	$
Specialized Outpatient Medical Services			$	$
Acute Primary Care			$	$
General Health Screens, Tests and Immunizations			$	$
Comprehensive Care Management			$	$
Care coordination and Health Promotion			$	$
Comprehensive Transitional Care			$	$
Individual and Family Support			$	$
Referral to Community Services Dissemination			$	$
Prevention (Including Promotion)			$	$
Screening, Brief Intervention and Referral to Treatment			$	$

Brief Motivational Interviews			$	$
Screening and Brief Intervention for Tobacco Cessation			$	$
Parent Training			$	$
Facilitated Referrals			$	$
Relapse Prevention/Wellness Recovery Support			$	$
Warm Line			$	$
Substance Abuse (Primary Prevention)			$	$
Classroom and/or small group sessions (Education)			$	$
Media campaigns (Information Dissemination)			$	$
Systematic Planning/Coalition and Community Team Building(Community Based Process)			$	$
Parenting and family management (Education)			$	$
Education programs for youth groups (Education)			$	$
Community Service Activities (Alternatives)			$	$
Student Assistance Programs (Problem Identification and Referral)			$	$
Employee Assistance programs (Problem Identification and Referral)			$	$

Community Team Building (Community Based Process)			$	$
Promoting the establishment or review of alcohol, tobacco, and drug use policies (Environmental)			$	$
Engagement Services			$	$
Assessment			$	$
Specialized Evaluations (Psychological and Neurological)			$	$
Service Planning (including crisis planning)			$	$
Consumer/Family Education			$	$
Outreach			$	$
Outpatient Services			$	$
Evidenced-based Therapies			$	$
Group Therapy			$	$
Family Therapy			$	$
Multi-family Therapy			$	$
Consultation to Caregivers			$	$
Medication Services			$	$

Medication Management			$	$
Pharmacotherapy (including MAT)			$	$
Laboratory services			$	$
Community Support (Rehabilitative)			$	$
Parent/Caregiver Support			$	$
Skill Building (social, daily living, cognitive)			$	$
Case Management			$	$
Behavior Management			$	$
Supported Employment			$	$
Permanent Supported Housing			$	$
Recovery Housing			$	$
Therapeutic Mentoring			$	$
Traditional Healing Services			$	$
Recovery Supports			$	$
Peer Support			$	$
Recovery Support Coaching			$	$

Recovery Support Center Services			$	$
Supports for Self-directed Care			$	$
Other Supports (Habilitative)			$	$
Personal Care			$	$
Homemaker			$	$
Respite			$	$
Supported Education			$	$
Transportation			$	$
Assisted Living Services			$	$
Recreational Services			$	$
Trained Behavioral Health Interpreters			$	$
Interactive Communication Technology Devices			$	$
Intensive Support Services			$	$
Substance Abuse Intensive Outpatient (IOP)			$	$
Partial Hospital			$	$

Assertive Community Treatment			$	$
Intensive Home-based Services			$	$
Multi-systemic Therapy			$	$
Intensive Case Management			$	$
Out-of-Home Residential Services			$	$
Children's Mental Health Residential Services			$	$
Crisis Residential/Stabilization			$	$
Clinically Managed 24 Hour Care (SA)			$	$
Clinically Managed Medium Intensity Care (SA)			$	$
Adult Mental Health Residential			$	$
Youth Substance Abuse Residential Services			$	$
Therapeutic Foster Care			$	$
Acute Intensive Services			$	$
Mobile Crisis			$	$
Peer-based Crisis Services			$	$

Urgent Care			$	$
23-hour Observation Bed			$	$
Medically Monitored Intensive Inpatient (SA)			$	$
24/7 Crisis Hotline Services			$	$
Other (please list)			$	$

Footnotes:

DMHAS does not collect data in this manner.

III: Use of Block Grant Dollars for Block Grant Activities

Table 4 SABG Planned Expenditures

Planning Period - From 10/01/2013 to 09/30/2015

Expenditure Category	FY 2014 SA Block Grant Award	FY 2015 SA Block Grant Award
1 . Substance Abuse Prevention* and Treatment	$ 29,035,234	
2 . Substance Abuse Primary Prevention	$ 11,751,879	
3 . Tuberculosis Services	$ 0	
4 . HIV Early Intervention Services**	$ 2,205,662	
5 . Administration (SSA Level Only)	$ 1,120,477	
6. Total	$44,113,252	

* Prevention other than primary prevention

** HIV Early Intervention Services

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period - From 10/01/2013 to 09/30/2015

Strategy	IOM Target	FY 2014	FY 2015
		SA Block Grant Award	SA Block Grant Award
Information Dissemination	Universal	$ 242,605	
	Selective	$ 363,907	
	Indicated	$ 412,804	
	Unspecified	$	
	Total	$1,019,316	
Education	Universal	$ 985,273	
	Selective	$ 1,516,021	
	Indicated	$ 2,789,957	
	Unspecified	$	
	Total	$5,291,251	
Alternatives	Universal	$	
	Selective	$ 131,917	
	Indicated	$ 68,664	
	Unspecified	$	
	Total	$200,581	
Problem Identification and Referral	Universal	$	
	Selective	$ 76,817	
	Indicated	$ 306,963	
	Unspecified	$	

	Total	$383,780	
Community-Based Process	Universal	$ 121,302	
	Selective	$ 216,700	
	Indicated	$ 304,869	
	Unspecified	$	
	Total	$642,871	
Environmental	Universal	$ 4,214,080	
	Selective	$	
	Indicated	$	
	Unspecified	$	
	Total	$4,214,080	
Section 1926 Tobacco	Universal	$	
	Selective	$	
	Indicated	$	
	Unspecified	$	
	Total	$	
Other	Universal	$	
	Selective	$	
	Indicated	$	
	Unspecified	$	
	Total	$	
Total Prevention Expenditures		$11,751,879	
Total SABG Award*		$44,113,252	
Planned Primary Prevention Percentage		26.64 %	

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 5b SABG Primary Prevention Planned Expenditures

Planning Period - From 10/01/2013 to 09/30/2015

Activity	FY 2014 SA Block Grant Award	FY 2015 SA Block Grant Award
Universal Direct	$ 1,699,180	
Universal Indirect	$ 3,864,080	
Selective	$ 2,305,412	
Indicated	$ 3,883,207	
Column Total	$11,751,879	
Total SABG Award*	$44,113,252	
Planned Primary Prevention Percentage	26.64 %	

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 5c SABG Planned Primary Prevention Targeted Priorities

Targeted Substances	
Alcohol	þ
Tobacco	þ
Marijuana	þ
Prescription Drugs	þ
Cocaine	þ
Heroin	þ
Inhalants	þ
Methamphetamine	þ
Synthetic Drugs (i.e. Bath salts, Spice, K2)	þ
Targeted Populations	
Students in College	þ
Military Families	þ
LGBTQ	þ
American Indians/Alaska Natives	¢
African American	¢
Hispanic	¢
Homeless	¢
Native Hawaiian/Other Pacific Islanders	¢
Asian	¢
Rural	þ
Underserved Racial and Ethnic Minorities	þ

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 6a SABG Resource Development Activities Planned Expenditures

Planning Period - From 10/01/2013 to 09/30/2015

Activity	FY 2014 SA Block Grant Award				FY 2015 SA Block Grant Award			
	Prevention	Treatment	Combined	Total	Prevention	Treatment	Combined	Total
1. Planning, Coordination and Needs Assessment	$ 597,759	$ 1,426,277	$	$2,024,036				
2. Quality Assurance	$	$ 1,891,946	$	$1,891,946				
3. Training (Post-Employment)	$	$ 1,004,784	$	$1,004,784				
4. Education (Pre-Employment)	$	$	$	$				
5. Program Development	$	$	$	$				
6. Research and Evaluation	$ 498,791	$ 1,049,306	$	$1,548,097				
7. Information Systems	$ 96,008	$ 261,298	$	$357,306				
8. Enrollment and Provider Business Practices (3 percent of BG award)	$ 0	$ 1,323,398	$	$1,323,398				
9. Total	$1,192,558	$6,957,009	$	$8,149,567				

Footnotes:

Table 6b MHBG Non-Direct Service Activities Planned Expenditures

Planning Period - From 07/01/2013 to 06/30/2014

Service	Block Grant
MHA Technical Assistance Activities	$
MHA Planning Council Activities	$ 23,913
MHA Administration	$ 584,030
MHA Data Collection/Reporting	$
Enrollment and Provider Business Practices (3 percent of total award)	$ 350,418
MHA Activities Other Than Those Above	$
Total Non-Direct Services	$958361
Comments on Data:	

Footnotes:

IV: Narrative Plan

C. Coverage M/SUD Services

Narrative Question:

Beginning in 2014, Block Grant dollars should be used to pay for (1) people who are uninsured and (2) services that are not covered by insurance and Medicaid. Presumably, there will be similar concerns at the state-level that state dollars are being used for people and/or services not otherwise covered. States (or the Federal Marketplace) are currently making plans to implement the benchmark plan chosen for QHPs and their expanded Medicaid programs (if they choose to do so). States should begin to develop strategies that will monitor the implementation of the Affordable Care Act in their states. States should begin to identify whether people have better access to mental and substance use disorder services. In particular, states will need to determine if QHPs and Medicaid are offering mental health and substance abuse services and whether services are offered consistent with the provisions of MHPAEA.

Please answer the following questions:

1. Which services in Plan Table 3 of the application will be covered by Medicaid or by QHPs on January 1, 2014?
2. Do you have a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs and Medicaid?
3. Who in your state is responsible for monitoring access to M/SUD services by the QHPs? Briefly describe their monitoring process.
4. Will the SMHA and/or SSA be involved in reviewing any complaints or possible violations or MHPAEA?
5. What specific changes will the state make in consideration of the coverage offered in the state's EHB package?

Footnotes:

C. Coverage M/SUD Services

New Jersey's Comprehensive Medicaid Waiver application was approved by CMS in October 2012. The Comprehensive Waiver is a collection of reform initiatives designed to sustain the program long-term as a safety-net for eligible populations, rebalance resources to reflect the changing healthcare landscape, and prepare the state to implement provisions of the federal Affordable Care Act (ACA) in 2014.

The behavioral health components of the Waiver calls for the development and implementation of an innovative delivery system supported by a managed behavioral health organization (MBHO) to enhance and coordinate services to specialty populations, integrate behavioral health and primary care, support community alternatives to institutional placement, and braid federal and state funding to coordinate access to services across multiple payers with different eligibility requirements and covered benefits. The Waiver also provides an opportunity for rate balancing and a transition from cost reimbursement and slot funded contracting for state and block grant funded services to a uniform fee for service rate structure for all funding streams managed by the MBHO.

DMHAS is collaborating with the DMHAS (Medicaid) on the design and implementation of the MBHO. A significant aspect of this effort has been the development of an integrated service inventory across funding streams to support the seamless coordination of access to care across multiple payers with different eligibility requirements. Medicaid state plan services include hospital-based inpatient and ambulatory services, as well as independent clinic services, for mental health and substance use disorders. In addition, the Medicaid state plan includes targeted case management, assertive community treatment, and community support services (pending adoption of regulations), as well as methadone and the services of independent licensed psychiatrists and psychologists. Services covered by Medicaid and listed in Plan Table 3 include: engagement services, outpatient services, medication services, community support, out of home residential services, and acute intensive services.

In February 2013, Governor Christie announced New Jersey's intention to expand Medicaid coverage under the ACA. DMAHS, in consultation with DMHAS, is currently developing the mental health and substance use disorder benefit package to be available under the Alternative Benefit Plan to ensure adherence to Mental Health Parity and Addiction Equity Act (MHPAEA).

In the fall of 2012, DMHAS and DMAHS staff participated in a workgroup convened by the Office of the Governor to review the available benchmark plan options and provide recommendations to ensure coverage of the ten essential health benefit categories and adherence to parity in the designated benchmark plan. The Department of Banking and Insurance (DOBI) provided significant leadership to the workgroup, including technical assistance regarding the regulatory review and monitoring practices of DOBI to ensure compliance with MHPAEA. Each of the benchmark plan options had been determined to be in compliance with MHPAEA prior to the convening of this workgroup). The benchmark plan designated by the Governor's office (as well as the other benchmark plan options) includes inpatient and outpatient mental health and substance use disorder benefits. DMHAS and DMAHS provided information to the workgroup on the essential behavioral health benefit service elements as detailed in SAMHSA's

"Description of a Good and Modern Addictions and Mental Health System" paper. The group identified significant differences in the approach to service definitions and provider/practitioner requirements across the publicly-funded and commercially insured behavioral health systems which create particular challenges for ensuring continuity and consistency of services across state, Medicaid, and QHPs. DOBI has indicated an interest in continuing to work with DMHAS and DMAHS to address these challenges and work with the QHPs to educate them regarding the availability of community-based providers to participate in their plan networks.

The MBHO will provide a "single point of entry/no wrong door" approach intended to improve access to care for consumers eligible for state- and Medicaid-funded services. The MBHO will screen all consumers for eligibility for Medicaid, state-only, or QHP benefits. DMHAS and DMAHS will establish appropriate service, provider type, and geographical access standards for the MBHO provider network and will monitor adherence to these requirements through network capacity surveillance, consumer surveys, and review of service utilization volume, type, and recipient characteristics. Consumers will have access to grievance and appeals processes through the MBHO and through the state.

New Jersey has opted for a federally-operated health insurance exchange. Monitoring access to services through the QHPs available for New Jersey residents through this exchange will be the responsibility of DOBI as these plans will be under their regulatory oversight. DMHAS and DMAHS will continue to work with DOBI as described above to support the capacity of the QHPs to provide behavioral health services. At this time there is no specific plan for the SMHA/SSA to be involved in reviewing complaints or violations of MHPAEA.

DMAHS and DMAHS anticipate that, as subsidized affordable coverage for mental health and substance use disorder treatment services becomes available through the QHPs for eligible recipients, the state will be able to redirect resources that have historically supported these services for the under or uninsured elsewhere in the system. While the MBHO will be expected to screen consumers for eligibility for QHPs and provide consumer education to facilitate enrollment in QHPs, DMHAS anticipates that there will continue to be a need to provide "gap" coverage for consumers as they transition to the QHPs.

IV: Narrative Plan

D. Health Insurance Marketplaces

Narrative Question:

Health Insurance Marketplaces (Marketplaces) will be responsible for performing a variety of critical functions to ensure access to desperately needed behavioral health services. Outreach and education regarding enrollment in QHPs or expanded Medicaid will be critical. SMHAs and SSAs should understand their state's new eligibility determination and enrollment system, as well as how insurers (commercial, Medicaid, and Medicare plans) will be making decisions regarding their provider networks. States should consider developing benchmarks regarding the expected number of individuals in their publicly-funded behavioral health system that should be insured by the end of FY 2015. In addition, states should set similar benchmarks for the number of providers who will be participating in insurers' networks that are currently not billing third party insurance.

QHPs must maintain a network of providers that is sufficient in the number and types of providers, including providers that specialize in mental health and substance abuse, to assure that all services will be accessible without unreasonable delay. Mental health and substance abuse providers were specifically highlighted in the rule to encourage QHP issuers to provide sufficient access to a broad range of mental health and substance abuse services, particularly in low-income and underserved communities.

Please answer the following questions:

1. How will the state evaluate the impact that its outreach, eligibility determination, enrollment, and re-enrollment systems will have on eligible individuals with behavioral health conditions?

2. How will the state work with its partners to ensure that the Navigator program is responsive to the unique needs of individuals with behavioral health conditions and the challenges to getting and keeping the individuals enrolled?

3. How will the state ensure that providers are screening for eligibility, assisting with enrollment, and billing Medicaid, CHIP, QHPs, or other insurance prior to drawing down Block Grant dollars for individuals and/or services?

4. How will the state ensure that there is adequate community behavioral health provider participation in the networks of the QHPs, and how will the state assist its providers in enrolling in the networks?

5. Please provide an estimate of the number of individuals served under the MHBG and SABG who are uninsured in CY 2013. Please provide the assumptions and methodology used to develop the estimate.

6. Please provide an estimate of the number of individuals served under the MHBG and SABG who will remain uninsured in CY 2014 and CY 2015. Please provide the assumptions and methodology used to develop the estimate.

7. For the providers identified in Table 8 -Statewide Entity Inventory of the FY 2013 MHBG and SABG Reporting Section, please provide an estimate of the number of these providers that are currently enrolled in your state's Medicaid program. Please provide the assumptions and methodology used to develop the estimate.

8. Please provide an estimate of the number of providers estimated in Question 7 that will be enrolled in Medicaid or participating in a QHP. Provide this estimate for FY 2014 and a separate estimate for FY 2015, including the assumptions and methodology used to develop the estimate.

Footnotes:

D. Health Insurance Marketplaces

1. How will the state evaluate the impact that its outreach, eligibility determination, enrollment, and re-enrollment systems will have on eligible individuals with behavioral health conditions?

   The MBHO will function as a "no wrong door/single point of entry" to screen consumers for potential eligibility for QHP, Medicaid, or state-only funded behavioral health services. All federally and state funded behavioral health services will be authorized by the MBHO using a payer of first-last resort logic and a coordination of benefits across payers that ensures Medicaid and third-party coverage is utilized before block grant or state dollars are drawn down. Because it is anticipated that consumers may not be enrolled in plans at the time that they present for services, DMHAS will establish policies for "gap" coverage prior to QHP or Medicaid enrollment. DMHAS and DMAHS will collaborate to monitor the number of expansion-eligible consumers who enroll in Medicaid and the number of this group that access services through the MBHO, as well as the number of expansion-eligible consumers who present for care through the MBHO and do or do not ultimately enroll in Medicaid. These indicators can be monitored geographically and by population characteristic to identity where outreach and enrollment efforts have been successful and where improvements are needed.

   New Jersey will have a federally facilitated health insurance exchange (FFE).

2. How will the state work with its partners to ensure that the Navigator program is responsive to the unique needs of individuals with behavioral health conditions and the challenges to getting and keeping the individuals enrolled?

   Please refer to the response provided in question #1 above.

3. How will the state ensure that providers are screening for eligibility, assisting with enrollment, and billing Medicaid, the CHIP, QHPs, or other insurance prior to drawing down Block Grant dollars for individuals and/or services?

   Please refer to the response provided in question #1 above.

4. How will the state ensure that there is adequate community behavioral health provider participation in the networks of the QHPs, and how will the state assist its providers in enrolling in the networks?

   Please refer to the response provided in question #1 above.

5. Please provide an estimate of the number of individuals served under the MHBG and SABG who are uninsured in CY 2013. Please provide the assumptions and methodology used to develop the estimate.

Please refer to the response provided in question #1 above. Further information was not available at the time of this writing for this question.

6. Please provide an estimate of the number of individuals served under the MHBG and SABG who will remain uninsured in CY 2014 and CY 2015. Please provide the assumptions and methodology used to develop the estimate.

   Please refer to the response provided in question #1 above. Further information was not available at the time of this writing for this question.

7. For the providers identified in Table 8 -Statewide Entity Inventory of the FY 2012 MHBG and SABG Reporting Section, please provide an estimate of the number of these providers that are currently enrolled in your state's Medicaid program. Please provide the assumptions and methodology used to develop the estimate.

   Please refer to the response provided in question #1 above. Further information was not available at the time of this writing for this question.

8. Please provide an estimate of the number of providers estimated in Question 7 that will be enrolled in Medicaid or participating in a QHP. Provide this estimate for FY 2014 and a separate estimate for FY 2015, including the assumptions and methodology used to develop the estimate.

   Please refer to the response provided in question #1 above. Further information was not available at the time of this writing for this question.

IV: Narrative Plan

E. Program Integrity

Narrative Question:

The Affordable Care Act directs the Secretary of HHS to define EHBs. Non-grandfathered plans in the individual and small group markets both inside and outside of the Marketplaces, Medicaid benchmark and benchmark-equivalent plans, and basic health programs must cover these EHBs beginning in 2014. On December 16, 2011, HHS released a bulletin indicating the Secretary's intent to propose that EHBs be defined by benchmarks selected by each state. The selected benchmark plan would serve as a reference plan, reflecting both the scope of services and any limits offered by a "typical employer plan" in that state as required by the Affordable Care Act.

SMHAs and SSAs should now be focused on two main areas related to EHBs: monitoring what is covered and aligning Block Grant and state funds to compensate for what is not covered. There are various activities that will ensure that mental and substance use disorder services are covered. These include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including EHBs as per the state benchmark; (2) ensuring that individuals are aware of the covered mental health and substance abuse benefits; (3) ensuring that consumers of substance abuse and mental health services have full confidence in the confidentiality of their medical information; and (4) monitoring utilization of behavioral health benefits in light of utilization review, medical necessity, etc.

States traditionally have employed a variety of strategies to procure and pay for behavioral health services funded by the SABG and MHBG. State systems for procurement, contract management, financial reporting, and audit vary significantly. SAMHSA expects states to implement policies and procedures that are designed to ensure that Block Grant funds are used in accordance with the four priority categories identified above. Consequently, states may have to reevaluate their current management and oversight strategies to accommodate the new priorities. They may also be required 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. States should describe their efforts to ensure that Block Grant funds are expended efficiently and effectively in accordance with program goals. In particular, states should address how they will accomplish the following:

1. Does the state have a program integrity plan regarding the SABG and MHBG?
2. Does the state have a specific staff person that is responsible for the state agency's program integrity activities?
3. What program integrity activities does the state specifically have for monitoring the appropriate use of Block Grant funds? Please indicate if the state utilizes any of the following monitoring and oversight practices:
    a. Budget review;
    b. Claims/payment adjudication;
    c. Expenditure report analysis;
    d. Compliance reviews;
    e. Encounter/utilization/performance analysis; and
    f. Audits.
4. How does the state ensure that the payment methodologies used to disburse funds are reasonable and appropriate for the type and quantity of services delivered?
5. How does the state assist providers in adopting practices that promote compliance with program requirements, including quality and safety standards?
6. How will the state ensure that Block Grant funds and state dollars are used to pay for individuals who are uninsured and services that are not covered by private insurance and/or Medicaid?

SAMHSA will review this information to assess the progress that states have made in addressing program integrity issues and determine if additional guidance and/or technical assistance is appropriate.

Footnotes:

E. Program Integrity

1. Does the state have program integrity plan regarding the SABG and MHBG?

   DMHAS intends to implement a program integrity plan regarding the SABG and MHBG supported by the MBHO to ensure that these funds are utilized to provide priority treatment and support services for individuals without insurance or for whom coverage is terminated for a short period of time, and to fund these services not covered by Medicaid, Medicare, or private insurance for low-income individuals. DMHAS has drafted income eligibility guidelines for state and Block Grant funding that align with current and anticipated Medicaid and QHP subsidy eligibility scales. The MBHO will authorize services according to income and program eligibility guidelines that:

   - Maximizes utilization of Medicaid reimbursement for state plan services;
   - Maximizes utilization of subsidized QHP reimbursement for covered plan services; and
   - Reserves state and Block Grant reimbursement for non-state plan services for Medicaid enrolled consumers and non-covered QHP services as gap coverage when between subsidized plans or for services not covered by these plans.

   All consumers will be required to meet income eligibility guidelines to receive state and BG funded services and will be screened for Medicaid enrollment and eligibility. While Medicaid will be the payer of first choice for state plan services, Medicaid enrolled consumers will also qualify for state and BG funded services not covered by the state plan. Consumers with potential eligibility will be referred for Medicaid enrollment, and must complete the application process in order to maintain eligibility for continued services. Consumers who do not qualify for Medicaid but meet established income and program eligibility criteria will be enrolled in services under the MBHO, referred for enrollment in a QHP, and must complete the application process in order to maintain eligibility for continued services.

2. Does the state have a specific staff person that is responsible for the state agency's program integrity activities?

   The state has not identified a specific staff person responsible for program integrity activities. It is anticipated that this role will be established within the Office of Care Management.

3. What program integrity activities does the state specifically have for monitoring the appropriate use of Block Grant funds? Please indicate if the state utilizes any of the following monitoring and oversight practices:

   a. Budget review

      Yes, the state reviews the budget proposals of all providers to ensure proposed costs, and as applicable, offsetting revenues comply with applicable cost principles. Additionally, there is a communication issued to providers each year advising them of the amount of their contract which is funded with BG resources along with any applicable restrictions.

The Division is moving toward a Fee-for-Service (FFS) compensation system within the framework of a managed care organization which will enable much more precise targeting of the use of Block Grant funds with specific individuals and services.

b. Claims/payment adjudication

With limited exceptions BG funding is provided through cost reimbursement contracts, not through FFS claims.

c. Expenditure report analysis

Yes, the state receives periodic expenditure reports and subjects such reports to analysis for compliance against the approved contract and governing cost principles.

d. Compliance reviews

The majority of providers are subject to the Single Audit 133 requirements including compliance testing and reporting. Additionally, with regard to addiction services, the Monitoring Unit conducts at least one annual site visit to review and ensure agency compliance with contractual requirements.

e. Encounter/utilization/performance analysis

The state conducts evaluation of actual utilization against budgeted utilization to inform decisions regarding on-going service acquisition. For those services that do not use a standard rate within the structure of cost-reimbursement contracts which are primarily the MH contracts, cost is correlated with utilization to develop median rates to use to inform contract negotiations.

f. Audits

As noted above, the majority of providers are required to have a Single Audit. Additionally, the Division requests targeted audits of providers as indicated by issues arising during the year and the Division is attempting to move to a periodic cycle of routine contract audits.

4. How does the state ensure that the payment methodologies used to disburse funds are reasonable and appropriate for the type and quantity of services delivered?

As noted above, the vast majority of services are provided via cost reimbursement contracts which are compensated on a reimbursement basis or advance payment basis. Advance payment providers are provided 1/12 of their contact ceiling in the month immediately preceding service delivery. Quarterly reports of expenditures and service provision are reviewed to determine if adjustments to the contract and/or payments are necessary during the course of the contact.

5. How does the state assist providers in adopting practices that promote compliance with program requirements, including quality and safety standards?

   The MBHO will collect service utilization, performance, and outcome data to facilitate the evaluation of the effectiveness of mental health and substance use disorder treatment services. This information will be shared with providers and consumers to support program improvement activities and informed consumer choice. The MBHO will also convene a Quality Committee that includes staff from the Office of Licensure, DMHAS program managers and research and evaluation staff, providers, advocates, and consumers to review MBHO utilization management, performance and outcomes data at the service and systems level and recommend performance improvement and new service implementation activities.

6. How will the state ensure that Block Grant funds and state dollars are used to pay for individuals who are uninsured and services that are not covered by private insurance and/or Medicaid?

   As the state moves to a FFS system employing managed care principles, we are developing an RFP to engage a managing entity to manage Medicaid services and individuals as well as non-Medicaid services and individuals. The managing entity will be required to braid funding employing rules prescribed by the state which will include the targeting of block grant resources as noted above.

IV: Narrative Plan

F. Use of Evidence in Purchasing Decisions

Narrative Question:

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers decisions regarding mental health and substance abuse services. SAMHSA is requesting that states respond to the following questions:

1) Does your state have specific staff that are responsible for tracking and disseminating information regarding evidence-based or promising practices?

2) Did you use information regarding evidence-based or promising practices in your purchasing or policy decisions?

a) What information did you use?

b) What information was most useful?

3) How have you used information regarding evidence-based practices?

a) Educating State Medicaid agencies and other purchasers regarding this information?

b) Making decisions about what you buy with funds that are under your control?

Footnotes:

F. Use of Evidence in Purchasing Decisions

1. Does your state have specific staff that are responsible for tracking and disseminating information regarding evidence-based or promising practices?

   Information about promising practices is usually disseminated by program staff responsible for those practices, such as supported housing, medication assisted treatment, self-help and recovery centers, SBIRT, etc. Executive staff will disseminate this information at different forums, stakeholder meetings, conferences, etc. Staff in the DMHAS Office of Research, Planning, Evaluation, Information Systems and Technology are responsible for tracking this information through its various IT systems, such as the USTF, the QCMR and NJSAMS.

   In addition, there are Program Coordinators who are assigned oversight responsibility for key programs such as Supportive Housing, PACT, Supported Employment, IMR, Supported Education, IDDT, etc. The Program Coordinators are instrumental in facilitating the development and implementation of EBPs and promising practices and strategizing ongoing implementation and expansion of these practices throughout the state. The IDDT EBP has now developed into an Integrated Treatment for Co-Occurring Disorders. The Program Coordinators maintain and disseminate information regarding EBPs and promising practices. They also are focused on both clinical and fiscal issues as they relate to the EBPs and the use of resources, delivery of the services, expansion of services, and the attainment of outcomes.

   Licensed clinical staff at DCSOC, as well as staff at UBHC, DCSOC's Training and Technical Assistance Program, disseminate information regarding evidence-based and/or promising practices. Licensed clinical staff at PerformCare, DCSOC's Contracted Systems Administrator (CSA), review and authorize the use of evidence-based practices as part of a child, youth or young adult's ISP. The CSA tracks utilization and outcome measurements of evidence-based practices implemented by DCSOC providers.

2. Did you use information regarding evidence-based or promising practices in your purchasing or policy decisions?

   a. What information did you use?

      SAMHSA toolkits, including suggested outcomes and fidelity measures have been useful tools. DMHAS utilizes data to drive planning decisions. Outcomes and cost effectiveness are two major areas of consideration.

      Information regarding evidence-based and/or promising practices was utilized by DCSOC in its purchasing decisions. DCSOC arranged for training from the National Improvement Research Network at University of North Carolina at Chapel Hill for DSCOC staff, County Inter-Agency Coordinating Councils and System Partners on the implementation of EBPs, assessing community readiness, and maintaining fidelity to the model. Additionally, DCSOC contracted with the University of South Florida

through its UBHC Training and Technical Assistance Program contract to provide technical assistance and training on evidence-based practice to provider agencies.

DCSOC reached out to other states for examples of their policies and guidelines regarding evidence based practices and best practices standards. DCSOC received 47 responses to the request. The material received included legislation; state policies and regulations; state practices and guidelines; trainings and Power Point presentations; RFPs; articles; and, resource material and references for additional information. DCSOC Policy Unit staff reviewed the material and developed recommendations for DCSOC implementation of EBPs.

b. What information was most useful?

SAMHSA toolkits, including suggested outcomes and fidelity measures have been useful tools. DMHAS utilizes data to drive planning decisions. Outcomes and cost effectiveness are two major areas of consideration.

Training and Technical Assistance provided by University of North Carolina and University of South Florida; state guidelines, policies and regulations; and, examples of RFPs were most useful in developing DCSOC implementation of EBPs.

3. How have you used information regarding evidence-based practices?

a. Educating State Medicaid agencies and other purchasers regarding this information?

A cost model was prepared for Medicaid to demonstrate the cost-effectiveness of implementing SBIRT to make the case to turn on the Medicaid codes for this service. The good outcomes from the Supportive Housing pilot for clients with a history of homelessness and intravenous drug use was a driving force to work on developing a supported housing program for pregnant and parenting women struggling with addiction. The success of New Jersey's first Recovery Center has led to development of a second one.

DCSOC synthesized the information received and used it as a foundation for the development and implementation of EBPs in the children's system of care. In order to improve the quality of care provided to the children and families served, DCSOC supports the incorporation of evidence-based practices into the work of system partners and providers. A principle strategy for this was to develop a Medicaid reimbursement rate that adequately supports evidence-based practice. Since evidence-based practices typically have significant up front training costs and involve significant non-billable activities (e.g., use of web-based clinical case note systems and weekly case supervision with clinicians who work to ensure that the evidence-based model is implemented with fidelity), a rate must be built take takes these factors into consideration. DCSOC has simultaneously developed a strategy for implementation of these practices that include educating the provider community about these practices and how they might develop them. DCSOC contracted with the

University of South Florida through our UMDNJ Training and Technical Assistance Program contract to provide technical assistance and training on evidence-based practice to provider agencies.

b. Making decisions about what you buy with funds that are under your control?

Research indicates that Vivitrol has been demonstrated to be an effective medication for use with alcoholics and also to prevent the relapse of opiate addiction. Based on the compelling evidence, a decision was made to pilot the use of this medication with 100 indigent clients who are participating in the Driving Under the Influence Initiative (DUII) within the DMHAS.

Supportive Housing has been proven to be an effective model as a placement option for consumers who are seriously mentally ill and being discharged from a state hospital. DMHAS has been creating additional Supportive Housing placements each year to increase its Supportive Housing capacity and to facilitate the placement of consumers who are currently designated CEPP (Conditional Extension Pending Placement) in the state hospitals. Supportive Housing provides the consumer an opportunity to live independently in the community of their choice.

DCSOC contracts for 157 Therapeutic Nursery slots and 729 Treatment Home beds (New Jersey's Therapeutic Foster Care program). Beginning in the fall of 2008 in select counties, DCSOC began offering two types of evidence-based programs for delinquent and at-risk youth, Functional Family Therapy (FFT) and MultiSystemic Therapy (MST). Additionally, in June 2009 DCSOC released a request for spending plans to each County Inter-Agency Coordinating Council (CIACC) to begin implementation of clinical EBP's in each of NJ's 21 counties. DCSOC provided up to $50,000 to each county for start-up costs, including training and the purchase of materials (manuals, videos). DCSOC arranged for training from the National Improvement Research Network at University of North Carolina at Chapel Hill for CIACC members and System Partners on the implementation of EBPs, assessing community readiness, and maintaining fidelity to the model. DCSOC awarded 15 grants covering: Camden, Cumberland, Bergen, Burlington, Gloucester, Hunterdon, Monmouth, Morris, Ocean, Passaic, Salem, Somerset, Sussex, Union, and Warren counties for provision of the following EBPs: Trauma Focused-Cognitive Behavioral Therapy, Cognitive Behavioral Therapy, Real Life Heroes, Parent Child Interaction Therapy, Kendall Coping Cat, Motivational Assessment, Motivational Interviewing, Strengthening Families, Structural Family Treatment, and Brief Strategic Family Treatment.

IV: Narrative Plan

G. Quality

Narrative Question:

Up to 25 data elements, including those listed in the table below, will be available through the Behavioral Health Barometer which SAMHSA will prepare annually to share with states for purposes of informing the planning process. The intention of the Barometer is to provide information to states to improve their planning process, not for evaluative purposes. Using this information, states will select specific priority areas and develop milestones and plans for addressing each of their priority areas. States will receive feedback on an annual basis in terms of national, regional, and state performance and will be expected to provide information on the additional measures they have identified outside of the core measures and state barometer. Reports on progress will serve to highlight the impact of the Block Grant-funded services and thus allow SAMHSA to collaborate with the states and other HHS Operating Divisions in providing technical assistance to improve behavioral health and related outcomes.

	Prevention	Substance Abuse Treatment	Mental Health Services
Health	Youth and Adult Heavy Alcohol Use - Past 30 Day	Reduction/No Change in substance use past 30 days	Level of Functioning
Home	Parental Disapproval Of Drug Use	Stability in Housing	Stability in Housing
Community	Environmental Risks/Exposure to prevention Messages and/or Friends Disapproval	Involvement in Self-Help	Improvement/Increase in quality/number of supportive relationships among SMI population
Purpose	Pro-Social Connections Community Connections	Percent in TX employed, in school, etc - TEDS	Clients w/ SMI or SED who are employed, or in school

1) What additional measures will your state focus on in developing your State BG Plan (up to three)?

2) Please provide information on any additional measures identified outside of the core measures and state barometer.

3) What are your states specific priority areas to address the issues identified by the data?

4) What are the milestones and plans for addressing each of your priority areas?

Footnotes:

G. Quality

1. What additional measures will your state focus on in developing your State BG Plan (up to three)?

   The priority areas are: Supportive Housing, Suicide Prevention, and Consumer Operated Services for mental health.

   The additional measures for the addictions system are: Increase in supportive housing, decrease in prescription drug misuse, and increase in employment upon discharge from treatment.

   The DCSOC will focus on the following additional Quality Measures in the State BG Plan:

   - Stability in housing;
   - Improvement/Increase in the Number of Supportive Relationships; and,
   - Children, Youth, and Young Adults with SED in School.

2. Please provide information on any additional measures identified outside of the core measures and state barometer.

   As enumerated in Step 4 "Develop objectives, strategies and performance indicators", the three specific priority areas are: Supportive Housing, Suicide Prevention and Consumer Operated Services for the SMHA.

   The relevant data for Supportive Housing includes observation of: the numbers of consumers served annually, the numbers of community-based housing opportunities (a.k.a. 'beds") developed annually, and the number of workforce development trainings facilitated by the SMHA. The data from each of these will come from the QCMR database, fiscal/contracting data and SMHA workforce development records, respectively.

   The relevant data for Suicide Prevention will include the call record datasets provided to DMHAS by the National Suicide Prevention Lifeline Network (NSPLN). Specifically the SMHA will be looking to see what proportion of calls transferred by the Lifeline and originating in New Jersey are answered by the DMHAS-funded suicide prevention hotline during times when the NSPLN is closed or experiencing heavy call volume.

   The relevant data for Consumer Operated Services will include data on the use and participation in wellness and recovery activities provided to consumers at Self Help Centers, vis-à-vis the SHOUT™ self-help center electronic utilization and outcome record system. In addition electronic surveys will be administered annually with self-help center members and in combination with SHOUT utilization data in order to assess performance against the stated indicator.

   For the SSA, there is a dearth of supportive housing for clients with addiction issues. Supportive housing is critically needed to support consumers in their recovery. Currently

there are only two programs serving 63 consumers with substance abuse issues, which is inadequate to meet the existing need.

Prescription drug misuse and abuse is a growing problem in New Jersey which must be addressed. The existing SSA data system, NJSAMS, will be modified to better capture information on this priority, particularly among 18-25 year olds and the older adult population. The DMHAS also submitted a SPF Partnership for Success grant application to address this priority.

There are no formal employment programs, such as Supported Employment, for clients with substance abuse problems. Employment is a key factor that is needed to support clients in their recovery.

The additional measures identified by DCSOC fall within the core measures and state barometer.

3. What are your states' specific priority areas to address the issues identified by the data?

For the SMHA, the goal of the first adult mental health core measure is to improve level of functioning among consumers served by the SMHA. The strategy by which this is to be accomplished is that consumers will report an increase in their Level of Functioning as measured by the SMHA's Annual Consumer Perception of Care Survey. The performance indicator is to be the measurement of consumer perception of Level of Functioning through the distribution of annual Mental Health Statistical Improvement Program (MHSIP) surveys that specifically capture consumer perceptions of Level of Functioning. In SFY 2014, 95% of all respondents to the relevant survey questions will either "agree" or "strongly agree" that their level of functioning is satisfactory. In SFY 2015 this number will increase to 96.2%. The numerator is the number of valid respondents who answered affirmatively. The denominator is the total number of valid respondents. In order to collect and measure change in this core measure clients are to respond to consumer survey questions about their level of functioning as measured by questions 29 - 32 on the 2006 MHSIP Consumer Survey (DRAFT v.1.2,). Those questions correspond to questions that will be included on the SMHA's 2013 and 2014 Consumer Perception of Care Survey.

The goal of the second adult mental health core measure is to increase stability in housing among consumers served by the SMHA. The strategy by which this is to be accomplished is to increase the number of consumers with mental illness who are utilizing the evidence based practice of supportive housing. Success will be determined based on a calculation of the following: the number of adults with mental illness receiving Supportive Housing Services (the numerator), divided by the total unduplicated number of adults with SMI served (the denominator). Our target for SFY 2014 is 4%. The target for SFY 2015 is 4.2%. In order to collect and measure change, the SMHA will collect relevant data through the QCMR database, the USTF database and URS Data Table 16 ("Profile of Adults with Serious Mental Illnesses and Children with Serious Emotional Disturbances Receiving Specific Services").

The goal of the third adult mental health core measure will be to demonstrate improvement/increase in quality/number of supportive relationships among SMI population served by the SMHA. This will be accomplished through the reporting of consumers about their feelings of social connectedness as measured by questions pertaining to "Social Connectedness" included in the 2014 and 2015 SMHA Consumer Perception of Care Surveys. Critical data will involve the measurement of consumer perception of Social Connectedness, through the distribution of annual MHSIP surveys that specifically capture consumer perceptions of Level of Functioning. In SFY 2014, 92% of all respondents to the relevant survey questions will either "agree" or "strongly agree" that their level of social connectedness is satisfactory. In SFY 2015 this number will increase to 92.4%. The numerator is the number of valid respondents who answered affirmatively. The denominator is the total number of valid respondents. Measurement of change in progress towards this goal will be measured vis-à-vis clients reporting to survey questions about their level of functioning as measured by questions 33 - 36 on the 2006 MHSIP Consumer Survey (DRAFT v.1.2). Those questions correspond to questions that will be included on the SMHA's 2014 and 2015 Consumer Perception of Care Survey.

The goal of the fourth adult mental health core measure is to increase the number of adult clients with SMI or SED who are employed. This is to be accomplished through the measurement of adult consumer employment status as indicated by consumers on the SMHA's USTF Client Registry Database will continued to be collected on consumers enrolling and discharging from state-funded, community-based mental health programs. The relevant data will be calculated as the number of adult clients competitively employed full or part time, including supported employment, divided by the number of persons employed (competitively employed full or part-time, including Supported Employment) plus the number of persons unemployed plus the number of persons not in the labor force (e.g. Retired, Student Volunteer, Disabled, Etc.). The targets for this indicator are 29% in SFY 2014, and 29.5% in SFY 2015. This data will be obtained from the SMHA's USTF Client Registry Database and URS Data Table 4 ("Profile of Adult Clients by Employment Status"). DCSOC specific priority areas to address the issues identified by data are:

- Stable family environment
- Ensure families/caregivers access to support and advocacy; and
- Improve educational performance and attendance at school.

4. What are the milestones and plans for addressing each of your priority areas?

SMHA

Supportive Housing: In the next several months, the SMHA will release several RFPs for the creation of permanent, community-based housing opportunities for individuals on CEPP status, for people at risk of homelessness & inpatient hospitalization, and targeted subpopulations (e.g., Megan's Law registrants, mentally ill individuals who also have serious primary health conditions, etc.). Proposals will be carefully and fairly reviewed, and award notices will be given to the provider who can best meet the community housing needs of these populations, as entailed in the RFPs. The contracts will contain specific language

obligating providers to: serve a pre-determined number of consumers annual, create a specific number of permanent housing opportunities, participate in mandatory workforce development trainings designed to increase client well-being & community tenure, and dutifully comply with reporting protocols (e.g. USTF, QCMR, BEDS).

In October 2013, the SMHA will review the associated datasets (USTF, QCMR, workforce development records, and BEDS—if complete) for Q1 SFY 2014 on bed utilization, bed creation and participation in workforce development sessions. DMHAS staff will notify providers not making satisfactory progress toward the Supportive Housing performance indicators and will receive remediation and support from the SMHA if necessary. In SFY 2015, these processes will continue to ensure that those with serious mental illness have safe, permanent, affordable, and clinically-appropriate housing options in community settings.

Suicide Prevention: An award was issued in Q3 of SFY 2013 to Rutgers – University Behavioral Healthcare (UBHC) in response to the RFP for the development of a NJ-based suicide hotline to be answered by a trained staff member or volunteer and to accept calls that are routed by the National Suicide Prevention Lifeline Network (NSPLN). The phone number launched in May 2013 and is 855—NJHOPELINE (855-654-6735).

In the summer of 2013, DMHAS will begin reviewing NSPLN call record data to learn about the format and quality of the data. In October 2013, the SMHA will receive the first call record data for the first quarter of SFY 2014. Every quarter subsequent to that, the SMHA will review the additional datasets provided by NSPLN for SFY 2014 to measure if the DMHAS-funded suicide prevention hotline answered 85% of the calls originating in New Jersey transferred by NSPLN which couldn't be answered by the current active New Jersey Lifeline Crisis Centers during times of excess call volume or after the Lifeline Crisis Centers' operating hours. If unsatisfactory trends are observed by the SMHA, the contracted suicide prevention hotline will receive scrutiny and assistance to improve performance. In year two of the grant award (SFY 2015), this benchmark will be increased to 90%, and the sequence of data monitoring, evaluation and remediation (if necessary) will continue.

Consumer Operated Services: The plans for addressing the priority areas for Consumer Operated Services are to: 1. provide a wide range of peer delivered wellness and recovery activities at the DMHAS sponsored self-help centers statewide, 2. encourage participation by publicizing planned activities in monthly activity calendars, discussing at center community meetings, networking with DMHAS self-help centers, and 3. marketing self-help services with other community service providers. The milestones are to be as follows: in SFY 2014, 80% of individuals participating in Consumer Operated Services will be enrolled in wellness/recovery activities (e.g., enrolled in an Exercise Group, Anxiety Support Group, etc.). In SFY 2015, this proportion will increase to 83%. These milestones will be monitored at the 30 community-based, and DMHAS- funded self-help centers through a unified, individual record system specifically designed for self-help centers (the SHOUT™ database application). Reports are generated by SHOUT on a monthly and quarterly basis to assess performance against contract indicators (including this milestone). To meet these performance measurement objectives, self-help center staff will input and monitor self-help

center member participation in wellness and recovery activities statewide through the use of this SHOUT self-help center electronic utilization and outcome record system.

SSA

Priority Area: Supportive Housing
Milestone: Develop a supportive housing program for women with addiction issues and their children.
Plan: Secure services funding and housing vouchers and develop an RFP for this program.

Priority Area: Prescription Drug Misuse and Abuse
Milestone: Decrease the misuse of prescription drugs
Plan: Apply for Partnership for Success Grant which includes this milestone as one of its objectives and develop strategies to reduce this problem.

Priority Area: Employment
Milestone: A supported housing program for individuals with substance abuse issues
Plan: Begin to design a supportive housing program for individuals with substance abuse problems and identify potential funding sources.

DCSOC

Specific Priority Area: Stable family environment
Milestone: Increase the number of youth with SED that are able to remain in their current living situations as a result of receiving Mobile Response and Stabilization Services (MRSS).
Plan: Provision of comprehensive behavioral health and support services for youth and their families/caregivers to avoid disruption of living arrangement.

Specific Priority Area: Ensure parents access to support and advocacy
Milestone: Families/caregivers report increased social supports/connectedness on the DCSOC Youth Services Survey for Families.
Plan: Continue DCSOC's efforts to address the need for a statewide support and advocacy network to support individual parents as they navigate the System of Care on behalf of their children, and to identify parent leaders who will function as system advocates in addressing policy, procedures and program development needs at the local, regional and statewide levels. One to one peer support and support group services are available to all families receiving Care Management Organization services.

Specific Priority Area: Improve educational performance and attendance at school.
Milestone: Families/caregivers report improvement in school attendance and performance on the DCSOC Youth Services Survey for Families.
Plan: The provision of behavioral health services as part of a comprehensive children's system of care must include consideration of the need to maintain each youth's educational activities during treatment. Services shall be provided in the least restrictive educational setting.

IV: Narrative Plan

H. Trauma

Narrative Question:

In order to better meet the needs of those they serve, states should take an active approach to addressing trauma. Trauma screening matched with trauma-specific therapies, such as exposure therapy or trauma-focused cognitive behavioral approaches, should be used to ensure that treatments meet the needs of those being served. States should also consider adopting a trauma-informed care approach consistent with SAMHSA's trauma-informed care definition and principles. This means providing care based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate so that these services and programs can be more supportive and avoid being traumatized again.

Please answer the following questions:

1. Does your state have any policies directing providers to screen clients for a personal history of trauma?
2. Does the state have policies designed to connect individuals with trauma histories to trauma-focused therapy?
3. Does your state have any policies that promote the provision of trauma-informed care?
4. What types of evidence-based trauma-specific interventions does your state offer across the life-span?
5. What types of trainings do you provide to increase capacity of providers to deliver trauma-specific interventions?

Footnotes:

H. Trauma

1. Does your state have any policies directing providers to screen clients for a personal history of trauma?

   A statement on Trauma Informed Care is awaiting review and comment by the DMHAS Assistant Commissioner for release throughout the system. This statement will outline the formation of workgroups over the next year to assess and recommend EBPs, assessment, policies, program development, and a plan for Trauma Informed Care.

   DCSOC 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 his or her 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 DCSOC as possessing the capacity to complete the Information Management Decision Support Needs Assessment.

2. Does the state have policies designed to connect individuals with trauma histories to trauma-focused therapy?

   Please refer to above. EBPs will be selected and recommended for use throughout the system. Agencies will be asked to assess their readiness to deliver trauma care as well as their needs for cultural change. In addition, agencies will be asked to assess the wellness and trauma issues among staff delivering clinical treatment.

   DCSOC strives to provide children, youth and young adults and their families with the right services, at the right time, for the right amount of time. Through the children's system of care, children, youth and young adults can access an array of evidence based mental and behavioral health treatments, including trauma focused therapies, such as CBT and TF-CBT. In addition, DCF's Office of Child and Family Health has a full-time clinical team that includes a pediatrician, a child/adolescent psychiatrist, and a neuropsychologist.

3. Does your state have any policies that promote the provision of trauma-informed care?

   Please refer to above. DMHAS policies will be in formation over the next year.

   The mission of the DCF is intentionally broad: In partnership with NJ's communities DCF will ensure the safety, well-being and success of NJ's children and families. DCF has the largest workforce directly interacting with children and families who are amongst our most vulnerable and have experienced the most complex trauma-related challenges. There is a growing awareness across disciplines about the need for systems working with traumatized children to be trauma-informed. Likewise, there is a call for child protection systems to be trauma-informed. 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 division to understand, prevent and mitigate the impact of trauma that children, youth and young adults and their families' experience.

DCF is confident that among our community partners, providers, and within DCF's own system, there are programs, organizational units and individuals who approach their work with a trauma-informed lens. DCF and our community partners also offer an array of trauma-specific services intended to address trauma and its impact. Yet, DCF, similar to some of our counterparts in other states and jurisdictions, believes there is a long way to go in creating a trauma-informed culture of care and services.

4. What types of evidence-based trauma-specific interventions does your state offer across the life-span?

   This is sporadic at the present time. Over the next year DMHAS will assess the capabilities across age groups and for staff as well. In addition, DMHAS contracted licensed substance abuse treatment agencies that provide gender specific treatment to pregnant and parenting women are required to provide trauma informed and trauma responsive treatment using the "Seeking Safety" curriculum.

   DCSOC provides services to children, youth and young adults and their families up to age 21.The following evidence-based trauma-specific interventions are provided within the NJ children's system of care: Trauma Focused-Cognitive Behavioral Therapy, Cognitive Behavioral Therapy, Post Traumatic Stress Management Training and Psychological First Aid with Ethnocultural, Gender, and Developmental Specificity (PTSM)**;** Advanced PTSM: Response Protocols to Suicide**;** and, Classroom Based Psychosocial Intervention (CBI) and Traumatic Incident Intervention (TII).

5. What types of trainings do you provide to increase capacity of providers to deliver trauma-specific interventions?

   Over the past 5 years there has been training in the following areas:
   - Addiction, Trauma and Suicide – given regionally – twice each region
   - Seeking Safety – three sessions
   - Sanctuary – one session
   - Trauma Art Narrative Therapy – two sessions
   - Three annual conferences on trauma

   As DMHAS assesses the service needs and clinical needs in the system, we will begin to develop the capacity for training and information/technology sharing.

   The following trauma-specific workshops are available through the Traumatic Loss Coalitions for Youth program sponsored by DCSOC:
   - After a Suicide – Guidelines for Schools
   - An Introduction to Evidence Based and Best Practice Suicide Prevention Programs for Schools

- Applied Suicide Intervention Skills Training (ASIST) for educators, law enforcement, mental health professionals, clergy, medical professionals, administrators, volunteers, and anyone else who might be interested in adding suicide intervention to their list of skills
- Creating Safe and Respectful Environments
- Crisis Planning for Vulnerable School Populations
- Depression in Children and Adolescents
- Enhancing Your School's Crisis Plan
- Helping a Grieving Child
- Managing Trauma and Loss in Schools For Administrators and Crisis Teams
- Preventing Youth Suicide: Awareness Training For Teachers, Parents, and Non-Mental Health Personnel
- People Skills
- Responding to Grief and Loss
- School Crisis – an Administrator's Guide to Management and Recovery
- Schools and Mental Health-Bridging the Gap in Treating the Whole Child
- School Safety is Every Adult's Responsibility
- Stress, Burnout and Vicarious Trauma
- Suicide Assessment Training for Clinicians and Counselors
- Supporting Adolescents As They Transition from High School
- Trauma and Youth
- Understanding Trauma and Loss in Youth
- Using the School I&RS Team to Support Students with Mental Illness
- Working with Resistant Teens
- Working with Youth with Mental Health Disorders

IV: Narrative Plan

I. Justice

Narrative Question:

The SABG and MHBG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.

Communities across the United States have instituted problem-solving courts, including those for defendants with mental and substance abuse disorders. These courts seek to prevent incarceration and facilitate community-based treatment for offenders, while at the same time protecting public safety. There are two types of problem-solving courts related to behavioral health: drug courts and mental health courts. In addition to these behavioral health problem-solving courts, some jurisdictions operate courts specifically for DWI/DUI, veterans, families, and reentry, as well as courts for gambling, domestic violence, truancy, and other subject-specific areas. [42,43] Rottman described the therapeutic value of problem-solving courts: Specialized courts provide a forum in which the adversarial process can be relaxed and problem solving and treatment processes emphasized. Specialized courts can be structured to retain jurisdiction over defendants, promoting the continuity of supervision and accountability of defendants for their behavior in treatment programs. Youths in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient utilization of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; and therefore, risk factors remain unaddressed.[44]

A true diversion program takes youth who would ordinarily be processed within the juvenile justice system and places them instead into an alternative program. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with mental and/or substance use disorders from correctional settings. States should also examine specific barriers such as lack of identification needed for enrollment; loss of eligibility resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention

Please answer the following questions:

1. Does your state have plans to enroll individuals involved in the criminal and juvenile justice systems in Medicaid as a part of coverage expansions?

2. What screening and services are provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders?

3. Are your SMHA and SSA coordinating with the criminal and juvenile justice systems with respect to diversion of individuals with mental and/or substance use disorders, behavioral health services provided in correctional facilities, and the reentry process for those individuals?

4. Do efforts around enrollment and care coordination address specific issues faced by individuals involved in the criminal and juvenile justice systems?

5. What cross-trainings do you provide for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system?

42 The American Prospect: In the history of American mental hospitals and prisons, The Rehabilitation of the Asylum. David Rottman,2000.

43 A report prepared by the Council of State Governments. Justice Center. Criminal Justice/Mental Health Consensus Project. New York, New York for the Bureau of Justice Assistance Office of Justice Programs U.S. Department of Justice, Renee L. Bender, 2001.

44 Journal of Research in Crime and Delinquency: Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice. Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNiel, Dale E., and Renée L. Binder. OJJDP Model Programs Guide.

Footnotes:

I. Justice

1. Does your state have plans to enroll individuals involved in the criminal and juvenile justice systems in Medicaid as a part of coverage expansions?

   Currently, adults and youth in the criminal and juvenile justice systems are eligible for Medicaid or New Jersey FamilyCare (S-CHIP) only after release to a non-secure setting. Adults who are no longer inmates or incarcerated will be considered part of the Medicaid Expansion population under the Affordable Care Act beginning in January 2014. DHS is working with the State Department of Corrections and the county Administrative Offices of the Courts to coordinate Medicaid Expansion enrollment determination upon an inmate's release.

2. What screening and services are provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders?

   The SMHA has a limited number of pilot projects that provide for screening availability for mental illness and or co-occurring disorders within the municipal and superior courts systems. A mental health professional is available to court staff who believe that a defendant is presenting with significant emotional issues. If the defendant has a mental illness, he or she is linked to behavioral health treatment and support services.

   Any referral for service to one of the SMHA's Justice Involved Service Providers (JIS) by the courts/probation will be assessed for the presence of a mental illness as criteria for participation and for needed mental health services.

   SSA's Drug Court Substance Abuse Evaluators conduct a comprehensive clinical assessment on all Drug Court applicants once they are found legally eligible for Drug Court. As part of the substance use assessment they also conduct a mental health screening and refer participants to mental health professionals for a full evaluation, as needed.

   <u>Protocol for Court-Ordered Assessment of Children with Emotional and Behavioral Health Needs (14 Day Plan Protocol)</u>

   In the course of proceedings involving juvenile delinquency matters or family crisis petitions, the court may learn that the child involved exhibits behavior suggesting a need for emotional, behavioral, or mental health services. When this becomes apparent at any point in court proceedings, the court may order DCF to submit a service plan to the court within 14 days (14 Day Plan) that assesses the needs of the child and the family and details how those needs may be met.

   Attached is the Protocol for Court-Ordered Assessment of Children with Emotional and Behavioral Health Needs (14 Day Plan Protocol) between the DCF DCSOC and the New Jersey Judiciary, Family Division.

   <u>Biopsychosocial Assessments</u>

The NJ regulations for juvenile detention facilities require that all youth entering Detention must receive the Massachusetts Youth Screening Instrument (MAYSI) within 24 hours of admission. DCSOC and JJC developed a process that permits juvenile detention centers to request a Biopsychosocial clinical evaluation on any youth that may score on the MAYSI regarding possible mental health concerns.

When a court-involved youth held in a county juvenile detention facility is ordered by a Family Court judge into an out-of-home treatment facility, the youth must be transitioned from the juvenile detention center as quickly as possible. To effectively accomplish this, it is critical that youth for which a congregate care placement is contemplated be identified as early in the court involvement as possible. DCSOC has implemented an easily accessed clinical assessment process for any youth in a county juvenile detention center that may have behavioral and/or mental health issues. Clinical assessments, which a have a turn-around time of five business days, can be requested by the Social Services staff at the detention center. To accomplish this, DCSOC developed a tracking system for children in county detention centers for whom a congregate care placement is being considered. The contracted system administrator's (CSA) management information system was modified to incorporate information about detention status for system-involved children. The information in the CSA management information system identifies children for whom proactive placement is initiated.

3. Are your SMHA and SSA coordinating with the criminal and juvenile justice systems with respect to diversion of individuals with mental and/or substance use disorders, behavioral health services provided in correctional facilities, and the reentry process for those individuals?

   Yes, the SMHA's JIS provides post booking diversion and re-entry services for adults in sixteen of New Jersey's 21 counties. The SMHA does assist with re-entry from state prisons on a case by case basis but has a more robust re-entry effort with the county correctional facilities. The SSA works closely with the statewide Drug Court programs to provide substance abuse and co-occurring services for those individuals deemed legally and clinically appropriate to enter the Drug Court program. The DMHAS Mutual Agreement Program (MAP) provides co-occurring services including psychotropic medications for the placement of parolees demonstrably in need of such services.

   Yes, the DCF DCSOC is represented on the New Jersey Council for Juvenile Justice Improvement. Diversion and the Reentry processes are being addressed by the Access to Treatment and Racial Disparities sub-committees of the Council. Formal recommendations will be presented to the full Council by the individual sub-committees.

4. Do efforts around enrollment and care coordination address specific issues faced by individuals involved in the criminal and juvenile justice systems?

   Adults who are entangled in the criminal justice system are referred to the SMHA/SSA through a variety of sources including, families, law enforcement, jails, courts, probation,

prison and parole. Regardless of the source, JIS case managers will assess with the individuals their individual needs for mental health and co-occurring treatment, medical, entitlements, housing, employment and other needs. They will then develop with the participant a services/re-entry plan to establish successful linkages with community providers who can deliver the services needed.

DMHAS has several initiatives that provide substance abuse treatment for individuals involved with the criminal and juvenile justice systems. The DMHAS MAP provides substance abusing inmates and parolees with the opportunity to receive structured, community based substance abuse treatment that introduces intensive therapy for behavioral and psychological problems related to addiction. This funding is a combination of direct appropriations to DMHAS and funds transferred from the Department of Corrections (DOC) and State Parole Board (SPB) to support a FFS network of licensed community-based substance abuse treatment programs. Funding for long term residential is available for DOC inmates pending parole through a network of FFS providers. For SPB, 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, intensive outpatient, and outpatient treatment for SPB parolees.

The Drug Court is a cooperative initiative between the Administrative Office of the Courts (AOC) and DMHAS which commenced in 2002. This agreement allows the AOC to transfer treatment funding to DMHAS who then secures and implements a complete continuum of care for Drug Court offenders sentenced in New Jersey Superior Court. Drug Court participation was originally voluntary and clinically-driven. New legislation has now made Drug Court mandatory for nonviolent individuals convicted of drug related offenses. Fifteen vicinage Drug 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. The mission of Drug Courts is to stop the abuse of alcohol and other drugs and related criminal activity. Drug Courts are unique because they build a close collaborative relationship between criminal justice and drug treatment professionals. The DMHAS develops, supports and monitors the treatment provider network, provides fiscal and data management and partners with the AOC in the management of Drug Court treatment and program expansion.

DCF/DCSOC have established cooperative relationships with the JJC. In December 2004, the Department and the JJC signed a Memorandum of Understanding (MOU) that outlines a distinct process by which youth in the JJC can be referred directly into the Children's Behavioral Health System before being discharged from a JJC facility. Representation from both DCP&P and DCSOC participate in the JJC and Annie E. Casey Foundation driven Juvenile Detention Alternative Initiative 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 process and in case review process.

The JJC 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 teach 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 juveniles, 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/DCP&P due to court orders for diversion or aftercare, special presenting problems, and/or homelessness; and those who are being referred or are accepted by DCF/DCSOC.

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 the DCP&P Central, Middlesex, Union and Camden offices, 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 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, from 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 and supervisors and program staff.

In addition to this population of JJC/DCP&P involved juveniles, DCP&P maintains an existing MOU with JJC. This MOU stipulates that DCP&P has the responsibility to plan for any homeless juvenile pending discharge from JJC. The Special Needs Review Committee will identify those juveniles and make referrals to DCP&P via State Centralized Screening (SCR) when appropriate for homeless juveniles not known to DCP&P or those juveniles whose DCP&P cases are closed. In cases where a juvenile with an open DCP&P case is pending discharge and known to be homeless, it is expected that the DCP&P worker is already engaged in permanency plans.

When JJC juveniles have permanency and treatment needs that require the intervention of DCSOC, the JJC Special Needs Review Committee will work with DCSOC and DCP&P to make appropriate referrals prior to time of discharge. In circumstances where DCSOC is unable to facilitate a timely permanency plan in accordance with mandatory release dates, DCP&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.

DCSOC developed three Detention Alternative Programs (DAP) with a total of 15 beds. The priority population is youth in DCF DCP&P custody awaiting DCF placement once their charges have been disposed. These DAP beds ensure DCF is in compliance with the child welfare Modified Settlement Agreement (MSA). The DCSOC liaison also refers youth in detention centers with mental health needs.

Attached is the DCF DCSOC "Protocol for Supervision of Juvenile Probationers Court-ordered to Attend and Complete a DCSOC Specialty Services Program." This protocol was approved in 2012 by the following: NJ Juvenile Probation Managers; NJ Conference of Chief Probation Officers; DCSOC Representative for Specialty Programs; NJ Juvenile Committee of Family Presiding Judges; and, the NJ Conference of Family Presiding Judges.

5. What cross-trainings do you provide for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system?

   The SMHA has been involved along with the Office of the Attorney General, in facilitating the establishment of Crisis Intervention Teams (CIT) in six counties, with the individual counties providing the CIT training for law enforcement within their locals. The county CIT trainings also provide for individual officers from other counties and jurisdictions to attend.

   The SMHA has provided training to the Judiciary including Superior Court Judges and selected vicinages at the municipal court level as well as adult probation. Training has also been provided to the State Parole Board and parole officers. Representatives from the SMHA have provided training on criminal justice issues to staff of targeted case management, partial care and supported employment. In the fall of 2012, the SSA's Medical Director provided information on MAT and Drug Court to the Drug Court Judges.

   DCF/DCSOC funds the Technical Assistance Center through University Behavioral Health Care to provide training statewide. DCSOC, through the UMDNJ Training contract, offers training to all children's system of care providers free of charge. The following courses are available on a regularly scheduled basis throughout the year:

   - Risk Assessment and Mental Health
   - Crisis Intervention for At-Risk Youth
   - Crisis Assessment for Parents and Caregivers
   - Crisis Cycle
   - Developing and Managing the Family Crisis Plan
   - Safety Issues Working in the Community
   - Youth Behavior, Diagnosis and Intervention Strategies
   - Risk Assessment and Mental Health
   - Domestic Violence: An Introduction to Domestic Violence
   - Working with Challenging and Aggressive Adolescent Behaviors
   - Working with Traumatized and Aggressive Youth
   - MRSS Orientation – Crisis Response Protocol (Day One)
   - MRSS Orientation – Crisis Assessment Tool (CAT) and Developing the

- Individualized Crisis Plan (ICP)
- MRSS Orientation – Crisis Response Protocol (Day 2)
- Understanding Child Abuse and Mandatory Reporting Laws
- Youth Gang Involvement in NJ
- Substance Use and Abuse: Youth with Co-Occurring Developmental and Mental Health Challenges
- Substance Abuse 2: A Closer Look – Family and Addiction

In addition, DCF/DSCOC staff provides training on working with individuals with behavioral health challenges to staff of the JJC. Attached is the DCSOC JJC PowerPoint presentation.

NEW JERSEY JUDICIARY, FAMILY DIVISION
AND
DEPARTMENT OF CHILDREN AND FAMILIES, DIVISION OF CHILD BEHAVAVIORAL HEALTH

PROTOCOL FOR COURT-ORDERED ASSESSMENT OF CHILDREN WITH EMOTIONAL AND BEHAVIORAL HEALTH NEEDS (14 DAY PLAN PROTOCOL)[1]

April 11, 2008

I. BACKGROUND

The New Jersey Department of Children and Families (DCF) is by statute the government entity responsible for services and supports for children in need of protection, permanency and emotional, behavioral and mental health services. DCF oversees various services for children and families to ensure children's safety, permanency and well-being and to help families and children through social, emotional and other problems that could result in family disruption.

DCF encompasses two agencies of concern in the present matter: the Division of Youth and Family Services (DYFS) and the Division of Child Behavioral Health Services (DCBHS). DYFS has statutory responsibility for youth and families for whom safety and permanency concerns are evident. DCBHS is responsible for the emotional and behavioral health needs of youth. DCBHS is ensures, through contracted providers, that services are delivered through family centered planning and community based treatment for children driven by clinical assessment and determined need. It is the imperative of all DCF services that youth are served in their communities, with fortified connections to family. Best practices and overwhelming data demonstrate attending to the behavioral health needs of youth in a family-centered, community-based model maximizes positive change and reduces the likelihood of readmission to services to recidivism with the court. Typically, DCBHS recommends community-based treatment services to the court, including other community based treatment programs and informal supports, rather than out-of-treatment options.

In the course of proceedings involving juvenile delinquency matters or family crisis petitions, the court may learn that the child involved exhibits behavior suggesting a need for emotional, behavioral, or mental health services. When this becomes apparent at any point in court proceedings, the court may order DCF to submit a service plan to the court within 14 days (14 Day Plan) that assesses the needs of the child and the family and details how those needs may be met.

This document sets forth a protocol delineating the roles and responsibilities of DCF and the court in ordering, completing, and executing 14 Day Plans. This protocol is applicable to all cases involving children and families in need of mental health assessments and is consistent with the protocol issued by the Administrative Director of the Courts on May 17, 2005 regarding mental health assessments of juveniles in detention. This protocol was collaboratively developed

[1] Revised to reflect the new statute limiting disclosure clinical information prior adjudication.

and has been endorsed by the Conference of Family Presiding Judges. The language of the protocol was jointly prepared by the Judiciary and DCF in order to accommodate recent organizational changes at DCF.

II. PRINCIPLES

The Judiciary and DCF have agreed to the following principles concerning the evaluation of children and families with apparent emotional or behavioral health needs.

A. Judiciary

1. Under ordinary circumstances, when seeking to identify emotional or behavioral health needs, the court should order only DCF to prepare the 14 Day Plan and to identify service needs. The court should generally resist the temptation to identify more specific case management entities within DCF, (e.g., DCBHS, DYFS, CMO, YCM, Value Options, etc.) The court should avoid ordering DCF to conduct specific and multiple assessments when ordering the 14 Day Plan such as psychological, psychiatric, and neurological recognizing that the determination of an appropriate evaluation is a clinical activity in and of itself.

2. The court's initial order should not specify a presumed level of care. This protocol works best when DCF, through its use of clinically licensed practitioners, exercises its function by identifying needs and provide the court with an appropriate proposed plan on the basis of those needs.

3. In cases in which out-of-home treatment is clearly required, the court should order the development of a plan that provides for DCF out-of-home treatment, rather than specify a particular treatment facility or presumed level of care.

4. In a situation in which the court has ordered out-of-home treatment but the case manager suggests another viable option exists to meet the needs of the child and family, the court should consider either modifying its order or allowing concurrent pursuit of both the court-ordered plan and the suggested alternative. While the court maintains the final authority to determine the proper disposition, the court should give fair consideration to proposed plans that provide for community based services (rather than out-of-home treatment options), so long as the issue of the community safety is addressed.

B. DCF

1. The DCF Court liaison is responsible for communications between the court and DCF and its component divisions. A DCF Court liaison had been designated in each county and is responsible for reviewing court orders and routing each such court order to the appropriate agency.

2. The 14 Day Plan must specify the level of need and the services that will be required and include a specific time frame for the initiation of services.

3. If case management entities have difficulty engaging a youth and/or family in developing the 14 Day Plan, staff must immediately notify the court of the situation while continuing to pursue development of a response to the court's order to the extent possible. The court may

compel the parents or child to cooperate or may direct completion of the plan without their cooperation.

4. On the rare occasion that a court order contradicts a clinical decision, the order must be recognized as an exception and nevertheless be aggressively pursued. Thus, DCF authorizes staff of DYFS and DCBHS contractors and providers listed below to comply with the provisions of the court order as they relate to out-of-home treatment settings. It is the responsibility of the assigned staff to take steps to ensure compliance with the order of the court.

III. PROCEDURES

The Judiciary and DCF, through its management contractors and service providers (see below), have agreed to the following procedures concerning the evaluation of children and families with apparent emotional or behavioral health needs.

DCBHS contractors include:

- Contracted System Administrator (CSA) – Coordinates the care needs of children and their families across all child-serving systems.

- Youth Case Management (YCM) – Provides case management services for children and families with moderate behavioral and emotional health needs. In Camden, Essex, and Middlesex counties, YCM services are provided by the Youth Advocacy Program or the Detention Alternative Program (YAP/DAP). YCM is also an authorized referral source for out-of-home treatment settings.

- Care Management Organization (CMO) – Provides individual case management for children and youth with complex behavioral and emotional health needs.

A. Judiciary

To refer children and families with emotional and behavioral health needs for services in the context of determining and exercising the Courts imperative to ensure community safety :

1. Judges should order the completion of a 14 Day Plan and forward the order to the DCF Court Liaison.

2. Court staff will share available information with the appropriate case management entity as determined by the DCF Court Liaison.

3. The court will enforce parental participation if necessary.

4. The court will give serious consideration to any alternative plans proposed by the appropriate case management entity that address the needs of the child as well as the concerns of the court.

B. DCF Court Liaison

The DCF Court Liaison will review the court order and route the order to the appropriate case management entity based on the following criteria:

1. The DCF Court Liaison will transmit court orders with referrals for protection and permanency issues where DYFS has current involvement with the child's family to the DYFS Local Office, where a DYFS worker will prepare the 14 Day Plan.

2. The DCF Court Liaison will transmit court orders with referrals for emotional or behavioral issues—but with no protection or permanency issues—to the YCM supervisor to prepare the 14 Day Plan.

3. In the cases where the court order includes referrals for both protection/permanency and emotional/behavioral needs, the DCF Court Liaison will transmit the court order to the appropriate DYFS Local Office where a DYFS worker will prepare the 14 Day Plan.

4. In some cases, the court will order DCF to effect an out-of-home placement at the inception of the 14 Day Plan. The DCF Court Liaison will direct these cases to the appropriate DCF entity for preparation of the 14 Day Plan.

C. Youth Case Management (YCM)/Care Management Organization (CMO)

The case management agencies contracted by DCBHS, Youth Case Management (YCM) and Care Management Organization (CMO), should observe the following procedures:

1. The YCM/CMO supervisor or designee reviews the referral received from the DCF Court Liaison,
assigns the child and the family to a youth case manager, and notes in the record that a delinquency charge is pending. The DCBHS contracted case management entity will send a letter to the attorney representing the juvenile indicating the contracted case management entity's involvement with the family. The case manager assigned will register the child and family with the Contract Systems Administrator (CSA) by calling the CSA Customer Services Representative at 1-877-652-7652.

2. YCM/CMO will complete the Presumptive Eligibility process with the child and family.

3. YCM/CMO will complete the Needs Assessment and develop a Service Plan to meet the needs of
the child/family and arrange for appropriate services when necessary.

4. YCM/CMO will contact the Family Court and gather information necessary to complete the Needs
Assessment.

5. Prior to the adjudication of delinquency or finding of guilt, YCM/CMO will submit the Service Plan

to the attorney representing the juvenile within 14 days. However, an attorney representing a juvenile, with the juvenile's consent, may disclose the Service Plan and other such reports or records prior to the adjudication of delinquency or finding of guilt. See *N.J.S.A.* 2A:4A-60.3

6. YCM/CMO maintains primary responsibility for the completion of the Needs Assessment; the planning process will not depend exclusively on the information provided by the court.

7. YCM/CMO will coordinate the Service Plan process and arrange for delivery of services to the child.

8. YCM/CMO can seek assistance from the court if there is a lack of parental cooperation.

9. YCM/CMO will respond to any specific orders or directions from the court.

10. YCM/CMO will electronically submit the Needs Assessment and the Service Plan to the CSA for review and authorization after review and approval by the court.

11. YCM/CMO will use the "One Tab" Service Request Form and will enter any additional information regarding the Service Plan into Progress Notes, the DCF case record system.

12. YCM/CMO will have responsibility for implementation of the Service Plans for children and families with moderate needs. When YCM/CMO continues providing services to a child and family, the CSA will authorize YCM/CMO services for a period of no more than 90 days.

13. When YCM determines that the child and family require a higher level of case management services, YCM will contact the CSA and request that the child be referred to the CMO for case management services. If the CMO is not available, the YCM will retain responsibility.

14. YCM in conjunction with the Family Team, as designated by YCM, may request an extension of youth case management services beyond the initial 90-day authorization via an electronic submission of a Strengths and Needs Assessment and an updated Service Plan within two weeks prior to the authorization expiration date.

15. Whenever DCF services are part of a disposition, the case management entity must notify the court or probation if services are being terminated, for whatever reason.

D. Contracted Systems Administrator (CSA)

CSA, which determines appropriate level of care and authorizes appropriate services for children, adolescents and their families across all child-serving systems, should observe the following procedures.

1. CSA will register the child, check eligibility, and enter the authorization(s).

2. CSA will authorize 14 units of services for a period of time not to exceed 90 days from the date of registration.

3. CSA will give the YCM access to the child's Absolute-MIS case record at the time of registration.

4. CSA will review the Clinical Evaluation and Needs Assessment and call the YCM with any questions.

Process to Access Children's System of Care
Evaluations in Detention

1. The Detention Social Worker or designee decides which youth need evaluations.
a. A release of information is obtained (if not court ordered)

b. The CSA Member service specialist (MSS) is called at 1-877-652-7624 to register the child./youth. They will also do the following:

c. Inform the MSS that he/s is requesting authorization for a clinical evaluation for a child/youth that is presently in detention.

d. Give the MSS the youth's first and last names, date of birth, social security number (if available) and Medicaid number (if available)

e. Give the MSS the name, Medicaid number, telephone number and fax number of the provider who will complete the assessment (see attached list of providers)

f. Give the MSS their name and a phone number they can be contacted. Provide additional information (including name of attorney and contact information). Simultaneously fax the request.

** g. This information can also be faxed to the CSA at secure fax (609 689 5435) with name and ID of provider. Please fax copy of request to the provider once authorization is received so they are aware of the request. The youth's name will be clearly printed OR TYPED on form to avoid misspelling/misidentification in CYBER

h. The requestor calls(or faxes request to) the provider to notify that request for BPS has been made, and to schedule the evaluation.

2. The CSA MSS will:

A. Check authorizations/ tracking element in youth/s CYBER record-.

Requests for BPS evals will be denied if:
-There is active CME
-Youth is on Youth Link for less than 90 days
-2 BPS evals have been authorized and submitted within last 12 months
-MST/FFT has current authorization and SNA has been submitted

Notification of active CME/non authorization of BPS faxed back to Detention

B Create an authorization to the chosen provider, for 3 hours of Intensive in Community services for a licensed clinical behavioral healthcare provider.
Progress note is entered to show request

C Give the provider an authorization number.

D Fax the authorization number to the provider who will complete the assessment, and to the Detention Center/requestor.

E review the submitted evaluation within 5 business days

3. The provider will complete the BPS evaluation once authorization number is received, and electronically submit the completed bio psycho social evaluation to the CSA within 5 business days of receiving the referral

A The provider will ensure information on face sheet is correct, including name, DOB, youth's current location, family address, name of parent/guardian. Provider will update information on face sheet if needed.

B The evaluation will include:
- At least 2 collateral contacts (including parent/guardian,defense attorney, Detention social worker)
- Axis 1 Diagnosis
- Clinical recommendations showing intensity, frequency and duration of treatment
- Provider is NOT to include youth's statements regarding his alleged offenses on pre adjudicated youth, although charges may be listed

C The provider will obtain appropriate signatures on release of information form. In some counties, the defense attorneys will have parents sign the consent forms while in Court, and fax to Detention

4. The provider will fax the completed the assessment and supporting documentation to the Detention Center, Public Defender and pertinent case manager (if known).

PROTOCOL FOR SUPERVISION OF JUVENILE PROBATIONERS COURT-ORDERED TO ATTEND AND COMPLETE A DCSC SPECIALTY SERVICES PROGRAM

The following protocol was developed in a collaborative work group comprised of representatives from the Department of Children and Families/ Division of Children's System of Care, Specialty Service Providers and the Judiciary Probation Division. It is recognized that Specialty Services Programs address particular treatment needs of youth whose needs are beyond the "traditional" complement of services. These youth, who may be ordered into such programs by the Family Court as a condition of Probation, exhibit sexual aggression, fire-setting, extreme violent behaviors and effects of complex trauma. Cooperation and understanding between the treatment providers and Probation Officers is crucial to the youths' successful reintegration with their families and communities. This protocol addresses key areas of initial and on-going communication between probation, the families, and the treatment providers to ensure a unified approach in addressing the needs of these youth during placement and in aftercare planning.

1. **Conditions of probation, which include the special condition to complete the treatment program, must be explained to the juvenile and parent/guardian and signed by all. If the juvenile goes to the program directly from detention, the shelter or an alternative detention program, the assigned Probation Officer (PO) must make arrangements to have the conditions explained and signed as quickly as possible.**

2. **Within 5 business days of the juvenile's entrance into the program, the PO must contact the program either by phone or e-mail to exchange contact information. All program contact information should be entered into CAPS. The program should be provided the phone numbers and e-mail addresses for the assigned PO and Supervisor as well as the address for correspondence/payments (including CAPS Case #). The PO should ensure that the program has the court order, signed conditions of probation, and any other court documents needed for the placement. The program should include Probation on consent forms that are signed at the time of admission and should notify Probation of all Child Family Team meetings and upcoming home visits and forward copies of all progress reports to the PO. The Child Family Team consists of the youth and the adults in that youth's life who will assist in the success of the treatment plan including but not limited to the parents/guardians, clinician, PO, and care manager.**

3. **The assigned PO should consult with the Youth Case Manager during Probation Intake in order to gather additional information about the juvenile/family situation. The initial home inspection should be completed before the juvenile comes home for their first visit.**

4. **The program or DCF care manager will provide the parent/guardian with the name and phone number of the treatment provider for their child. During the initial supervision contact, the assigned PO should ensure that the parent/guardian has this information. Parents should be encouraged to participate in the treatment protocol which normally includes Child Family Team meetings, scheduled visits to the program, and may include home visits for their child.**

5. **It should be stressed to the parent/guardian by both Probation and the Care Manager that the PO will work in collaboration with the youth, parent/guardian, and program to achieve a successful outcome. It should be explained that the PO may take part in Child Family Team meetings, will receive progress reports; will be apprised of behavior (both positive and negative) and will be notified of home visits. The parents/guardian should be advised that the PO will also maintain contact with them while their child is in placement. The PO may conduct a home visit when the probationer is home from the program on a home pass. Parents should be encouraged to report all behaviors, positive and negative, to probation following a**

home visit. While the probationer is in program, home inspections and home visits may be conducted as determined by the supervision plan.

6. **The parent/guardian should be advised that they may contact the PO/supervisor if they have concerns that cannot be addressed with the program or during Child Family Team meetings.**

7. **A minimum of once per month, per Outcome-Based Supervision Standards, the PO must monitor and document the probationer's progress. Every effort should be made to visit the program in-person but contact should also be made via telephone contacts to the treatment provider. Routine and on-going contact with the program ensures that interaction with Probation is not triggered by non-compliance rather it is an ongoing collaboration to achieve a positive outcome for that juvenile.**

8. **Every effort should be made for POs to attend the Child Family Team meetings in-person. When personal attendance is not possible, the PO should utilize video or phone conferencing or the assistance of a proxy PO as appropriate.**

9. **Probation should make every effort to assist program staff. This includes collaborating with assigned program staff to reward the probationer for progress and to counsel the probationer to come into compliance. While the juvenile is in placement, the PO may also assist by securing needed documents, contacting the parent/guardians, verifying or assessing the residence, or assisting to contact community agencies.**

10. **The PO is the point of communication between the program and the Courts. The PO will ensure that the Judge is apprised of issues as appropriate. The program will send all correspondence to the PO and not directly to the Judge unless otherwise ordered by the court. If a youth has a scheduled Court date on open charges, the correspondence is also sent to youth's defense attorney.**

11. **It is expected that program staff will address problem behavior by utilizing their approved interventions and sanctions. The PO should be kept informed of behavior and follow-up plans, however the PO should not be expected to file a VOP or request a bench warrant to have the probationer removed. In some circumstances, the PO, after consulting with the supervisor, may suggest an Administrative Review as an effort to address problem behavior. An Administrative Review is a formal scheduled meeting in the Probation office with the juvenile, parent/guardian, program treatment provider, probation officer and supervisor/manager. The purpose of the Administrative Review is to clarify expectations and consequences and to give the juvenile an opportunity to correct problem behavior. The program will transport the juvenile to and from the Probation office. If the program treatment provider is unable to attend the Administrative Review in-person, he or she should be available via conference call.**

12. **A decision will be made through the Child Family Team whether or not the juvenile can continue to be maintained at that program. Before any decisions are made regarding the placement status however, the provider must first follow the DCSC protocol ("No Eject/No Reject") to determine that all clinical interventions have been tried. If it is decided by the Child Family Team that a different program is needed, a Transitional Joint Care Review (TJCR) will be completed by the program and submitted to contract systems administrator (CSA). The care manager will enter a progress note stating they are in agreement with the TJCR. This will place the youth back on the Youth Link "bulletin board" pending transition to the next program.**

The program is expected to maintain the probationer in their program until an alternate program is secured.

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13. **If the probationer commits a new offense, the law enforcement officer filing the complaint will follow the normal procedure for detention. The next business day, the program will notify the PO of the new offense and any pertinent details surrounding the incident. If the offense did not meet detention criteria, the PO should not automatically be expected to request a bench warrant to have the probationer removed; rather the situation will be reviewed in consultation with the Child Family Team members and in consideration for the safety of the probationer, program staff, other program participants and members of the community.**

14. **If the probationer leaves the program without permission and his/her whereabouts are known to the program staff and parent/guardian, the PO should be notified immediately and every effort should be made to return the youth to the program. If the youth is not returned or refuses to return and the program decides to discharge the youth per Medicaid regulations, an incident summary will be forwarded to the PO. A VOP or court review may be requested depending on the circumstances.**

15. **If the probationer leaves the program without permission and his/her whereabouts are unknown to program staff and parent/guardian, the program will immediately make reasonable attempts to locate the juvenile by contacting family and known associates, utilizing the assistance of the Youth Case Manager, CMO, DYFS, UCM or other authorities. If the youth has not returned or cannot be located within 3 hours, the program should follow protocol for reporting the youth as a missing person and should also notify the PO at that time. Upon notification, the PO may make additional reasonable attempts to locate the juvenile. The program will forward an incident summary report to the PO by the next business day. If the youth's whereabouts remain unknown at the time the PO receives the incident summary report, a VOP will be filed and a warrant will be requested at that time.**

16. **It should be noted that the Transitional Joint Care Review (TJCR) is also utilized when a juvenile has completed a particular program and is clinically appropriate for a step-down placement. The supervising PO should be involved in the team meetings for this discussion.**

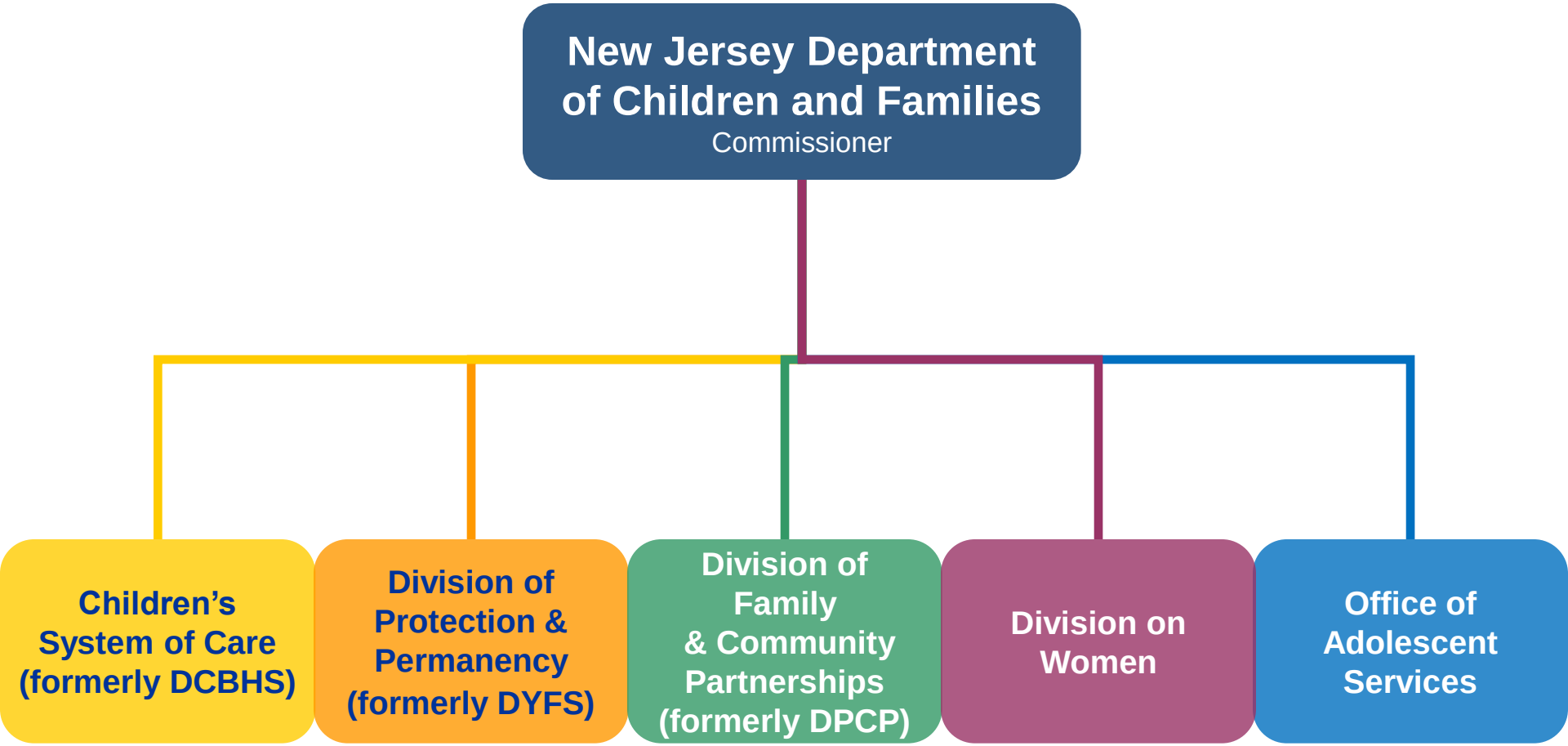
17. **The aftercare planning should begin a minimum of 90 days before release. The PO should be actively involved in aftercare planning, not limited to: identifying community resources; assessing the most current living situation; linking with the school; and developing a case plan consistent with identified aftercare needs and safety plans and ensuring that Megan's Law registration requirements are met. Upon discharge, program staff will supply the PO with a copy of the Discharge Summary and Aftercare Plan, including dates of any appointments which have already been scheduled. A Probation reporting date should be established prior to discharge and incorporated into the scheduled appointments. Upon the probationer's return to the family, the supervision level should be "CLOSE" for a minimum of 30 days in order to support the Aftercare Plan and assist the probationer to make a positive adjustment. The PO/supervisor will assess the youth's progress after 30 days to determine the appropriate supervision level. Specialized supervision cases will remain at close supervision. Coordination may also be made with the local multi-disciplinary team to support the juvenile's needs and the availability of resources.**

Approved: Juvenile Probation Managers 3-27-12
Approved: Conference of Chief Probation Officers 3-28-2012
Approved: DCSC representative Specialty Programs 4-17-12
Approved Juvenile Cmte of Family PJs 6-5-2012
Approved Conference of Family Presiding Judges 6-13-2012

Accessing Services for Youth through the Children's System of Care

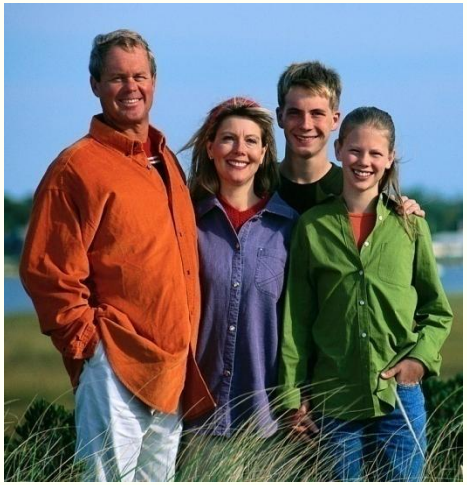
Kim Maloney
Children's System of Care
(609) 888-7200

NJ Department of Children and Families

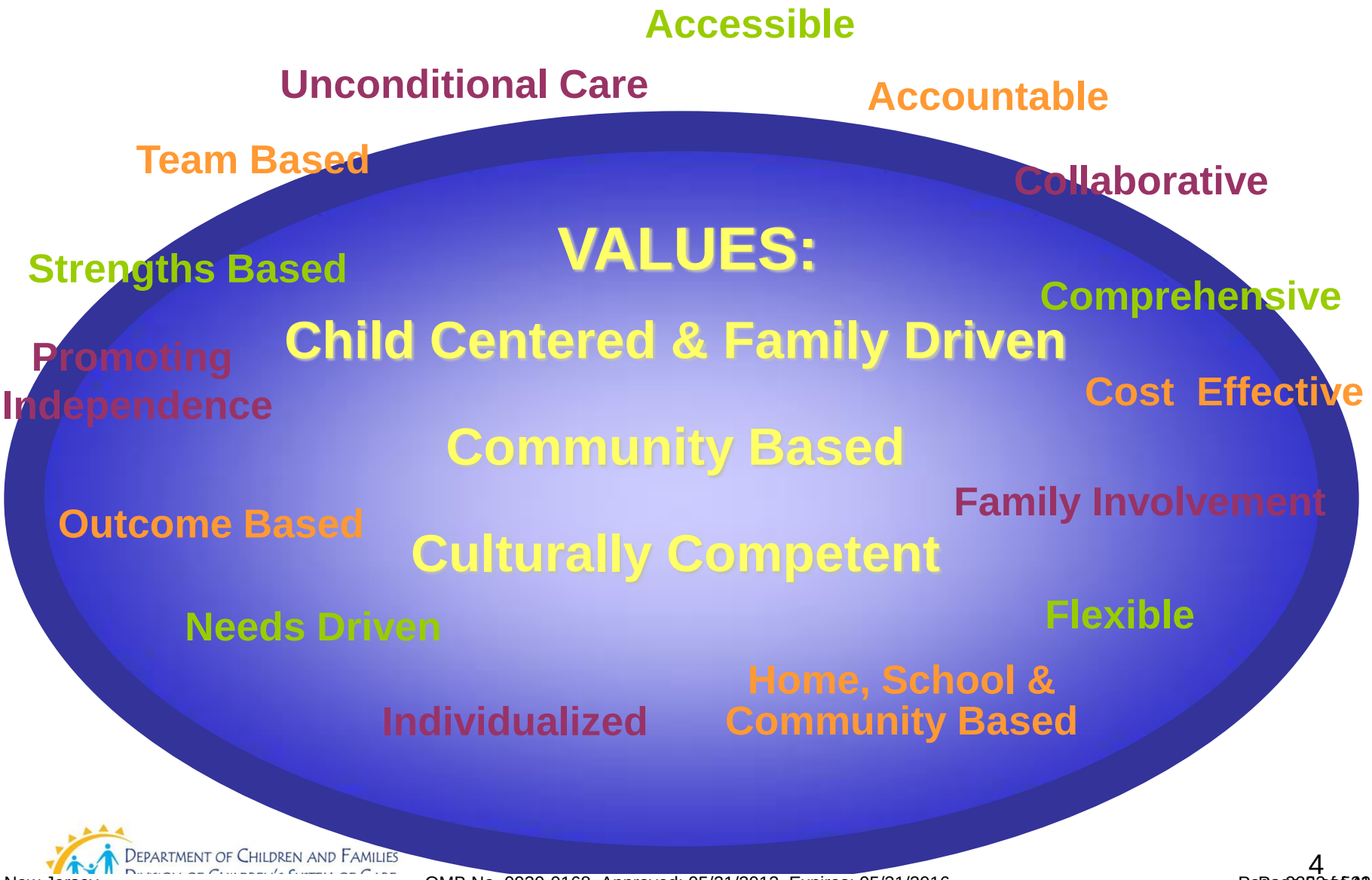


CSOC Mission

DCF's Division of Children's System of Care (CSOC) serves children and adolescents with emotional and behavioral health care challenges and their families; and children with developmental disabilities. CSOC is committed to providing these services based on the needs of the child and family in a family-centered, community-based environment.



Children's System of Care Values and Principles



Children's System of Care Objectives

We want to keep kids…

At Home

(with their families and not in out-of-home treatment settings)

In School

(in their regular school in their school district)

In the Community

(and not involved with the Juvenile Justice System or at risk of detention or incarceration)

PerformCare is Contracted Systems Administrator (CSA) for CSOC

PerformCare functions as the single point of access for youth into the Children's System of Care.

CSA authorizes services, based on the most recent clinical information that is submitted to them.

CSA does not provide direct services.

Anyone helping children and families may contact PerformCare on behalf of a youth in need of a referral. **However, the parent/legal guardian of the youth must give consent for services.**

CSA responsibilities include:

- Providing 24-hour/day, 7 days/week availability
- Coordinating access to services for all eligible youth
- Helping youth obtain any necessary specialized behavioral health services
- Supporting the CSOC goals of promoting best practices and assisting the state in assuring compliance with state and federal guidelines
- Offering complaint, reconsideration, and appeal processes

Treatment Options

In Community

- Outpatient – individual, group and family
- Partial Care
- Partial Hospitalization
- Intensive In Home – IIC
- Behavioral Assistance
- Mobile Response & Stabilization Services
- MST and FFT

Out of Home Treatment*

- Treatment Home
- Group Home
- Residential Treatment
- Specialty Program
- Psych Community Residence
- Intensive Residential Treatment Services
- CCIS / Inpatient Hospital

*** Intensity of Service** is the level of OOH treatment based on *intensity*, *frequency*, and *duration* of treatment.

Referral process

- For youth with complex behavioral health needs and in need of care coordination, a Needs Assessment, along with updated clinical evaluations, is faxed to PerformCare for review.
- Recommendations for services can include Care Management with OOH treatment or Care Management alone to transition the youth back into the community. Recommendations must be clinically supported by attached documents
- Perform Care will conduct clinical review of documents within five business days of receipt.
- JJC SW should contact Perform Care to determine outcome of clinical review.

Referral process

- Referrals for DCSOC services must be within the following timeframes:
- DCSOC Out of Home treatment: within 90 days from expected discharge
- DCSOC community based services via Care Management: within 45 days from expected discharge
- Concurrent planning for both community and out of home services is desirable.

Inclusionary Criteria:

- Youth is identified with moderate to severe behavioral and mental health needs, requiring service coordination to access behavioral health care treatment such as psychotherapy and or psychiatric medication management.
- Aggressive behavior primarily towards family is seen as reflective of a family treatment need and so Care Management may be appropriate. Aggression towards others may not necessarily indicate referral for mental health treatment, and this would be reviewed within the context of all identified behavioral health needs.
- Care Management Expectations:
- Initial Service Planning:
- Care Management shall begin interaction with the youth and family before release from the JDC or JJC facility.
- Care Management shall participate in case planning meetings with JJC staff at which time services would be identified and coordination processes be established

General Exclusionary Criteria for DCSOC Care Management

The youth meets criteria for MST; JJC should refer directly to MST

- Youth requiring anger management treatment only
- Youth requiring mentoring services only
- Sole need is vocational or finding a job
- Youth is refusing consent for behavioral health services
- Youth has a primary treatment need of substance abuse
- Youth is about to age out of DCSOC services and has a Serious and Persistent Mental Illness (SPMI) that may warrant a referral for Adult Intensive Care Management Services (ICMS). Please note that youth referred to ICMS must have a stable living environment (i.e. not in need of OOH treatment).
- Referral to treatment mandated by the court with no identified behavioral health needs (youth's needs do not warrant care management)

MST

If youth meets criteria for MST, JJC may refer directly to these providers.

- ***Center for Family Services***
  (Camden County)
  Program Capacity: 30
  Contact Person:
  Carolyn Gribbin, MST Director
  (856) 964-1990

- ***Community Solutions, Inc.***
  (Hudson and Essex Counties)
  Program Capacity: 20 per each county
  Contact Person:
  Karen Fennell, Interim MST Program Director
  (973) 297-0500

FFT

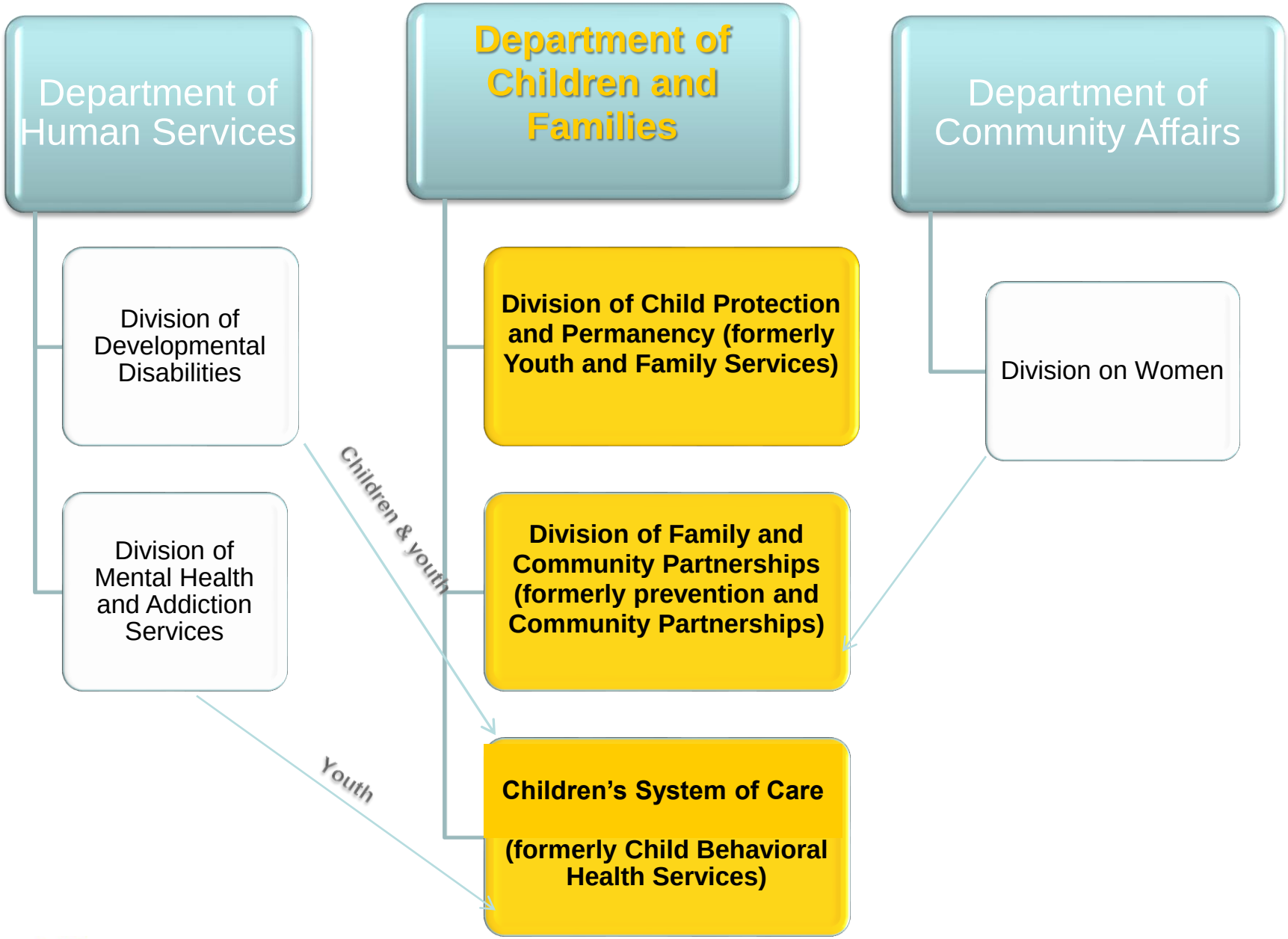
- ***Cape Counseling and Jewish Family Services***
  (Atlantic and Cape May Counties)
  Program Capacity: 42
  Contact Person:
  Anne Adamson, FFT Coordinator
  (609) 465-4100

- ***Community Treatment Solutions***
  (Burlington, Ocean Counties, and Mercer)
  Program Capacity: 30
  Contact Person:
  Dr. Mario Tommasi, Vice President, Clinical Affairs
  (856) 642-9090 (Ext. 242)

- ***Robins' Nest***
  (Cumberland, Gloucester and Salem Counties)
  Program Capacity: 41
  Contact Person:
  J.R. Griffin, LCSW, Program Director
  856-589-0046 (Ext. 105)

The Way Forward

Becoming a Comprehensive Child and Family Service Agency


Department of Human Services
Department of Children and Families
Department of Community Affairs
Division of Developmental Disabilities
Division of Mental Health and Addiction Services
Division of Child Protection and Permanency (formerly Youth and Family Services)
Division of Family and Community Partnerships (formerly prevention and Community Partnerships)
Children's System of Care
(formerly Child Behavioral Health Services)
Division on Women
Children & youth
Youth

Children's System of Care

Reasons for Restructuring

- Synchronized service coordination; elimination of duplicated services
- Support sustainable communities and balanced resource coordination
- Proposed integration of children and family-related services housed in other State Departments
- Selected services that further current progress and achievement of strategic objectives of the DCF

Children's System of Care

Supporting children with developmental disabilities

- As of July 1, 2012, residential services transitioned to the DCF Children's System of Care
- In 2013, the Children's System of Care will assume greater responsibility for serving youth with developmental disabilities
  - Determining eligibility for developmental disability services
  - Authorizing and providing residential services
  - Authorizing and providing family support services

Children's System of Care

Eligibility Determination

Beginning on 1/1/13 eligibility for CSOC Functional Services, (formerly known as DDD services) will be determined by CSOC. An application and instructions for applying for CSOC Functional Services will be available on the PerformCare website. A youth must have a developmental disability, meet the minimum requirements of being a New Jersey resident and US citizen; and be under the age of 18.

Children's System of Care

Oversight of Youth with Developmental Disabilities

- Below age 21 – DCF-Children's System of Care
- Age 21 and older – DHS-DDD
- Opportunity for meaningful and coordinated transition planning and seamless transition into adult services prior to 21st birthday

Children's System of Care

Who to Contact for Services for Children with Developmental Disabilities

- DDD eligibility
  Contact DDD (1-800-832-9173) until at least January 2013 to apply for DD services
- Residential Services
  Contact child's current DDD case manager until family receives formal notice that child has a CSOC case manager
- DDD Family Support Services
  Contact DDD Regional Offices until at least January 2013

Children's System of Care

Adolescent Substance Abuse Programs

- The programs currently funded by DMHAS will be transferred to DCF in or around June 2013.
- These include both inpatient and outpatient programs.
- Current referral process to these programs will remain the same until the contracts are transferred to DCF.

Children's System of Care

Unified Care Management Organizations

- Children's System of Care will have a UCMO in every County by 2013.
- Unification was recommended by families and the USF independent assessment of our system in 2006-07.
- UCMO will provide one care manager to a family with children who may have different clinical needs and ensure seamless care coordination.

Children's System of Care

DCF website:

http://www.state.nj.us/dcf/

PerformCare Member Services:

1-877-652-7624

www.performcarenj.org

Community Resource Directory:

http://njmhc-portal.communityos.org/taxonomy/taxonomy_overview.taf

IV: Narrative Plan

J. Parity Education

Narrative Question:

SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action states can develop communication plans to provide and address key issues. SAMHSA is in a unique position to provide content expertise to assist states, and is asking for input from states to address this position.

Please answer the following questions:

1. How will or can states use their dollars to develop communication plans to educate and raise awareness about parity?

2. How will or can states coordinate across public and private sector entities to increase awareness and understanding about benefits (e.g., service benefits, cost benefits, etc.?

3. What steps and processes can be taken to ensure a broad and strategic outreach is made to the appropriate and relevant audiences that are directly impacted by parity?

Footnotes:

J. Parity Education

1. How will or can states use their dollars to develop communication plans to educate and raise awareness about parity?

   DMHAS is addressing consumer access to prevention, treatment and recovery service changes and opportunities resulting from the passage and implementation of the Mental Health Parity and Addictions Equity Act (MHPAEA) and the Affordable Care Act. The need to raise consumer, provider and policy maker awareness of the changes in health insurance coverage and the implications of those changes for client choice, service utilization and access to quality preventive, treatment and recovery services is being addressed through internal staff presentations, external public forums, contractual language, the DMHAS website and our planned statewide Newsletter.

   To meet the challenges and pace of healthcare system change, DMHAS is currently integrating its public information, community relations and digital media resources as an information management and knowledge building project between internal and external stakeholders. The focus is on system change, client advocacy, health literacy and special population needs.

   For more information, please refer to: http://www.samhsa.gov/healthreform/parity/

2. How will or can states coordinate across public and private sector entities to increase awareness and understanding about benefits (e.g., service benefits, cost benefits, etc.)?

   DMHAS is currently integrating its separate Mental Health and Addiction Services websites to reflect the merger of the Divisions. The merged website will include access to public and private sector marketing and education resources addressing healthcare system change in the areas of mental health parity and addictions equity and healthcare reform policies. All public information channels are being reviewed to support a client centered approach, health literacy principles, and access to integrated services in the areas of prevention, treatment and recovery.

   DMHAS will be developing a mental health and addictions statewide newsletter that will include consumer advocacy resources, healthcare system change updates, and healthcare reform success stories and challenges. The newsletter will be online as well as disseminated directly to DMHAS staff, DMHAS contractees, public and private mental health and addictions providers and policy makers.

   The New Jersey Association of Mental Health and Addiction Agencies, a DMHAS stakeholder group, will continue to make information regarding parity available to agencies to increase awareness and understanding about benefits.

   NAMI New Jersey, The Mental Health Association of New Jersey, the Community Health Law Project and Disability Rights New Jersey work individually and in various coalitions to increase awareness and understanding about the MHPAEA and the Affordable Care Act by

providing public education, information and referral and advocacy services to consumers and their families.

3. What steps and processes can be taken to ensure a broad and strategic outreach is made to the appropriate and relevant audiences that are directly impacted by parity?

   DMHAS will post on its website parity information, updates on service improvements and resources available to support individuals and families in need of mental health and addiction services.

   DMHAS will continue to work with its network of community stakeholders and advisory groups, including its Citizens Advisory Council (CAC) and the Mental Health Planning Council, to receive input on the client specific and the local community focused content for its public relations, public information, client advocacy and digital media projects.

   As stated above, the New Jersey Association of Mental Health and Addiction Agencies, NAMI New Jersey, the Community Mental Health Law Project, and Disability Rights New Jersey are stakeholder groups that will continue to make information regarding parity available to agencies to increase awareness and understanding about benefits. In addition, as more information becomes available specific to New Jersey, presentations can be made at the New Jersey Mental Health Planning Council to advise members (who in turn advise their own networks) regarding parity updates. These meetings are open public meetings and have a broad reach.

IV: Narrative Plan

K. Primary and Behavioral Health Care Integration Activities

Narrative Question:

Numerous provisions in the Affordable Care Act and other statutes improve the coordination of care for patients through the creation of health homes, where teams of health care professionals will be rewarded to coordinate care for patients with chronic conditions. States that have approved Medicaid State Plan Amendments (SPAs) will receive 90 percent Federal Medical Assistance Percentage (FMAP) for health home services for eight quarters. At this critical juncture, some states are ending their two years of enhanced FMAP and returning to their regular state FMAP for health home services. In addition, many states may be a year into the implementation of their dual eligible demonstration projects.

Please answer the following questions:

1. Describe your involvement in the various coordinated care initiatives that your state is pursuing?

2. Are there other coordinated care initiatives being developed or implemented in addition to opportunities afforded under the Affordable Care Act?

3. Are you working with your state's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHC), other primary care practices and the publicly funded behavioral health providers?

4. Describe how your behavioral health facilities are moving towards addressing nicotine dependence on par with other substance use disorders.

5. Describe how your agency/system regularly screens, assesses, and addresses smoking amongst your clients. Include tools and supports (e.g. regular screening with a carbon monoxide (CO) monitor) that support your efforts to address smoking.

6. Describe how your behavioral health providers are screening and referring for:

   a. heart disease,

   b. hypertension,

   c. high cholesterol, and/or

   d. diabetes.

Footnotes:

K. Primary and Behavioral Health Care Integration Activities

1. Describe your involvement in the various coordinated care initiatives that your state is pursuing?

   New Jersey is pursuing multiple initiatives designed to promote and provide integrated care. These initiatives are being developed at the state and provider level. The initiatives below are those in which DMHAS is involved.

   In October 2012, NJ received CMS approval of the state's Comprehensive Medicaid Waiver. There are multiple initiatives within the waiver designed to integrate services, including the transition of the current behavioral health care system from a cost-based and fee-for-service system to a coordinated and managed system through the procurement of an Administrative Services Organization (ASO). It is anticipated that NJ's ASO will coordinate with the current Managed Care Organizations (MCO) that manage the medical benefits for the state's Medicaid enrolled individuals. The ASO and MCO's are expected to share data, coordinate referrals, and work jointly on outcomes. DMHAS and DMAHS Medicaid are working jointly to design, procure and ultimately implement an ASO. The two Divisions are also working jointly to amend the current Medicaid MCO contracts to ensure their collaboration with the ASO.

   New Jersey has legislation that requires Medicaid to establish a three year Medicaid ACO demonstration project. The regulations for the ACOs are being developed now. NJ Medicaid has solicited DMHAS's input on these regulations. The regulations have not been adopted and are moving through the state's regulatory process. As of this writing, the regulations state that each ACO will be required to include four behavioral health agencies.

   DMHAS and DMAHS are collaborating to develop a Medicaid State Plan Amendment (SPA) for the development of Behavioral Health Homes through Section 2703 of the Affordable Care Act. The Health Homes developed through this SPA will focus on providing this service to individuals who are DD and/or MI.

   In July 2012, SAMHSA awarded the DHS a five-year $7.5 million cooperative agreement for SBIRT services. Entitled NJ SBIRT, the project is a partnership between the DMHAS and the Henry J. Austin FQHC, a partner organization of the Trenton Health Team, Inc. (THT), a community health improvement collaborative serving the city of Trenton, NJ and its surrounding areas. NJ SBIRT aligns with and supports the THT's mission to transform healthcare by forming community partnerships to expand access to high quality, coordinated healthcare. Specifically, NJ SBIRT seeks to expand and enhance the existing continuum of care by integrating evidence-based services, proven effective in reducing substance use and associated negative health consequences, in primary care and community health settings.

2. Are there other coordinated care initiatives being developed or implemented in addition to opportunities afforded under the Affordable Care Act?

   New Jersey DMHAS is working in collaboration with the New Jersey Department of Health to integrate existing regulations. The NJ Department of Health has asked DMHAS to

develop basic behavioral health standards that can be added to existing medical ambulatory regulations. These standards would signify that an ambulatory clinic has the ability to identify behavioral health treatment, provide basic behavioral health treatment and refer to the behavioral health specialty providers when that is required.

3. Are you working with your state's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHC), other primary care practices and the publicly funded behavioral health providers?

   As indicated in item 2, New Jersey DMHAS is working in collaboration with the New Jersey Department of Health to integrate existing regulations. The NJ Department of Health has asked DMHAS to develop basic behavioral health standards that can be added to existing medical ambulatory regulations. Through this integration, individuals who are assessed by FQHCs as needing a higher level of care than can be provided will be referred to behavioral health specialty providers. This is expected to lead to enhanced and more formal relationships between the FQHCs and behavioral health provider community.

4. Describe how your behavioral health facilities are moving towards addressing nicotine dependence on par with other substance use disorders.

   All state psychiatric hospitals are smoke-free. Learning About Healthy Living, a manualized treatment program for smoking cessation, has been implemented at all state psychiatric hospitals. Staff have all been trained in Nicotine Replace Therapy. In addition, peer tobacco advocates through the DMHAS funded CHOICES Program have had a strong presence at the state psychiatric hospitals. They conduct brief peer-to-peer interventions and conduct carbon monoxide readings with consumers who are patients at the hospitals. The peer tobacco advocates also participate in health fairs and other special initiatives related to tobacco dependence.

   DMHAS began funding a Smoking Cessation Program for all of our inpatient addictions programs in November 2011. These programs continue to be provided with technical support for both staff and clients. Programs were issued carbon monoxide monitors and staff were instructed in the use of the instruments. Additionally, the staff have been conducting nicotine assessments, providing Nicotine Replacement Therapy (NRT) - patches, lozenges and gum) and providing motivational interviewing. Free counseling services and NRT were made available to nicotine dependent staff as well as clients. The majority of these residential programs are now addressing nicotine dependence on a par with other substance use disorders and the others are far more aware of nicotine dependence than they had been previously.

5. Describe how your agency/system regularly screens, assesses, and addresses smoking amongst your clients. Include tools and supports (e.g. regular screening with a carbon monoxide (CO) monitor) that support your efforts to address smoking.

   Administrative Bulletin 3:32 ensures that patients in state psychiatric hospitals are educated about cigarettes harmful effects, and are assessed for tobacco use and treated for tobacco

addiction. NRT is administered to consumers who are tobacco dependent. Tobacco addiction treatment refers to medical and psychosocial interventions that decrease or eliminate tobacco usage. Tobacco products and paraphernalia are prohibited for consumers and staff.

Upon admission, physicians and nurses shall evaluate patients' tobacco addiction and potential for nicotine withdrawal using the Fagerstrom test, which shall also determine an appropriate dosage of NRT or other smoking cessation medication.

Every patient shall be advised of the availability of tobacco addiction treatment on their unit and in centralized programs. This shall include individual counseling, group health education and therapy, which shall utilize the Learning About Healthy Living Manual and other proven approaches.

The hospitals shall use pre-printed physician order forms for NRT. PRN (i.e. as needed) orders shall allow RNs to provide patients with NRT, including nicotine patches, lozenges and gum. Patients can have the nicotine patch made available as floor stock if they have a physician's order specifically for this.

6. Describe how your behavioral health providers are screening and referring for:
   a. heart disease,
   b. hypertension,
   c. high cholesterol, and/or
   d. diabetes.

Heart disease, hypertension, high cholesterol, and diabetes are all risk factors for Metabolic Syndrome. Newly implemented tracking forms for Metabolic Syndrome in the state psychiatric hospitals screen for risk factors of metabolic syndrome, such as BMI, blood pressure, glucose, hemoglobin and lipids. The goal is to prevent and/or treat cardiovascular disease and Type 2 diabetes.

IV: Narrative Plan

L. Health Disparities

Narrative Question:

In the Block Grant application, states are routinely asked to define the population they intend to serve (e.g., adults with SMI at risk for chronic health conditions, young adults engaged in underage drinking, populations living with or at risk for contracting HIV/AIDS). 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, Latino adults with SMI may be at heightened risk for metabolic disorder due to lack of appropriate in-language primary care services, 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, and African American women may be at greater risk for contracting HIV/AIDS due to lack of access to education on risky sexual behaviors in urban low-income communities.

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 being served or 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. In order for states to address the potentially disparate impact of their Block Grant funded efforts, they will be asked to address access, use, and outcomes for subpopulations, which can be defined by the following factors: race, ethnicity, language, gender (including transgender), tribal connection, and sexual orientation (i.e., lesbian, gay, bisexual).

In the space below please answer the following questions:

1. How will you track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBTQ, and age?

2. How will you identify, address and track the language needs of disparity-vulnerable subpopulations?

3. How will you develop plans to address and eventually reduce disparities in access, service use, and outcomes for the above disparity-vulnerable subpopulations?

4. How will you use Block Grant funds to measure, track and respond to these disparities?

Footnotes:

L. Health Disparities

1. How will you track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBTQ, and age?

   The New Jersey Substance Abuse Monitoring System (NJ-SAMS) collects information on race, ethnicity, gender, primary language spoken, date of birth and ASAM level of care for any client admitted to substance abuse treatment. It also collects information on National Outcome Measures, so the SSA can easily track this information. Similarly, the mental health client information system (USTF) collects this information, with the exception of outcome measures, and program element in lieu of ASAM level of care, for clients admitted to mental health treatment, allowing the SMHA the ability to track this information. The USTF is currently being redesigned to be web-based and outcome measures will be added, allowing this additional level of tracking.

   Questions on LGBTQ are not part of either system's admission form. Targeted surveys using Survey Monkey would be utilized to garner information for this population, or for more details on language services. A survey was conducted of Drug Court providers in March 2013 to determine their ability to provide Spanish language services and results are being analyzed. Nineteen agencies responded, with 51% of the counselors being fluent in Spanish: on average, 42% of the Spanish speaking counselors in an agency are bilingual. Approximately 5% of drug court clients required Spanish in order for services to be provided; however, 10% preferred their services to be provided in Spanish. Of 18 agencies who responded, 33% provide drug court materials in Spanish. The responses to some of the items in this survey pose questions about how well the respondents understood the item.
   Within the NJ children's system of care access and/or enrollment in services, types of services received, and outcomes by race, ethnicity, gender and age are tracked by the Contracted Systems Administrator (CSA) management information system.

2. How will you identify, address and track the language needs of disparity-vulnerable subpopulations?

   The language needs of disparity-vulnerable subpopulations is identified, addressed and tracked by:

   - Using DMHAS' client level IT systems and conducting special surveys.
   - Preparing reports of findings for action by Executive Management.

   Within the NJ children's system of care language needs of disparity-vulnerable subpopulations are identified, addressed and tracked by the DCSOC CSA. County-wide needs assessments are also conducted on the local level by the Care Management Organizations and the County Inter-Agency Coordinating Councils.

3. How will you develop plans to address and eventually reduce disparities in access, service use, and outcomes for the above disparity-vulnerable subpopulations?

DMHAS is currently in the process of updating its Multicultural Competence Plan to integrate Addictions Services within the Plan. The plan will provide for the increased representation of membership on the Multicultural Services Advisory Committee to reflect members of the Substance Abuse Community that provide services to consumers with SUDs. The advisory committee, updated plan, and the monitoring and reporting of data of consumers served by race, age, etc, are key in the planning for services, assuring access, reducing disparities, and monitoring outcomes.

DCSOC develops plans to address and reduce disparities in access, service use, and outcomes for disparity-vulnerable subpopulations through the following mechanisms:

- having a customized utilization management program for the CSA based on unique local, regional, and programmatic needs;
- employing licensed clinical staff available 24 hours/day,7 days/week with specific experience and training focused on the population being served;
- holding initial and ongoing training regarding program requirements;
- incorporating evidence-based practices and clinical practice guidelines that promote resiliency in children/youth/young adults and families into the review process;
- promoting family-centered, strengths-based, culturally competent planning, and community-based services, natural supports, and active care coordination; and
- using the CSA 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.

4. How will you use Block Grant funds to measure, track and respond to these disparities?
Block grant funds are currently used, in part, to support IT and Research staff, as well as IT systems. This type of analysis is within the scope of staff's existing duties.

   DCSOC does not utilize Block Grant funds to measure, track or address to these disparities.

IV: Narrative Plan

M. Recovery

Narrative Question:

SAMHSA encourages states to take proactive steps to implement recovery support services. SAMHSA is in a unique position to provide content expertise to assist states, and is asking for input from states to address this position. To accomplish this goal and support the wide-scale adoption of recovery supports, 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.

Indicators/Measures

Please answer yes or no to the following questions:

1. Has the state has developed or adopted (or is the state in the process of developing and/or adopting) a definition of recovery and set of recovery values and/or principles that have been vetted with key stakeholders including people in recovery?

2. Has the state documented evidence of hiring people in recovery in leadership roles (e.g., in the state Office of Consumer Affairs) within the state behavioral health system?

3. Does the state's plan include strategies that involve the use of person-centered planning and self-direction and participant-directed care?

4. Does the state's plan indicate that a variety of recovery supports and services that meets the holistic needs of those seeking or in recovery are (or will be) available and accessible? Recovery supports and services include a mix of services outlined in The Good and Modern Continuum of Care Service Definitions, including peer support, recovery support coaching, recovery support center services, supports for self-directed care, peer navigators, and other recovery supports and services (e.g., warm lines, recovery housing, consumer/family education, supported employment, supported employments, peer-based crisis services, and respite care).

5. Does the state's plan include peer-delivered services designed to meet the needs of specific populations, such as veterans and military families, people with a history of trauma, members of racial/ethnic groups, LGBT populations, and families/significant others?

6. Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services?

7. Does the state have an accreditation program, certification program, or standards for peer-run services?

8. Describe your state's exemplary activities or initiatives related to recovery support services that go beyond what is required by the Block Grant application and that advance the state-of-the-art in recovery-oriented practice, services, and systems. Examples include: efforts to conduct empirical research on recovery supports/services, identification and dissemination of best practices in recovery supports/services, other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system.

Involvement of Individuals and Families

Recovery is based on the involvement of consumers/peers and their family members. States must work to support and help strengthen existing consumer, family, and youth networks; recovery organizations; and community peer support and advocacy organizations in expanding self-advocacy, self-help programs, support networks, and recovery support services. There are many activities that SMHAs and SSAs can undertake to engage these individuals and families. In the space below, states should describe their efforts to actively engage individuals and families in developing, implementing and monitoring the state mental health and substance abuse treatment system. In completing this response, state should consider the following questions:

1. How are individuals in recovery and family members utilized in the planning, delivery, and evaluation of behavioral health services?

2. Does the state sponsor meetings or other opportunities that specifically identify individuals' and family members' issues and needs regarding the behavioral health service system and develop a process for addressing these concerns?

3. How are individuals and family members presented with opportunities to proactively engage the behavioral health service delivery system; participate in treatment and recovery planning, shared decision making; and direct their ongoing care and support?

4. How does the state support and help strengthen and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?

Housing

1. What are your state's plans to address housing needs of persons served so that they are not served in settings more restrictive than necessary?

2. What are your state's plans to address housing needs of persons served so that they are more appropriately incorporated into a

supportive community?

Footnotes:

M. Recovery

Indicators/Measures

1. Has the state has developed or adopted (or is the state in the process of developing and/or adopting) a definition of recovery and set of recovery values and/or principles that have been vetted with key stakeholders including people in recovery?

   First and foremost, a recovery-oriented system is one based on the belief that recovery is in fact possible. A recovery-oriented system recognizes the potential inherent in all consumers. It values and seeks to build upon individuals' strengths. The system ensures access to effective and timely treatment, rehabilitation, crisis intervention, on-going peer and other natural support services that promote meaningful lives, the attainment of valued roles, and true empowerment. A recovery oriented system offers hope, is culturally competent, accountable, and is sagacious in its use of resources. Consumers experience transformation on a personal level and take personal responsibility for their lives.

   DMHAS did adopt a definition of recovery based on SAMHSA's definition of a recovery system based on their ten fundamental components: self-direction, empowerment, hope, respect, responsibility, holistic, individualized and person-centered, peer support, strength-based, and non-linear. "The key messages of transformation are that treatment works, evidence-based practices yield better results, and recovery is not only possible, but is the expected outcome of treatment." A. Kathryn Power.

   Guiding Principles: The Mental Health Task Force delineated values for improving New Jersey's mental health system, and prescribed many actionable recommendations for the State to follow. These guiding values and principles shape New Jersey's mental health system and guide our system as we move forward with our transformation efforts.

   - The system is grounded in a ***Recovery orientation.***
   - All services are ***Welcoming***, there is no wrong door.
   - ***Consumers and their families drive the service needs*** based on wellness and recovery. ***Access*** to services promote ***Continuity of Care.***
   - Services are ***Culturally Competent.***
   - Services are ***Integrated and Collaborative.***
   - Services are held ***Accountable, Cost Effective and Monitored*** at the local level.
   - ***Stigma will no longer be tolerated*** and education and awareness regarding mental illness and mental health will be increased and at the forefront of our mental health system.
   - The system emphasizes ***Evidence-Based and Best Practices, Quality of Care, and Outcomes.***

   Over the course of the next three to six months the Office of Prevention, Early Intervention and Community Services will develop a set of Recovery Values and Principles based on consumer feedback at State Consumer Advisory Committee meetings.
   The Children's System of Care adopted by DCF/DCSOC was developed through the joint

efforts of families, providers, advocates, and other stakeholders across the state. It is based on basic principles designed to create a children's service delivery system that:

- increases access to services and supports.
- empowers parents and guardians in seeking care and positively impacting the system to improve it.
- ensures the ability of families to share their ideas, concerns, needs, and suggestions.
- enhances the integrity and quality of family and community life.

Through an organized system of care, DSCOC is committed to providing emotional and behavioral health care services that are:

1. clinically appropriate and accessible, without regard to income, private health insurance or eligibility for Medicaid/NJ FamilyCare or other health benefits programs;
2. individualized, reflecting a continuum of services and/or supports, both formal and informal, based on the unique strengths of each youth and their family;
3. provided in the least restrictive, most natural setting appropriate to meet the needs of the youth and their family;
4. family-driven, with families engaged as active participants at all levels of planning, organization, and service delivery;
5. community-based, coordinated, and integrated at the community level with the focus of services as well as management and decision-making responsibility resting at the community level;
6. culturally competent, with agencies, programs, services, and supports that are responsive to the cultural, racial, and ethnic differences of the populations they serve; and
7. protective of the rights of youth and their families.

2. Has the state documented evidence of hiring people in recovery in leadership roles (e.g., in the state Office of Consumer Affairs) within the state behavioral health system?

   DMHAS has a special assistant for consumer affairs, who is a member of the DMHAS executive staff and a peer support specialist, and a vacancy for an addictions consumer advocate within the Office of Prevention, Early Intervention and Support Services.

3. Does the state's plan include strategies that involve the use of person-centered planning and self-direction and participant-directed care?

   Yes. State hospitals have provided training for staff through SAMHSA on person-centered planning, self-direction and participant-directed care. New initiatives funded through DMHAS have become wellness and recovery-focused and give additional consideration to RFPs that include Peer Providers in their plans for person-centered planning and participant-directed care.

The RFP process encourages the use of consumer and family member involvement to incorporate the positive and negative issues that the consumers and family members found in each proposal and that information is shared at reconciliation prior to the scoring process. A mental health consumer in recovery currently works as a DMHAS staff person in the Office of Prevention, Early Intervention and Community Services in a TES role, and is given the opportunity to score submitted proposals during the reconciliation phase of the RFP.

FY 2013 saw DMHAS collaborate with UMDNJ's Center for Excellence in Psychiatry in developing a shared decision making tool. This tool has been piloted at our state hospitals and has been reviewed by consumer stakeholders and revised accordingly. The document was available for wide dissemination in on July 1, 2013 (FY 2014).

A SAMHSA document entitled: *Action Planning for Prevention and Recovery: A Self-Help Guide* is available on the DMHAS website.

DCSOC views children and their families as full partners in the development of their ISPs and in assessing progress toward their own outcomes. DCSOC is committed to providing services based on the needs of the child, youth or young adult and their family in community-based, family-centered environment. DCSOC services are coordinated through one entity and are based on a single, strength-based ISP developed with the family for the child, young adult and their family.

4. Does the state's plan indicate that a variety of recovery supports and services that meets the holistic needs of those seeking or in recovery are (or will be) available and accessible? Recovery supports and services include a mix of services outlined in The Good and Modern Continuum of Care Service Definitions, including peer support, recovery support coaching, recovery support center services, supports for self-directed care, peer navigators, and other recovery supports and services (e.g., warm lines, recovery housing, consumer/family education, supported employment, supported employments, peer-based crisis services, and respite care).

   Yes. The state plan discusses its implementation of various recovery supports such as: peer support, recovery mentors, self-help and recovery centers, recovery housing, supported housing, supported education, supported employment, etc.

   There are a variety of Peer Support Initiatives that are State sponsored and funded through DMHAS such as Peer Support Groups and our 33 consumer-run self-help centers. They offer effective, evidence-based and best practices to ensure consumer goals are attained. Tools that teach and promote person-centered, individualized recovery planning are made available to center participants. A competent peer workforce is employed and sustained at each center. Services are culturally responsive and are co-occurring capable to meet the vast need for these services and emphasize a life in the community for everyone.

   DMHAS received federal funding for Peer Recovery Support Coaching and State dollars to train Peer Supportive Housing Staff in the Peer Wellness Coaching Model.

The Division encourages the education of consumers and providers on self-directed care and has developed and implemented a new tool on self-directed care.

DMHAS funds and supports a state-funded Warm Line that incorporates the Intentional Peer Support (IPS) Model as well as WRAP Planning. The Warm Line is fully staffed by peers and is accessible on holidays, weekends and other times when traditional services are not available.

In FY 2013, DMHAS funded three new Peer Respite Centers which will be fully operational in six months. Consumer and family education is best exemplified through the Hearts and Minds Program. DMHAS currently funds and supports NAMI National Hearts and Minds Program to educate peers and their families about how to minimize risk factors associated with Cardio-Metabolic Syndrome.

The following links to Health and Wellness Resources are available on the PerformCareNJ website: http://www.performcarenj.org/families/health-wellness.aspx.

Health and Wellness Resources

Below are links to helpful information for parents and caregivers interested in such topics as social environment, economic circumstances, health care, physical environment and safety, behavior, education and health.

- http://www.njfamilycare.org/
  A federal and state-funded health insurance program created to help New Jersey's uninsured children and certain low-income parents and guardians to have affordable health coverage. It is not a welfare program. NJ FamilyCare is for families who do not have available or affordable employer insurance, and cannot afford to pay the high cost of private health insurance.
- http://www.nj.gov/njhealthlink/
  A comprehensive health care consumer information website serving seniors, families, children and health care professionals.
- http://www.childstats.gov/
  This forum fosters coordination, collaboration and integration of federal efforts to collect and report data on conditions and trends for children and families.
- http://www.cdc.gov/healthyyouth/obesity/facts.htm
  The Center for Disease Control's (CDC) Division of Adolescent and School Health (DASH) promotes the health and wellbeing of children and adolescents to enable them to become healthy and productive adults.
- http://www.letsmove.gov/
  Let's Move! is a comprehensive initiative launched by the First Lady, dedicated to solving the problem of obesity within a generation.
- http://preventobesity.net/
  Online networks to reverse the childhood obesity epidemic.
- http://www.bradleyhospital.org/parenting-resources/mental-health-resources
  A one-stop resource for all parents - from those who simply have questions about common children's mental health problems such as ADHD, self-esteem or depression, to

those who are looking for advocacy organizations and support groups to help with difficult issues concerning their child's diagnosis. The guide is written for parents, but other caregivers, family members, community organizations, schools, and health care providers can also use the information in this guide.

- http://www.healthynj.org/kids/wellness.html
  Information for healthy living on various topics such as nutrition, emotions, family life, safety, school, and much more.
- http://kidshealth.org/
  A fun website for parents, kids and teens to get information on health.
- http://www.publicdoman.com/Health-Wellness-Links.html
  Comprehensive wellness information on various topics.
- http://www.school-wellness.org/Links.aspx
  Nutrition and school wellness information.

ADHD

- Attention Deficit Disorder Association http://www.add.org/
- Links and Resources http://www.angelfire.com/ny/Debsimms/add.html
- LD Podcast http://ldpodcast.com/resources/resources-by-type/adhd-links-and-info/

Suicide Prevention

- National Suicide Prevention Hotline http://www.suicidepreventionlifeline.org/GetHelp
- Grief Net http://griefnet.org/resources/suicide.html
- American Association of Suicidology http://www.suicidology.org/web/guest/prevention-links

Puberty

- keepkidshealthy.org http://www.keepkidshealthy.com/adolescent/puberty.html
- LaGrange District 102 http://www.dist102.k12.il.us/teacher_pages/johnsoca/puberty-resources-parents
- Child Development http://childdevelopmentinfo.com

Substance Abuse

- CDC Alcohol and Drug Use http://www.cdc.gov/healthyyouth/alcoholdrug/links.htm
- Teen Drug Abuse http://www.teen-drug-abuse.org/resources.htm
- Sober Recovery http://www.soberrecovery.com/

Oppositional Defiant Disorder and Conduct Disorder

- Association of Natural Psychology
  http://www.winmentalhealth.com/conduct_disorder_oppositional_defiant_disorder_children.php
- Oppositional Defiant Disorder
  http://www.insightpros.com/odd-oppositionaldefiantdisorder/

Bullying Prevention and Intervention

- StopBullying.gov http://www.stopbullying.gov/
- Kzoo Resources http://www.kzoo.edu/psych/stop_bullying/resources/websites.html

- Committee for Children http://www.cfchildren.org/
- Bully Online http://www.bullyonline.org/schoolbully/links.htm
- A Call to Stop Bullying http://www.qualityansweringservice.com/call-stop-bullying

5. Does the state's plan include peer-delivered services designed to meet the needs of specific populations, such as veterans and military families, people with a history of trauma, members of racial/ethnic groups, LGBT populations, and families/significant others?

   In 2005, DMHAS provided funding and support for peer providers to offer supportive recovery services in designated screening centers. New and expanded DMHAS initiatives prioritize and utilize peers in the delivery of crisis services.

   DMHAS has introduced trauma-informed care in state care continuums and have introduced alternatives such as comfort rooms and use of peers in crisis de-escalation. DMHAS has strong policy of providing Culturally Competent Services in both state and community based services. We have not yet included mental health and substance use disorders treatment services specific to the LGBTQ community, but would like to explore this need in the future. DMHAS currently funds IFSS Programs in every county for family members and significant others to provide coping skills and support in dealing with loved ones living with serious mental illnesses. DMHAS also funds and supports the use of Family Companions through the Family Support Organization (FSO) in some of our county screening centers. DMHAS also trains and supports the use of Family Monitors in our state hospitals.

   Within the Children's System of Care, FSO are nonprofit, county-based organizations run by families of children with emotional and behavioral challenges. FSOs work collaboratively with the Care Management Organizations, Mobile Response and Stabilization Services, the CSA, state agencies and provider organizations to ensure that the system is open and responsive to the needs of families and youth. The FSO provides peer support, education, advocacy and system feedback to families. They ensure that the key values of the DCSOC are upheld.

6. Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services?

   DMHAS received a grant through NASMHPD which has allowed for our collaborating partners to develop and implement a Supervisor Manual for Program Supervisors to fully integrate Peer Wellness Coaching into the service delivery system.

7. Does the state have an accreditation program, certification program, or standards for peer-run services?

   The Certified Recovery Support Practitioner (CRSP), the Peer Wellness Coach Certification and the Psychiatric Rehabilitation Counselor (CPRP) are eligible to bill Medicaid under Community Support Services (CSS) for peer providers.

DMHAS has implemented a Policy and Procedure Manual for Peer Run Self-Help Centers statewide and DMHAS is also in the process of implementing a Quality Assessment Tool at all 33 self-help centers.

8. Describe your state's exemplary activities or initiatives related to recovery support services that go beyond what is required by the Block Grant application and that advance the state-of-the-art in recovery-oriented practice, services, and systems. Examples include: efforts to conduct empirical research on recovery supports/services, identification and dissemination of best practices in recovery supports/services, other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system.

   DMHAS involves both consumers and family members through several initiatives, funding streams and policies including, but not limited to: the Statewide Consumer Advisory Committee (SCAC), which provides the State's guidance as the recovery and wellness based system of care continues to transition. SCAC meets once a month in each of the three regions of the state (northern, central and southern). These meetings are a platform for SCAC members to give input on specific DMHAS-sponsored initiatives. SCAC makes recommendations to DMHAS on all issues affecting consumers such as: housing, transportation, medication, co-pays, employment opportunities, etc. During monthly meetings SCAC members share in their ideas on wellness and recovery-focused activities and groups that different self-help centers offer. This permits an open forum for members to exchange their vast assortment of wellness and recovery approaches that are innovative and fresh, and are taking place in the various community centers throughout the State.

   DMHAS has a Citizen's Advisory Council (CAC) comprised of individuals in addiction recovery and their families which creates a bridge between DMHAS and the community.

   In efforts to promote family member involvement, the State also sponsors IFSS Programs in 21 counties. IFSS Programs are based in wellness and recovery principles and educate families on mental illness, treatment options, the mental health and addictions system, and skills useful in managing and reducing symptomatic behaviors of consumers living with mental health and/or addictions issues. IFSS Programs offer services in psycho education groups, family support groups, single family consultation, respite activities, and referral service. IFSS Programs receive input and feedback from family members via a variety of mechanisms including, but not limited to, satisfaction surveys, service preference forms and level of concern surveys.

   The Division has moved forward with their CSS State Plan and has received approval for reimbursable Peer Provided Services such as wellness coaching, Peer Outreach Support Teams (POST) and other such roles for which consumers are uniquely qualified. Implementation is pending the adoption of the regulations.

   The state actively includes consumers and family members in Patient Services Compliance Unit. In 2012, the Patient Services Compliance Unit conducted five separate on-site reviews in all state psychiatric hospitals. The reviews were each conducted for a three-day period and

each individual review team included one consumer and one family member. The consumer and family members are in all aspects of the review with the exception of medical records reviews. The process includes a review of therapeutic program, unit observations, patient care and staff development.

In accordance with New Jersey Administrative Code (NJAC) 10;190, consumer and family member participation is also required during on-site reviews of community mental health agencies conducted by Department of Human Services' Office of Licensure.

DMHAS has developed a best practice model through several grant initiatives made available through NASMHPD for Peer Wellness Coaching. This model has received national attention for excellence and we have been able to demonstrate positive outcomes related to health and wellness.

DMHAS utilizes the Self-Help Outcomes Utilization Tracking (SHOUT) System at the self-help centers to enhance and expand reporting criteria that ensures accountability for how services are being utilized.

In addition to state operated programs, NJ has a strong, active network of public consumer and family member organizations and programs, including but not limited to: Roads to Recovery Consumer-Operated Transportation Services, Leadership Training Academy, The Learning and Recovery Center of Wildwood, Consumer Advocacy Partnership, COMHCO (The Coalition of Mental Health Consumer Organization), The Institute for Wellness and Recovery Initiatives, Consumer Connections CORE Training, Certified WRAP (Wellness Recovery Action Plan) Training, Certified Wellness Coach Training, CHOICES-a smoking cessation Program active in state hospitals and self-help centers across the state, Hearing Voices, CPA (Consumer Providers Association), NAMI (National Association of Mental Illness) of NJ, NAMI Connection, NAMI NJ en Espanol, CAMHOP-NJ (Chinese Mental Health Self-Help Group), NJ Self-Help Group Clearing House, and Mental health Association of NJ (MHANJ).

Involvement of Individuals and Families

1. How are individuals in recovery and family members utilized in the planning, delivery, and evaluation of behavioral health services?

   Involvement of individuals in recovery from serious mental illness is critical to the transformation to a wellness and recovery-oriented system of care. A significant percentage of our Planning Council is comprised of primary consumers. They have direct input into the planning, delivery and evaluation of consumer-operated services funded by Block Grant dollars.

   Consumer input is also an integral part of new service development. Primary consumers are utilized in the RFP review process. Their feedback is solicited by DMHAS and incorporated into DMHAS decision-making. Consumers receive a stipend for each proposal that they review as well as receive compensation for participating in a consumer and family feedback session. Consumers and family members comment on the strengths and weaknesses of each

proposal reviewed. A DMHAS staff person records the consumer and family input. This information is then shared and considered at staff reconciliation meetings.

DMHAS also employs two primary consumers to strengthen consumer participation in the planning, delivery and evaluation of mental health services. DMHAS employs a full-time primary consumer to develop and monitor consumer-operated services statewide. The Special Assistant for Consumer Affairs is a member of the DMHAS executive staff, where she has the opportunity to participate in DMHAS policy and decision-making on a management level.

DMHAS recently hired a part-time consumer peer advocate who is responsible for participating in new service development. She reviews and scores each new RFP released by DMHAS and is present at all staff reconciliation meetings where decisions are made regarding funding awards by providers of proposed services. The peer advocate and addictions consumer advocate also actively participates in DMHAS-sponsored subcommittees dealing with newly developing DMHAS initiatives.

Families continue to fulfill an important role in the planning and development of mental health services for consumers, their families and significant others. The SMHA has designated the New Jersey Chapter of the National Alliance on Mental Illness (NAMI NJ) to administer the State Family Support Services Plan for Persons with a SMI. This Plan, which is reviewed and revised every three years, identifies the needs, goals and family priorities for the provision of family support services as well as recommending strategies for outreach and coordinated delivery of support services. The SMHA closely monitors the implementation of the State Family Support Plan via quarterly reports, regular meetings with the Executive Director of NAMI NJ and other documentation as requested.

In addition, the combined New Jersey Community Mental Health Citizen's Advisory Board and the Mental Health Planning Council consist of more than 50% of their membership as family and consumers. This Council continues to recruit consumers and family members of individuals in recovery with co-occurring and addiction disorders to enhance membership and to be more aligned with the changes at the federal level as well as the state level with the merger of the state's Divisions of Mental Health and Addiction Services in July 2010.

FSO are system partners within the DCSOC. FSOs are nonprofit, county-based organizations run by families of children with emotional and behavioral challenges. FSOs work collaboratively with the Care Management Organizations, Mobile Response and Stabilization Services, the CSA, state agencies and provider organizations to ensure that the system is open and responsive to the needs of families and youth. The FSO provides peer support, education, advocacy and system feedback to families. They ensure that the key values of the DCSOC are upheld.

2. Does the state sponsor meetings or other opportunities that specifically identify individuals' and family members' issues and needs regarding the behavioral health service system and develop a process for addressing these concerns?

The SSA's Citizens' Advisory Council (CAC) is comprised of consumers representing the voices of New Jersey residents at risk for, struggling with, or otherwise affected by the chronic disease of addiction. The CAC supports education, prevention, intervention, treatment, and recovery from addictive disorders and the elimination of associated stigma. The CAC meets monthly, represents the voice of addictions consumers, and provides guidance and recommendations to the SSA regarding recovery oriented service delivery in furthering its mission to strengthen and expand recovery services by linking the Division with consumers and advocating for needs and interests of individuals, families, and communities. The CAC identifies policy and program priorities, researches and takes official positions on relevant issues of concern to consumers, and provides consumer representation and input on various committees.

The Advisory Committee to the Alcoholism and Drug Abuse Program for the Deaf, Hard of Hearing and Disabled meets on a quarterly basis to ensure quality substance abuse treatment services are provided to individuals identified as Deaf, hard of hearing or disabled in the community. The Committee is comprised of individuals from statewide disability, substance abuse and social service providers, including five state staff in addition to five members who are identified as Deaf, Hard of hearing or disabled and two public members with an interest in substance and co-existing disabilities.

The SSA has a contract with an agency to offer communication access to individuals who are Deaf and/or hard of hearing via interpreter services or Communication Assisted Realtime Translation (CART) services at up to eight recovery support meeting groups held weekly statewide (this includes AA, NA, sober house meetings, etc.)

The SMHA's Statewide Consumer Advisory Committee (SCAC) is a diverse group of emerging leaders throughout the state who are experiencing recovery in their own lives. They are committed to having open, honest and compelling discussions with the leadership of the DMHAS around what a recovery and wellness-oriented system is about and what it is not. The SCAC has been greatly instrumental in working with the DMHAS on many aspects of the Transformation including focus groups to identify outcomes and other elements of service delivery. In addition, SCAC members have been used as consultants for subcommittee work, as trainers and for curriculum development for socialized DMHAS-sponsored initiatives, and as advisors for proposal reviews. The SCAC has been integrally involved in the completion of Federal Mental Health Block Grant consumer satisfaction survey, and also makes recommendations back to the SMHA on all issues affecting the quality of life of consumers living in New Jersey from housing to medication co-pays to access to employment-related services.

The SCAC meets once per month in each of the three regions of the state. SCAC meetings are frequently used to provide important input into specific DMHAS-sponsored projects and initiatives. The Regional Coordinators in each of the three regions of the state now attend monthly SCAC meetings to inform and educate consumers about relevant DMHAS activities, events and initiatives. They encourage and solicit consumer input into DMHAS initiatives as well as entertain questions, concerns and issues raised by consumers at monthly meetings.

The State Family Support Services Plan for Persons with a SMI convenes three regional family working groups which meet on a quarterly basis.

Located within each county, County Inter-Agency Coordinating Councils (CIACCs) were created by statute to serve as the mechanism in each county to develop and maintain a responsive, accessible, and integrated system of care for children with emotional and behavioral challenges and their families, through the involvement of parents, consumers, youth and child serving agencies as partners. The CIACCs provide a forum where the system of services for children with emotional and behavioral challenges is developed, reviewed, revised and/or redirected, through collaborative decision-making process with DCF to promote optimal services provided in the least-restrictive, but most appropriate setting possible. Each CIACC completes an annual county needs assessment to determine how DCSOC community development funds should be allocated within that county.

3. How are individuals and family members presented with opportunities to proactively engage the behavioral health service delivery system; participate in treatment and recovery planning, shared decision making; and direct their ongoing care and support?

   DMHAS contracts with 2-1-1 for an addictions hotline. Individuals seeking substance abuse treatment, as well as family members and significant others who may be exploring treatment options, can call the 2-1-1-hotline. Staff is trained and available 24/7 to engage and assist callers to access substance abuse treatment. Data collected from these calls are used for the expansion of the referral and engagement process for those in need of substance abuse services. Additionally, 2-1-1 provides information regarding all self-help groups to consumers seeking access to meetings throughout the state.

   The state is currently working on strengthening the role of mental health consumers in treatment and recovery planning, shared decision-making and directing their ongoing care and support. First and foremost, DMHAS has greatly expanded the number of peer providers in designated screening centers, on supportive housing services and on PACT Teams. New RFPs released by DMHAS require the hiring of peer providers to newly funded programs. They receive training in best and promising practices such as Intentional Peer Support, WRAPs, and Psychiatric Advance Directives (PADs). The peer providers deliver these services to service recipients of these programs. They frequently provide education and training to fellow staff on these practices leading to a more participatory process in treatment planning.

   DMHAS also contracts with Rutgers, who recently developed a Shared Decision-Making Tool for consumers and providers to use for medication appointments. The tool provides the opportunity for consumers to prepare for appointments with their prescriber, thereby empowering the consumer to be more proactive in decisions regarding psychotropic medications.

   Most recently, consumer participation has been solicited at state hospital Wellness Committees as well as the Statewide Hospital Wellness Committee, which is co-chaired by DMHAS' Medical Director. The purpose of these committees is to proactively address

metabolic syndrome and other risk factors associated with the increased medical co-morbidity of mental health consumers and the shortened life-span of consumers.

Finally, DMHAS is currently working to sponsor a Wellness Learning Collaborative to educate and inform the mental health community and the primary care community about the risk factors that contribute to poor health outcomes of mental health consumers. Shared decision-making will be one of the key topics of the Learning Collaborative once it is established.

Administrative Bulletin 4:12 " Professional Collaboration with Families of Adult Clients Hospitalized in New Jersey State Psychiatric Hospitals" (see http://www.state.nj.us/humanservices/dmhs/info/notices/adminbulletins/4 12.pdf) was enacted by the Division of Mental Health Services in 1996. This document directed that families be encouraged to become active participants in the treatment and discharge planning process for their family member with a serious mental illness. It also specified that families be made aware of significant events involving their loved one while in the hospital.

Administrative Bulletin 4:12 also instructed that a family advisory group be established for each state hospital excluding the Ann Kline Forensic Center. As a result, Concerned Family Groups were formed and commenced conducting monitoring visits of the hospital in their catchment area. Observations and recommendations were conveyed to hospital administration including the Chief Executive Officer via quarterly meetings. In State Fiscal Year 2011, additional family members were recruited and they, as well as veteran or established family monitors, received training regarding new family monitoring documentation which has undergone several revisions. Family monitors were also asked to comment and provide feedback on the document which permits uniform monitoring of both hospital programming and environment. Thus, it paves the way for family monitors to visit and tour the hospital of their choice regardless of the location. The family monitoring process has continued with the addition of new monitors in State Fiscal Years 2012 and 2013.

FSOs are family-run, community-based, non-profit agencies whose mission is to provide support, advocacy, and education to families of youth with emotional, behavioral, and mental health needs. Their purpose is to ensure that the highest quality, youth-centered, and family-friendly approaches to service delivery are created and maintained throughout New Jersey; provide a forum in which families, caregivers, providers, and other concerned individuals work collaboratively to identify needs, service barriers, and resources as well as appropriate, effective, and timely ways to intervene; and, to provide the resources necessary to support strong, community-based support programs.

4. How does the state support and help strengthen and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?

A recovery mentor certification is available through the Addiction Professionals Certification Board of New Jersey. Individuals must complete 72 hours of addiction training and 2,000 experience hours in a pre-approved facility. As the DMHAS works to integrate mental health and substance abuse services, the need to utilize recovery mentors remains crucial to

sustained client wellness. With the advent of healthcare reform, these types of services are expected to be reimbursable, and accordingly the Division plans to include addiction recovery mentors as part of a recovery oriented system of care. DMHAS is working to create a Medicaid reimbursable addictions recovery mentor certification.

At the SSA's two recovery centers (Recovery Center at Eva's Village and Living Proof Recovery Center), all the services are specific to the needs of the individuals. Services can include referrals to recovery oriented treatment, peer support, interpreter services, access to housing, employment assistance and child care. Wellness activities support recovery and include recreational activities and self-help advocacy. In addition, the Recovery Coach is a new role that functions between the professional and the sponsor. Recovery Coaches are consumers who have made significant progress in their personal development and are experientially credentialed and trained as peer specialists to assist others to achieve their recovery goals. Recovery Coaches are from the community and trained in cultural competence to ensure sensitivity to the needs of the individual and the family members. Recovery Coaches work with individuals across multiple pathways of recovery, provide outreach to the community, link people to professional treatment and to communities of recovery, and provide long-term, stage-appropriate recovery education and support that meet the individual and family needs. The Recovery Coach assists consumers to develop their Recovery Plan. The Recovery Plan assists the individual to identify goals within nine life domains: recovery from use/abuse, living and financial independence, employment, and education, relationships and social support, medical health, leisure and recreation, independence from legal problems and institutions, and spirituality and mental wellness. Recovery Coaches are trained to assist the individual to identify goals and strengths, skills and resources. Families are encouraged and welcome to participate. Together, they identify barriers and problems, and develop plans to utilize strengths and skills to remove the barriers with a goal of overall family wellness.

The DMHAS also provides support and funding to nearly $9M dollars in peer-operated services. These services provide innovative approaches to wellness and recovery. Some of these initiatives include: peer-operated self-help centers; financial literacy services; consumer-operated transportation services; dual recovery groups; advocacy for consumer parents; and a whole host of other promising practice peer-operated services.

New Jersey also provides significant funding and support to a large peer-operated service provider organization. This organization provides services such as hospital and community-based self-help centers; financial services including free tax return preparation and budgeting; supportive housing services; self-help groups; and systems advocacy. This organization is represented at key stakeholders meetings sponsored by DMHAS and is responsible for influencing service delivery statewide. This organization has partnered with DMHAS on the development and implementation of a Peer Coaching Model which has received national recognition. DMHAS has supported and funded the Peer Wellness Coaching Model through incorporating it into the delivery of supported employment and supportive housing. This is a National Model which has been replicated by several other states.

DMHAS also provides funding and support to a statewide peer advocacy organization. They are funded to hold monthly meetings on advocacy issues directly impacting services to consumers of mental health services. They also sponsor one Statewide Conference which is attended by several hundred consumers from various advocacy groups from throughout the state. The DMHAS Assistant Commissioner participates in the conference by providing an overview of DMHAS sponsored initiatives. Staff from the DMHAS management team frequently serve as workshop presenters. The advocacy organization is also included as key stakeholders who provide direct input into DMHAS policies, procedures and initiatives.

IFSS Programs are funded by the SMHA in each of New Jersey's 21 counties. These programs which encompass the SMHA's Wellness and Recovery philosophy, 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 and reducing symptomatic behaviors of the member with a serious mental illness. Families involved with IFSS also learn patterns of communication and levels of environmental stimulation which have been demonstrated to reduce the number of psychiatric crises and hospitalizations. Services offered include psychoeducation presentations, family support groups, single family consultation, respite activities and referral/service linkage. Services are delivered in the family home, at the agency or at other sites in the community convenient to individual family members.

Each IFSS Program receives input and feedback from family members via a variety of mechanisms including but not limited to participation on Advisory Boards, Family Satisfaction Surveys, Service Preference Forms, Level of Concern Survey's and suggestion boxes.

The SMHA also contracts for Acute Care Family Support Programs in 12 counties. These programs serve families with an adult member who is experiencing a psychiatric crisis and is being assessed in a Designated Screening Center or Affiliated Emergency Service. Staff, many of whom are family members themselves, are designed to provide on- site support to the family while their loved one is being assessed, educate them as to what to expect in an acute care setting, including the commitment process, and to link them to existing family support services in the community. The SMHA carefully monitors the performance of the Acute Care Family Support Programs.

Additionally, families are key participants in the Office of Mental Health Licensing Tri-annual Site Reviews and families play an integral role in each of the 21 County Mental Health Advisory Boards which meet on a monthly basis.

FSOs are directly funded through DCSOC. Meetings between DCSOC management and FSO Executive Directors are held on a monthly basis. A DCSOC staff serves as the liaison to the FSOs.

Housing

1. What are your state's plans to address housing needs of persons served so that they are not served in settings more restrictive than necessary?

   DMHAS continues to take a pro-active role in moving consumers to less restrictive settings. To date (May 8, 2013) in FY 2013, the DMHAS has provided rental subsidies to move the following consumers into their own apartments: 51 individuals from the state hospital setting; 14 consumers from Board and Care facilities; 10 consumers from group home settings; 23 consumers in acute care or homeless situations; and six consumers from county hospitals (an additional seven county hospital consumers were provided NED subsidies). In addition, DMHAS has funded 101 beds (subsidies and services) for consumers "At Risk" of hospitalization or homeless; six PACT expansion beds; 30 RIST expansion beds; 25 new RIST beds; 23 Supportive Housing beds for consumers with forensic backgrounds in the State Hospital setting; 89 Supportive Housing beds for CEPP consumers in the State Hospital setting, and 24 supportive housing beds for consumers in the state hospital setting who are not CEPP. We are in the process of developing 35 new RIST beds in Monmouth and Ocean County for CEPP consumers, as well as 16 Supportive Housing beds for individuals who are dually diagnosed (DD/MI) in the state hospitals. This has addressed the housing needs of 453 individuals directly funded by DMHAS and an additional seven provided NED subsidies from our collaboration with the Department of Community Affairs. For FY14, DMHAS anticipates the development of 250 additional Olmstead beds, and the continued use of recycled rental subsidies to assist consumers to live in their own apartments in the community of their choice.

2. What are your state's plans to address housing needs of persons served so that they are more appropriately incorporated into a supportive community?

   The Division continues to publish RFPs for Supportive Housing, as well as PACT expansion with rental subsidies funded for each consumer. Well over 95% of contracts awarded are for services being provided in a scattered-site housing models. All proposals are required to explain services to improve community inclusion/tenure as well as provide for opportunities for socialization, improving natural supports, and how they will promote full integration (housing, employment, money management, self-advocacy, social contexts, etc.) of persons served. Providers' proposals receiving maximum scores are expected to work with consumers to explore interests, prior experiences and options for social activities. Staff look for interest related clubs or hobby organizations, spiritual organizations, community musical, art or theater organizations or other socialization/recreation/education opportunities that matches consumer interests. Consumers are encouraged to explore their neighborhoods, self-help centers, assisted to learn public transportation routes, get library cards, and become active members of their community. Programs offer and help to arrange for specific social activities such as cooking lessons, hosting small dinners and creating opportunities for consumers to socialize with family members or friends. Consumers are expected to be linked with primary healthcare providers in the community, and encouraged to improve physical health care (smoking cessation, increased physical activity, improved nutrition, etc.). Reassurance, support, role modeling, assistance, and monitoring are provided. Attempts are made to identify and use personal strategies that match consumer hopes and desires for health and wellness. Proposals are required to explain how education and employment activities

will be explored. High scoring proposals involve consumers in activities that provide meaning and purpose, including employment, education or volunteer activities. Interest and skill inventories are completed and consumers identify desired objectives for occupational enhancement, such as volunteer work, training, or competitive employment. At the same time, high scoring proposals will discuss assistance with WRAPs, and behavioral support plans that will help to minimize any risk and assure safety for the consumer and others. Programs encourage individuals to develop alternative strategies for responding to internal or external stimuli and provide access to counseling and treatment of mental health needs to ensure continued community tenure.

IV: Narrative Plan

N.1. Evidence Based Prevention and Treatment Approaches for the SABG

Narrative Question:

As specified in 45 C.F.R. §96.125(b), states shall use a variety of evidence-based programs, policies, and practices to develop prevention, including primary prevention strategies (45 CFR §96.125). Strategies should be consistent with the IOM Report on Preventing Mental Emotional and Behavioral Disorders, the Surgeon General's Call to Action to Prevent and Reduce Underage Drinking, the NREPP or other materials documenting their effectiveness. 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 abuse 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 SABG statute directs states to implement strategies including : (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.

States should provide responses to the following questions:

1. How did the state use data on substance use consumption patterns, consequences of use, and risk and protective factors to identify the types of primary prevention services that are needed (e.g., education programs to address low perceived risk of harm from marijuana use, technical assistance to communities to maximize and increase enforcement of alcohol access laws to address easy access to alcohol through retail sources)?

2. What specific primary prevention programs, practices, and strategies does the state intend to fund with SABG prevention set-aside dollars, and why were these services selected? What methods were used to ensure that SABG dollars are used to purchase primary substance abuse prevention services not funded through other means?

3. How does the state intend to build the capacity of its prevention system, including the capacity of its prevention workforce?

4. What outcome data does the state intend to collect on its funded prevention strategies and how will these data be used to evaluate the state's prevention system?

5. How is the state's budget supportive of implementing the Strategic Prevention Framework?

6. How much of the SABG prevention set-aside goes to the state, versus community organizations? (A community is a group of individuals who share common characteristics and/or interests.)

7. How much of the prevention set-aside goes to evidence-based practices and environmental strategies? List each program.

Footnotes:

N.1. Evidence Based Prevention and Treatment Approaches for the SABG

1. How did the state use data on substance use consumption patterns, consequences of use, and risk and protective factors to identify the types of primary prevention services that are needed (e.g., education programs to address low perceived risk of harm from marijuana use, technical assistance to communities to maximize and increase enforcement of alcohol access laws to address easy access to alcohol through retail sources)?

   Beginning in late 2010 and continuing through mid-2011, then resuming in the summer of 2012, DMHAS convened a Substance Abuse Prevention Strategic Planning Committee (the Planning Committee) to develop a five-year prevention strategic plan that focuses statewide prevention efforts on specific data-driven priorities for which measurable change can be achieved at the state and regional levels. The committee used the Strategic Prevention Framework as the model for the development of the plan.

   The New Jersey State Epidemiological Outcomes Workgroup (SEOW), which is comprised of staff from various state and county level departments, and statewide provider agencies and organizations, was instrumental in collecting and analyzing epidemiological data to assess the magnitude of substance use related consequences and substance use patterns related to these consequences. The aim was to profile population needs, resources, and readiness to address the problems and gaps in service delivery. Specific responsibilities of the SEOW related to the work of the Prevention Strategic Planning Committee were to:

   - Help in the selection of prevention priorities by highlighting consumption patterns and problem outcomes;
   - Establish recommendations for resource allocation based on needs assessment data;
   - Identify data gaps and establish recommendations to include methods of addressing these gaps; and
   - Establish a baseline for ongoing data monitoring efforts.

   The Assessment Work Group, co-chaired by a DMHAS staff member and a community representative, reviewed and analyzed New Jersey population-based substance use epidemiological and archival data. The data findings were summarized and presented to the Planning Committee. The SEOW provided a significant portion of the data, such as the New Jersey Epidemiological Profile for Substance Abuse and other resources utilized by the Assessment Work Group.

   The Assessment Work Group reviewed and summarized a myriad of data from various sources, including:

   - National Survey on Drug Use and Health 2010 (NSDUH)
   - New Jersey Risk and Protective Factor Survey (for middle schools) 2010 (NJ MS RPFS)
   - New Jersey Risk and Protective Factor Survey (for high schools) 2008 (NJ HS RPFS)
   - New Jersey Student Health Survey 2009
   - New Jersey Household Survey on Drug Use and Health 2009
   - Youth Risk Behavior Surveillance System 2011 (YRBSS)
   - County Prevention Plans, including Municipal Alliance Plans and 2008 updates

- New Jersey Substance Abuse Treatment Admission trends
- New Jersey SPF-SIG Grantee Strategic Plans
- The President's National Drug Control Strategy (2011)
- SAMHSA Strategic Plan: Fiscal Years 2006-2011
- Strategic Plans from other States

Utilizing the SPF, the Assessment Work Group analyzed data in three categories:

- Consequences and social costs of substance use and addictions;
- Consumption levels and prevalence of substance use;
- Causal factors (i.e., risk and protective factors) that predict population prevalence.

For each of the three categories above, criteria were applied to guide the decision making process and establish the statewide priorities. These rating criteria included:

- Frequency/rates of consumption
- Severity of consequences
- Data trends
- Prevalence of risk & protective factors
- Other recent research

The Assessment Work Group then developed and used the following criteria to further refine the selection of prevention priorities:

- Substances most commonly used/abused that impact the greatest numbers of New Jersey residents.
- Substances that lead to the most severe consequences for the greatest numbers of New Jersey residents.

Information on readiness and system capacity, such as the current resources of the prevention system at the state, county, and local levels was then applied to the prioritization process to identify new recommendations.

Specific examples of indicators that were considered by the Work Group in making their determinations included:

<u>Lifetime Alcohol Consumption</u>
–11th/12thgrade = 80.9%

–9th/10thgrade = 64.3%

–8thgrade = 44.1%

–7thgrade = 24.1%

<u>Past 30 Day Alcohol Use</u>
–HS = 45.9%
–MS = 15%
23.7% of persons aged 12 or older participated in binge drinking at least once in the last 30 days (2009)

Annual Binge Alcohol use
-1.6% = 12 or 13 year olds
-7.0% = 14 or 15 year olds
-17.0% = 16 or 17 year olds
-34.7% = 18 to 20 year olds
-46.5% = 21 to 25 years old (peaked)

Full Time College Students	Not Enrolled in College
63.9% Current Drinkers	53.5% Current Drinkers
43.5% Binge Drinkers	37.8% Binge Drinkers
16%Heavy Drinkers	11.7% Heavy Drinkers

In 2009, 10.0% of youth ages 12 to 17 were current illicit drug users: 7.3percent used marijuana, and 3.1percent engaged in non-medical use of prescription-type psychotherapeutics.

In 2009, 21.2% of youth ages 18 to 25 used illicit drugs in the past 30 days:18.1 percent used marijuana & 6.3percent engaged in non-medical use of prescription-type psychotherapeutics.

Current use among full-time college students aged 18 to 22:
-Marijuana (2008 =17.9% to 2009 = 20.2%)
-Nonmedical psychotherapeutic drugs overall (2008 = 5.2% to 2009 = 6.3%)
-Oxycodone (2008 = 0.2% to 2009 = 0.6%)

In 2009 NSDUH, the specific drug categories with the largest number of recent initiates among persons aged 12 or older were:
-Marijuana (2.4 million)
-Non-medical pain relievers (2.2 million)

Lifetime use of marijuana (NJ High School/Middle School Risk and Protective Factor Survey):
–11th/12th grade: 41%
–9th/10th grade: 19.6%
-Past 30 days use of marijuana (NJ HS/MS RPFS):
–11th/12th grade: 23%
–9th/10th grade: 10.9%
-Lifetime and recent marijuana use: 35% (New Jersey State Household Survey)

Use of Other Illicit Drugs among High School Students: 10.2% (NJ HS RPFS)
-Sedatives, Oxycodone, amphetamines, ecstasy, club drugs, hallucinogens, steroids, heroin, cocaine, methamphetamines

28.6% of First Time Illicit Drug users (Nearly 1/3) initiated with psychotherapeutics, including:
–17.1% with pain relievers
–8.6% with tranquilizers

–2.0% with stimulants
–1.0% with sedatives

The number of substance dependent and abusing adults over age 50 is predicted to rise: from 1.7 million 2002 to 4.4 million by 2020 (Office of National Drug Control Policy)
Government survey of nearly 11,000 Americans aged 50 and up revealed:
–23% of men and 9% of women ages 50 -64 admitted to binge drinking in the past month
–14% of men and 3% of women ages 65 and older reported binge drinking

PREVENTION PRIORITIES

Using the criteria above, the Assessment Work Group provided recommendations for areas of highest need based on the data. The Planning Committee then used the data-driven priority recommendations to continue the prioritization process. The team factored in issues such as current system capacity, feasibility and the probability of affecting change. The Assessment Work Group identified a set of five priorities. The following are not in rank order:

- Reduce underage drinking
- Reduce binge drinking
- Reduce illegal drug use/misuse
- Reduce medication misuse
- Reduce use of new and emerging drugs of abuse (e.g., Salvia, bath salts, etc.)

Additionally, based upon its analysis, the Assessment Work Group identified underserved populations in need of enhanced services targeted to their unique needs:

1) Older adults
2) Members of the military and their families
3) College students – including students at two-year colleges
4) Individuals with special needs

Based upon input from the New Jersey Governor's Office and in consideration of data from ONDCP regarding the epidemic rate of deaths related to the misuse of opioid analgesics, and due to the prevalence of misuse of prescription drugs and resulting use of heroin among teenagers and young adults, the priority regarding medication misuse was modified to state:

- Reduce the use of illegal substances – with a special focus on the use of opioids among young adults 18-25 years of age

As a result of these findings, DMHAS determined that the most effective means of addressing these priorities at the statewide-level was through the use of environmental strategies and programs. Accordingly, it allocated block grant funding to develop a system of seventeen regional coalitions that are utilizing the SPF process to identify which state priorities are of the greatest concern in their region – and implement environmental programs and strategies to address those priorities. All coalitions are required to address underage drinking as well as other priorities identified as a result of their needs assessment.

2. What specific primary prevention programs, practices, and strategies does the state intend to fund with SABG prevention set-aside dollars, and why were these services selected? What methods were used to ensure that SABG dollars are used to purchase primary substance abuse prevention services not funded through other means?

   New Jersey funds both individual/family and environmental programs and strategies with block grant dollars. The individual/family programs utilize evidence-based curricula such as: Strengthening Families, Life Skills, I Can Problem Solve, and Incredible Years – among many others. Parameters for prevention contracts for individual/family programs include the following: 1) contractees are required to provide services according to the risk and protective factor domains identified and prioritized by the County Planning Committee for the county in which each agency is located 2) contractees are required to utilize an evidence-based curriculum, 3) contractees are also required to have a Certified Prevention Specialist (CPS), a Certified Health Education Specialist (CHES), or a Master's/Doctoral-level preventionist with a minimum of three years verifiable experience on staff to provide supervision and program oversight, and 4) to use DMHAS' Prevention Outcomes Management System (POMS) to report monthly program activities as well as program outcome measures to the Division.

   As indicated previously, DMHAS also funds a statewide system of 17 regional prevention coalitions that are utilizing the SPF process. The coalitions are using environmental programs and strategies to address underage drinking and other DMHAS-identified priorities in their regions. The coalitions are intensively collaborating with Municipal Alliances in their region, which are funded and overseen by the GCADA. DMHAS coalitions also coordinate their efforts with those of the nine 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.

   DMHAS funds both individual/family and environmental programs and strategies in order to deliver a comprehensive array of prevention programming to assure that communities as well as the individuals and families who live and work in those communities have access to prevention programs and services that can have an impact at all levels of the individual/family and community life.

   In order to avoid supplantation of funds, prevention contractees must certify that: DMHAS funds will not supplant expenditures from other federal, state, or local sources or funds independently generated by the contractee.

3. How does the state intend to build the capacity of its prevention system, including the capacity of its prevention workforce?

   Based upon its review of the Assessment Work Group's findings and its exhaustive analysis of substance abuse prevention capacity in New Jersey, the Prevention Strategic Plan Capacity Work Group encouraged DMHAS to support, preserve, and enhance the current statewide

prevention infrastructure – particularly DMHAS-funded programming. Further, the Planning Committee encouraged mechanisms be established that better ensure that the two primary statewide prevention systems (DMHAS and GCADA) collaborate effectively with each other so that the power of the volunteer Municipal Alliance System is strengthened in its capacity and effectiveness. The Capacity Committee also suggested that the County Alliance Steering Subcommittees (CASSs) need to be supported in their ability to effectively preserve, support, and guide and direct the Municipal Alliances.

The Planning Committee also noted that DMHAS' prevention planning would benefit from a closer alliance with its partners, particularly the GCADA and the County Drug and Alcohol Directors. These three entities could enhance collaboration on prevention planning, implementation, and evaluation efforts to ensure the best use of limited public resources. A recommendation is to share core functions such as a centralized database to better ascertain capacity by building on the SEOW activities and other mechanisms. Based upon this recommendation, DMHAS, GCADA, and County Drug and Alcohol Directors have formed a Unification Planning Workgroup in order to effectuate a successful, collaborative, non-duplicative prevention planning process in the coming years.

In order to increase the capacity and competency of New Jersey's substance abuse prevention workforce and other stakeholders to effectively plan, implement, evaluate and sustain comprehensive, culturally relevant individual and environmental prevention strategies and programs, DMHAS will follow SAMHSA recommendations to:

- Expand prevention workforce Strategic Prevention Framework (SPF) capacity building opportunities throughout the state and among traditionally underrepresented populations and communities
- Continue to develop and enhance workforce knowledge of and capacity to implement environmental prevention strategies.
- Increase the preparedness and readiness of the New Jersey prevention system to effectively implement prevention programming and strategies as they relate to health care reform.
- Attract, develop and retain a diverse, high quality, adaptable prevention workforce.

4. What outcome data does the state intend to collect on its funded prevention strategies and how will these data be used to evaluate the state's prevention system?

In the most recently issued RFP to fund individual and family curricula, an analysis of Prevention Unification needs, resources and priorities were established for available funding that identified domains and the risk and protective factors relevant to those domains for each of New Jersey's 21 counties. Awardees are expected to achieve program goals by reducing the risk factors and/or enhancing protective factors for substance abuse in the county within the identified domains.

DMHAS requires that contractees who are delivering individual and/or family curricula collect pre and post-test data from participants. We selected a set of domain-based Core Measures that were identified and compiled by SAMHSA and are briefly described below:

"This collection of free, public domain instruments was developed by SAMHSA for use in the projects that it funds. It was an attempt to gather up the best instruments that could capture data in a number of youth domains, including attitudes and behaviors, alcohol and drug use, academics, family and peer relations, and community perceptions. This collection will be useful to any program hoping to impact negative behaviors or personal attitudes and beliefs.

Summary of Instruments
The Core Measures document provides 70 ready-to-use evaluation instruments in the domains of:

- Alcohol, Tobacco, and Other Drugs
- Individual/Peer
- School
- Family
- Community

Most of the instruments are scored on a 4 or 5 item rating scale, so the majority of these instruments can be administered and scored by program staff without the assistance of a professional evaluator (although programs are encouraged to work with an evaluator whenever possible).

For each instrument, the document provides information on what exactly the instrument measures, the reliability and validity (if known), the target population, how it is administered, the source of the instrument, and details on the cost or permissions for using the instrument (almost all of them are public domain or free to use as long as you note the source)."

Contractees administer a pre-test prior to the first session of the curriculum and collect post-test data upon completion of the curriculum. The contractee then reports pre- and post-test data on DMHAS' POMS.

DMHAS has attempted to identify global measures that could accurately measure change in attitude or behavior that could possibly be attributed to the curriculum in which the individual or family participated. We have realized, however, that, because the measures are not specifically developed for the particular curriculum, it is challenging to determine if change has occurred. As such, DMHAS is collaborating with researchers from Rutgers University to modify the current measures or identify new measures.

DMHAS will also be forming a workgroup to review various instruments and select meaningful outcome measures. These measures will form the basis for the development of a new Outcomes Module which will be added to POMS, which is utilized by all contracted prevention providers.

DMHAS-funded coalitions collect baseline data specific to the prevention priorities identified in their region. Data regarding intervening variables are also collected. Follow-up data will be collected on a semi-annual basis. DMHAS has identified state-level baseline

measures and will review measures annually to determine if change at the regional levels has translated into change at the state level.

5. How is the state's budget supportive of implementing the Strategic Prevention Framework?

   The 17 recently established regional prevention coalitions all utilize the SPF to develop and implement their environmental programs and strategies. In the summer of 2012, DMHAS, in collaboration with CADCA, used State Prevention Enhancement funds to develop a two-day training on the SPF, which was delivered by communities that had been funded under New Jersey's SPF-SIG agreement and also by Drug Free Communities Coalition members. The training was offered to planning staff in county government substance abuse, mental health, and human services offices throughout the state.

   As indicated previously, the SPF was the model by which New Jersey's Substance Abuse Strategic Plan was developed. In the upcoming Prevention Unification Planning Cycle as a component of the county planning process, counties will be asked to utilize the SPF to conduct a needs assessment and identify priorities in consideration of and in collaboration with newly-funded DMHAS-funded regional coalitions to effectuate a unified approach to prevention at the county and regional levels.

   GCADA administers the state's $10 million Alliance to Prevent Alcoholism and Drug Abuse Program which is the largest network of community-based anti-drug coalitions in the nation with thousands of stakeholders serving on nearly 400 Alliances encompassing more than 530 municipalities throughout New Jersey. Municipal Alliances are established by municipal ordinance and engage residents, local government and law enforcement officials, schools, nonprofit organizations, the faith community, parents, youth and other allies in efforts to prevent alcoholism and drug abuse in communities throughout New Jersey. Over the previous two years, Municipal Alliance volunteers have participated in the three-week long CADCA Coalition Academy, in which they developed facility in the application of the Strategic Prevention Framework. The 17 regional coalitions, funded by DMHAS are collaborating extensively with the Municipal Alliances in their region to develop unified prevention plans and support each other's efforts in order to enhance service delivery and minimize service duplication.

6. How much of the SABG prevention set-aside goes to the state, versus community organizations? (A community is a group of individuals who share common characteristics and/or interests.)

   Of the 20 percent Prevention Set-Aside in the SAPT Block Grant, $9,931,637.73 goes to community organizations, while operating costs (Salary and resource development) are $988,397.76 and program support (administrative overhead) is $ 182,518.32.

7. How much of the prevention set-aside goes to evidence-based practices and environmental strategies? List each program.

DMHAS funds evidence-based programs and strategies exclusively. DMHAS utilizes the January 2009 guidance document titled, "Identifying and Selecting Evidence-Based Interventions: Revised Guidance Document for the Strategic Prevention Framework State Incentive Grant Program" in making these determinations.

Evidence-based curricula provided by DMHAS-funded agencies include: LifeSkills, Strengthening Families, Children in the Middle, Footprints for Life, WISE, Al's Pals, Positive Action, I Can Problem Solve, Raising a Thinking Child, Too Good for Drugs, Guiding Good Choices, Incredible Years, Keepin' it Real, and Dare to Be You.

Evidence-based environmental programs include: Community Trials Intervention and Communities Mobilizing for Change on Alcohol.

Evidence-based environmental strategies: Reduce Social Availability (Party patrols, shoulder taps, social host liability laws, private property ordinances), Reduce Retail Availability (Responsible Beverage Service trainings, Sticker Shock), Promotions (Restrict happy hour & drink promotions/specials, alcohol advertising restrictions), Changing Community Norms (Media campaigns, community mobilization), Alcohol-free options (Implement alcohol-free, expanded late-night student activities).

IV: Narrative Plan

N.2. Evidence Based Prevention and Treatment Approaches for the MHBG (5 percent)

Narrative Question:

States are being asked to utilize at least five percent of their MHBG funds to award competitive grants to implement the most effective evidence-based prevention and treatment approaches focusing on promotion, prevention and early intervention. States that receive two percent or more of the total FY 2014 state allotment will be required to implement a competitive sub award process. States should describe how they intend to implement the competitive grants and/or sub award process.

Footnotes:

N.2. Evidence Based Prevention and Treatment Approaches for the MHBG (5 percent)

DMHAS currently has contracts with provider agencies and has already provided awards to its provider agencies for SFY 2014 for Prevention, Treatment/Evidence Based Practices (such as PACT, Suicide Prevention Hopeline), and Recovery Supports. DMHAS initially procured these services through funding initially allocated through a competitive bid process via RFP. The DMHAS negotiates a contract with agencies that receive awards through the RFP process and renews these contracts annually based on the availability of state appropriations and adequate performance. Thereafter, the agencies are allocated this funding on an annual basis unless the program is terminated or the contract is terminated and rebid. Expansion programs or new programs, such as the Suicide Prevention Hopeline which was recently out for RFP and awarded, are competitively bid. However, unless there is a new program put out to bid (i.e. our new Suicide prevention line), or a contract or program deleted, these contracts are funded every year but the commitment levels may change. The determination for mental health state dollars or Block Grant dollars is not made during the competitive bid process, but rather after the award has been made.

IV: Narrative Plan

O. Children and Adolescents Behavioral Health Services

Narrative Question:

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 over 160 grants awarded to states and communities, and every state has received at least one CMHI grant. In 2011, SAMHSA awarded System of Care Expansion grants to 24 states to bring this approach to scale in states. In terms of adolescent substance abuse, in 2007, SAMHSA awarded State Substance Abuse Coordinator grants to 16 states to begin to build a state infrastructure for substance abuse treatment and recovery-oriented systems of care for youth with substance use disorders. This work has continued with a focus on financing and workforce development to support a recovery-oriented system of care that incorporates established evidence-based treatment for youth with substance use disorders.

SAMHSA expects that states will build on this well-documented, effective system of care approach to serving children and youth with behavioral health 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, like wraparound service planning, intensive care management, outpatient therapy, intensive home-based services, substance abuse intensive outpatient services, continuing care, and mobile crisis response; supportive services, like peer youth support, family peer support, respite services, mental health consultation, and supported education and employment; and residential services, like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification.

Please answer the following questions:

1. How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with mental and substance use disorders?

2. What guidelines have and/or will the state establish for individualized care planning for children/youth with mental, substance use and co-occurring disorders?

3. How has the state established collaboration with other child- and youth-serving agencies in the state to address behavioral health needs (e.g., child welfare, juvenile justice, education, etc.)?

4. How will the state provide training in evidence-based mental and substance abuse prevention, treatment and recovery services for children/adolescents and their families?

5. How will the state monitor and track service utilization, costs and outcomes for children and youth with mental, substance use and co-occurring disorders?

Footnotes:

O. Children and Adolescents Behavioral Health Services

1. How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with mental and substance use disorders?

   The DCF DCSOC continues working with DMHAS on the transition of adolescent substance abuse services over to DCF which occurred on July 1, 2013. Beginning in January 2009, CSOC staff maintained representation on the New Jersey DMHAS Adolescent Substance Abuse Task Force. The goal of the Task Force was to identify strengths and challenges in adolescent substance abuse treatment, determine actionable goals and steps that can be utilized to transform and enhance the adolescent treatment system and recommend changes and improvements to service delivery, systems and workforce. DCSOC maintained representation on two Task Force subcommittees: Integrating Adolescent Systems and Evidence Based Treatment and Outcomes.

   Due to the gap in services for youth with co-occurring disorders, one of the Task Force recommendations was to integrate mental health and substance abuse services. On March 13, 2012 the DHS DMHAS and the DCF DCSOC held a stakeholder meeting regarding the transition of adolescent substance abuse services from DMHAS to the DCSOC. Out of that meeting a smaller consultative group was formed to assist the State in planning the transition to develop co-occurring integrated substance abuse services for adolescents that occurred in July 2013. The Transition Advisory Group met monthly to work on the integration of programs, developing and defining a service array, determine business rules, evaluate unmet demand for treatment services and develop a fiscal model. DCF manages substance abuse services for youth under Child Welfare, Federal Substance Abuse Prevention and Treatment Block Grant and services funded under state aid.

2. What guidelines have and/or will the state establish for individualized care planning for children/youth with mental, substance use and co-occurring disorders?

   In collaboration with each enrolled youth and family, the Care Management Organization (CMO) designs and implements a single, integrated ISP that incorporates interdisciplinary clinical services with family and community resources. The ISP is implemented under the direction and authority of a Child/Family Team (CFT), organized and facilitated by a CMO care manager. All services are delivered and monitored under the authority of the CFT, and accountable to outcomes endorsed by the family. DCSOC and the DMHAS are in the process of finalizing assessment tools that will be utilized for the children/youth with substance abuse and co-occurring disorders.

3. How has the state established collaboration with other child- and youth-serving agencies in the state to address behavioral health needs (e.g., child welfare, juvenile justice, education, etc.)?

   DCSOC requires all youth be assessed for substance use/abuse as part of their Biopsychosocial and Strengths and Needs assessments. Substance abuse treatment must be provided to each youth who is identified as needing such services. In addition, youth and

family education regarding the additional risks to those receiving mental health treatment who abuse substances is presented as part of the individual service plan. DCSOC contracted agencies that identify family patterns of substance abuse encourage the family to accept services and make referrals for the family members for such services.

The Child Welfare Reform Plan Initiative provides a coordinated network of specialized substance abuse treatment services in licensed facilities, targeted to adolescents with first priority to those under the supervision of the DCP&P. Services include long-term residential treatment that provide a structured recovery environment, combined with professional clinical services designed to address addiction and living skill problems for adolescents with substance abuse diagnosis who require longer treatment stays to support and promote recovery. Intervention focuses on reintegrating into the greater community with emphasis on education and vocational development. Slots are available to adolescents needing enhanced substance abuse treatment in both outpatient and intensive outpatient settings. These enhanced services include individual, group and family counseling and also include access to support services. Joint case planning and case conferencing between the DCP&P case worker and the treatment provider are an essential component to this initiative.

4. How will the state provide training in evidence-based mental and substance abuse prevention, treatment and recovery services for children/adolescents and their families?

   Training in evidence-based mental and substance abuse prevention, treatment and recovery services for children and adolescents and their families will be provided by UBHC, the Training and Technical Assistance Program contracted by DCSOC.

5. How will the state monitor and track service utilization, costs and outcomes for children and youth with mental, substance use and co-occurring disorders?

   Service utilization, costs and outcomes for children and youth with mental health, substance abuse and co-occurring disorders will be monitored and tracked by the DCSOC Contracted Systems Administrator, PerformCare, beginning July 1, 2013.

IV: Narrative Plan

P. Consultation with Tribes

Narrative Question:

SAMHSA is required by the 2009 Memorandum on Tribal Consultation 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.

Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinions between 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.

For the context of the Block Grants 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. SAMHSA is requesting that states provide a description of how they consulted with tribes in their state, which should indicate how concerns of the tribes were addressed in the State Block Grant plan(s). States shall not require any tribe to waive its sovereign immunity in order to receive funds or in order 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. For states that are currently working with tribes, a description of these activities must be provided in the area below. States seeking technical assistance for conducting tribal consultation may contact the SAMHSA project officer prior to or during the Block Grant planning cycle.

Footnotes:

New Jersey does not have any federally recognized tribal governments or tribal lands.

IV: Narrative Plan

Q. Data and Information Technology

Narrative Question:

In the FY 2012/2013 Block Grant application, SAMHSA asked each state to:

- Describe its plan, process, and resources needed and timeline for developing the capacity to provide unique client-level data;
- List and briefly describe all unique information technology systems maintained and/or utilized by the state agency;
- Provide information regarding its current efforts to assist providers with developing and using EHRs;
- Identify the barriers that the state would encounter when moving to an encounter/claims based approach to payment; and
- Identify the specific technical assistance needs the state may have regarding data and information technology.

Please provide an update of your progress since that time.

Footnotes:

Q. Data and Information Technology

Background

The former Divisions of Mental Health Services (DMHS) and Addiction Services (DAS) were merged to create the Division of Mental Health and Addiction Services (DMHAS). A separate Office of Information Technology was created for the merged organization in December 2011. A significant change occurred in December 2012 when all information technology operations were placed under the Assistant Director for Research, Planning and Evaluation which expanded the office to become the Office of Research, Planning, Evaluation, Information Systems and Technology (ORPEIST). This change more closely aligns the information technology function with the business of the organization resulting in information technology systems that closely support the business needs of DMHAS.

1. Description of the State's Plan, Process, Resources Needed, and Timeline for Developing the Capacity to Provide Unique Client-Level Data

Both the SSA and SMHA have always had the capacity to provide client level data through their respective client administrative data systems, the NJSAMS and USTF, as described in the above section. The SSA has for many years been reporting to the Treatment Episode Data System (TEDS). New Jersey is currently attempting to use its Data Infrastructure Grant (DIG) funds to significantly improve its ability to provide unique client level data (CLD).

The SMHA has just completed the process for submitting a Basic Client Information (BCI) file to NRI. The SMHA developed its crosswalk which was submitted to NRI in August 2012. A test file for adults and children was submitted in November 2012. The requirement of NRI to have the SMHA include a crosswalk and data from the children's system of care has added a level of complexity for DMHAS since children's services are provided in a different department of state government, the DCF DCSOC) which uses a completely different data system. Through collaboration, DMHAS worked with the COSC and PerformCare (their ASO and information technology provider) to obtain the children's data. On February 13, 2013, New Jersey's Basic Client Information (BCI) production file passed all the data edits and was provisionally approved by NRI's CLD team.

Once some logic in our extraction programs for the BCI have been revisited and verified, DMHAS programmers will start work on the production of the State Hospital Report (SHR) file which should be submitted in March 2013.

2. Description of Information Technology Systems Maintained and/or Utilized by the State Agency

Addiction-Focused Systems

Overview. The SSA has several key information systems, described below, that provide information on: 1) provider characteristics, 2) client enrollment, demographics, and

characteristics, 3) admission, assessment, and discharge and 4) services provided, including type, amount, and individual service provider.

NJ-SAMS. The New Jersey Substance Abuse Monitoring System (NJ-SAMS) was developed and implemented by the SSA to be a real-time, web-based substance abuse treatment data collection and reporting system. The system is used by all licensed substance abuse treatment providers in New Jersey, regardless of whether or not they contract with the SSA. It collects basic demographic, financial, clinical and service information on all clients enrolled and served in New Jersey's substance abuse treatment system. In 2010 there were approximately 72,000 admissions to treatment. The system consists of numerous modules and contains all the clinical assessments providers are required to complete. There are approximately 346 providers reporting on NJ-SAMS, representing 491 sites; approximately 4,056 users are password-registered.

The NJ-SAMS 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. Providers reporting on NJ-SAMS require access to the internet in order to provide client information to the SSA. It runs on Microsoft SQL Server 2008; all new additions to NJ-SAMS are programmed within the .NET framework.

NJ-SAMS 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 the GPRA reporting requirements. It was piloted in October 2002, gradually phased in over time, and by July 2005 all providers were required to use NJ-SAMS for reporting. NJ-SAMS 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, and tracking of treatment through the continuum of care. The NJ-SAMS includes a modified version of the Addiction Severity Index, 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 which are distributed to all providers. Data from NJ-SAMS are used to fulfill Block Grant reporting requirements and are also submitted quarterly to the Treatment Episode Data System (TEDS). Due to its flexible design, additional data elements or modules can be easily added to meet any new federal reporting requirements or other treatment system considerations.

Currently there are 24 modules within NJ-SAMS and three additional modules are planned. The newest additions are the DAS Income Eligibility (DASIE) module, the Prior-Authorization Module which was designed to interface with the SSA's third-party Fiscal Agent FFS Billing System, an Extension Request Module to approve continuing treatment for all fee-for-service initiatives, a Child Protection Substance Abuse Initiative (CPSAI) Module for use by the DCP&P, and a Vivitrol Module to support all the data collection needs for a Vivitrol Pilot study that was launched in July 2011. Also being planned is a Drug Court Module for use by the Administrative Office of the Courts.

At the present time our unique client-level encounter data are collected and reported for services that may have different payors (e.g., Drug Court, Work First NJ, Chapter 51, Self Pay, Private Insurance, etc.) and are identified through the item on funding source in the Admission module in NJ-SAMS. However, we do not have a separate category for "Federal Block Grant". This is currently subsumed under the category for "DAS Slot Contract". Last year 72 providers received block grant funds; of these 28 received block grant funding only. The other 44 received a combination of block grant and other state funds. While it would be simple to report client level data for the 28 block grant funded only agencies, significant resources would be needed to be invested to get this level of detail for the other 44 agencies. This would require modification to the SSA's Contract Information Management System (CIMS) to include a Block Grant budget category, modification to NJ-SAMS to include this option and training to providers on utilizing this category in future reporting to the SSA.

A major project currently underway is the re-write of NJ-SAMS so it will be completely in a .NET framework. The existing system still includes sections written in classic ASP. Work began on this in September 2011 and plans are to begin user testing before the end of FY 2013. The new system is using Microsoft best practices, written in C#, and based on Object Oriented Programming (OOP) specifications. A tiered programming design is being utilized with a presentation layer for the user interface (UI), a business layer for the business logic and a data access layer for interaction with database. It has a new user friendly interface that utilizes accordion technology. New items are being added to reflect current system issues, e.g., chronic disease, prescription drug abuse, etc., while old ones are being retired. This new system is scalable, i.e., able to handle a growing amount of work in a capable manner, streamlined and faster. As one example, the ASI is currently 75 separate screens; in the rewrite 7 accordions are used to logically group items and only one web page is required.

POMS. The Prevention Outcomes Management System (POMS) was designed to collect basic process and demographic information, as well as outcome data, about substance abuse prevention services provided in New Jersey. POMS data include the type of service, target audience, group and curriculum information, dates the service was performed, applicable CSAP strategy and domain, and outcome measures in the individual/peer, family and school domains based on CSAP's core measures. The POMS collects data on the number and demographics of people served by education and training activities. Those are the domain-based programs and they serve selective and indicated populations. The information from POMS is used for Federal Block Grant reporting.

Numerous reports are included in the system. It is web-based and was developed and tested in-house over a six-month period during CY 2009. Focus groups were held for providers and staff in May and June 2009, and their feedback was incorporated into the system. All New Jersey substance abuse prevention providers that receive SSA contracts are required to use the system and were trained on it in July, which then went live on August 3, 2009. There are 35 providers reporting on POMS with 145 password-registered users.

Currently information about universal strategies (i.e., environmental strategies) is not collected on POMS, which is one of the modifications being made in FY 2013. The SSA applied for and

received a Strategic Prevention Enhancement (SPE) grant from SAMHSA which will provide financial assistance for the effort to add an environmental factors module to the system. This module will be deployed prior to the end of FY 2013. In addition, a Strategic Planning Framework (SPF) Module was also added to POMS, as one of the deliverables for the SPE grant, and has been completed. Prevention providers were trained on this new module which was deployed in March 2013. At the SSA's Technical Review by CSAP in July 2012, the reviewers noted that New Jersey was the first in the nation to implement these modules in its Prevention IT system.

CIMS. The Contract Information Management System (CIMS) is a web-based, paperless contract processing system developed in C# in a .NET environment. When fully evolved, it will follow a contract through its entire life span from the initial RFP through the latest contract renewal, modification, and Report of Expenditures. Provider agencies are able to complete and submit all of their contract actions through CIMS at any location that has internet access. 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 principles areas CIMS was designed to address are:

- ensure compliance with 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

Numerous enhancements have been added to the system since January 2011, including the addition of the quarterly Reports of Expenditure, as well as other management reports.

GEMS. The Guest and Emergency Medication System (GEMS) is a centralized, web-based .NET computer information system created by the SSA. The purpose of GEMS is to serve as both a guest dosing and disaster response system for opioid treatment programs (OTPs). It assists clients who are unable to obtain treatment at their home OTPs either due to a disaster or more routine service discontinuity or needing to travel to a different geographic location that is not easily accessible from the Home agency. During such instances, it is critical that clients are able to obtain needed medication. For this to occur, guest OTPs must have access to limited, but specific, information about each client to provide a safe and accurate dose. GEMS ultimate function is to provide this information, under appropriate restrictions, when needed due to emergency, other service disruption or guest access.

GEMS can interface with an OTP's third party clinical management methadone dosing software systems through an upload process to eliminate additional data entry regarding dosage and take home privileges. The OTP determines how frequently it will upload the information. It can also be used directly as the dosing information system for those agencies that do not have a third party software system. In the event that a client cannot reach his/her home clinic for treatment, another clinic, with the client's consent, will be able to securely access the needed dosing information from GEMS. Additionally, GEMS has been designed to interface with the NJ-SAMS, which is the SSA's client administrative data system. When an OTP admits a client, key

data fields will automatically transfer from NJ-SAMS to GEMS. GEMS was piloted with 12 providers in July 2011 and went statewide in July 2012.

GEMS was also planned to interface with the Federal D-ATM emergency dosing system in the event of a federally declared disaster in New Jersey. However, since SAMHSA announced the discontinuation of that system, New Jersey is seeking to collaborate with neighboring states (NY, PA, and DE). The SSA has also provided information to the State of Maryland concerning this system.

CSC Billing System. The Fiscal Agent Billing system contract was awarded to the Computer Sciences Corporation (CSC) through an open competitive bid process handled by Treasury's Division of Purchase and Property. The CSC system is a web-based billing system for all of the SSA's fee-for-service (FFS) initiatives: Drug Court, MAP-SPB, MAP-DOC, SJI, MATI, DUII and the Co-Occurring Network. The amount of funding dedicated to these initiatives is approximately $40 million. All providers that participate in these networks must submit their claims through the CSC system for payment. Detailed service data is input which includes the CPT code. This system went live July 1, 2010.

CSC and the SSA have developed an automated interface with NJ-SAMS to link services data reported in NJ-SAMS which correspond to the claim for payment. This link includes service provider fields, services paid elements (service code, units, dates of service, amount, etc.) and client identifier elements. CSC confirms all information prior to paying any bill and verifies all requests for services through the NJ-SAMS Prior-Authorization Module. Approximately 3,500 claims are processed per month. CSC reimburses and/or notifies the agency of claim status within 10 working days of receipt of the bill for all clients. In addition, all the CSC billing data tables, approximately 76, are transferred to NJ-SAMS on a nightly basis.

The CSC System also tracks services rendered to each beneficiary by specific service on the prior authorization and maintains a record of amounts reimbursed by Medicaid and those not reimbursed by Medicaid.

IDP Client Information System (ICIS). The Intoxicated Driving Program's (IDP's) former data system was a Fox Pro 2.6a database LAN application used to manage and report the Division's IDP class scheduling related information. It was operational before 1997 and has been modified extensively over the years. The system allows users to enter client, DUI violations and suspension data. It also produces class rosters for Intoxicated Driver Resource Centers (IDRCs), client form letters and management reports, and provides data for the microfiche imaging process. Because the system is antiquated and the software is no longer supported, continuation of this existing system presented a critical risk to the SSA. As a result, the system was redesigned into a web-based .NET application which went live in August 2011. There are approximately 400,000 client records and 500,000 violations in the system. All data has been successfully transferred to a web-server using a VPN connection and was imported into the new system. Because the new system uses the same technology and platform as the IDRC Data System, a scripting feature will be added that will allow the automatic transfer of class schedule data between the ICIS and the IDRC system, which is currently accomplished through a file extract and upload process. System improvements were made during FY 2013 such as enhanced

reporting features, and implementation of electronic image archive storage and retrieval. New enhancements are also planned for the system during FY 2014.

IDRC Data System. The Intoxicated Driver Resource Center (IDRC) Data Management System was developed to transfer information electronically from the State IDP to the 21 county and three regional IDRCs and from these IDRCs to their affiliated treatment providers and back again. The IDP receives data on all (30,000 or more) intoxicated driving convictions from the Administrative Office of the Courts. Clients are scheduled to attend 12-hour county-based IDRCs or 48-hour programs based on their sentencing and county of residence. The IDP is responsible for sending information back to the State Motor Vehicle Commission regarding these drivers' compliance or non-compliance with Statute 39:4:50.

Before 2008, all class rosters were printed and mailed to the IDRCs. Information regarding compliance was done through the mail and fax. If a client was sent to a treatment provider for further assessment and treatment, the referral was made and the paperwork was mailed to the agency. This is all done electronically with the implementation of the IDRC Data Management System. Since all IDRC Affiliated Providers are required to submit admission, discharge and assessment information to the NJ-SAMS, the IDRC referrals are "linked" and can be tracked, easing the burden of hard-copy tracking of clients, making follow-up phone calls to see if a client showed up to the treatment agency or not, and making reporting of client status instantaneous. The IDP can track client outcomes through the intervention (conviction), screening (IDRC), assessment and treatment (Treatment Agency) and discharge process.

CRIS. The Clinician Roster Information System (CRIS) supports the collection, review, and maintenance of provider agency clinical and medical staff information to ensure that each approved agency site meets licensure requirements for counselor credentialing as required by SSA regulations. Participating agencies are responsible for entering and maintaining up-to-date staff information through an accessible web-based portal. The system also facilitates reporting on systems-wide adherence to licensure requirements. The system was piloted in December 2011 and deployed in January 2012. All outpatient providers are required to use the system and residential providers were encouraged to begin using it prior to the adoption of the SSA's Residential Regulations which occurred in July 2013.

QAMS. The Quality Assurance Monitoring (QAMS) system will support the collection, analysis, and reporting of individual agency and system-wide adherence to contract requirements as identified during annual program monitoring and site review visits. It includes both a standardized tool for recording and scoring agency adherence to specific contract requirements at the time of each site visit, as well as a mechanism for calculating scores for compliance within and across agencies over time. The system supports the production of dashboard reports for the Division's 360° contract review process and data-driven program performance evaluation. The system will be architected to operate on a PC tablet with touch screen technology. After monitors complete their paperless survey, the data will be transferred to a master database at the SSA. Since the system will use a provider identifier, information from QAMS can easily be linked to CIMS and NJ-SAMS. Currently this project is on hold until a decision is made on the role of the monitoring function within DMHAS with the planned implementation of an ASO for managing New Jersey's public behavioral healthcare system.

Prescription Drug Utilization. In New Jersey the SSA is not the responsible entity for maintaining prescription drug information; that authority belongs with the Division of Consumer Affairs (DCA) within the Office of the Attorney General. The contract for New Jersey's prescription monitoring program (NJPMP) was awarded to Optimum Technology from Ohio. Pharmacies are required to report information about prescriptions dispensed for Schedules II, III, IV and V controlled substances and Human Growth Hormone (HGH) in outpatient settings. The first mandatory data reporting period was from 9/1/11 to 9/15/11. The NJPMP program began full operation on January 1, 2012. The program is intended to monitor, prevent and detect the diversion and abuse of prescription controlled substances and to identify patients for possible treatment. One of the SSA's challenges in 2012 was to try to coordinate with DCA and receive reports from the system in order to better understand the extent of this problem in New Jersey and help inform the development of prevention and treatment strategies regarding the abuse of prescription medication. To that end, the PMP Administrator was added to the membership of the NJ State Epidemiological Outcomes Workgroup (SEOW) in 2012. At the July 25, 2012 SEOW meeting the NJPMP Administrator presented an overview of the program including data submission procedures, patient data outcomes and limitations of the NJPMP database. Summary program data from the first six months of program operation was reviewed. The SEOW will continue to work with the NJPMP Administrator to access and analyze selected program data in 2013 on a regular and continuing basis.

SBIRT Module. DMHAS was awarded a five-year Screening, Brief Intervention and Referral to Treatment (SBIRT) grant in August 2012. A requirement of that grant is to submit GPRA data. The SSA has designed an SBIRT data collection module for that purpose. A test of the web services to transmit the data between DMHAS and SAMHSA has been successfully tested. The system was deployed in March 2013. This module has been designed to interface with NJSAMS so not only will the Division have information on all clients who undergo screening and brief treatment, but who was referred to specialty treatment and the outcomes of that treatment.

Mental Health-Focused Systems

Unified Services Transaction Form (USTF). The USTF database is an electronic client registry originally developed in 1978 (and revised in FY 1990). It serves as a primary source for populating the Uniform Reporting System (URS) data tables. Within the USTF, electronic records are completed when a person is admitted into a program, terminated from a program, or transferred within a program. Currently USTF data are entered at each agency site, and then submitted electronically as text (.txt) files to the SMHA on a quarterly basis. The data collected by the SMHA is then uploaded to a data master file at the New Jersey Department of Treasury's Office of Information Technology (OIT), which consolidates an entire year of USTF data on a CD. The USTF data is submitted to the SMHA from a large array of approximately 120 different service providers with varying degrees of technical skill. In FY 2010 there were approximately 460,000 records—with each record containing the potential for almost 50 separate data fields, which captures client data on: demographics, service enrollment/discharge, and Global Level of Functioning (GLOF) assessment. Information from this database is used to fulfill federal reporting requirements for data that is required to be submitted for the Community

Mental Health Block Grant, Data Infrastructure Grant, URS Data Tables, National Outcomes Measures (NOMs), and other data requests.

This system is in the process of undergoing a major re-write. Work began in March 2012 to begin the development of a real-time, web-based system. However, there were several setbacks affecting the project schedule as consultants would resign to seek other employment or the state's contract with the vendor for these services was renegotiated. Despite these problems, work continued and the system underwent user testing during April 2013.

The new system is using Microsoft best practice, based on Object Oriented Programming (OOP) specifications, being developed in a .NET framework and written in C#. A tiered programming design is being utilized with a presentation layer for the user interface (UI), a business layer for the business logic and a data access layer for interaction with database. The system is scalable and secure. New items are being added to reflect federal requirements and New Jersey specific system issues, e.g., new program elements. Some of the new functionality includes the ability to: record admissions and discharges into/from multiple program elements, record federal national outcome data at Time 1 and Time 2 within a Fiscal Year, collect and produce data needed for the URS data tables, collect and produce the client level evidence-based programs data, and produce data needed for the Client Level Data Reporting file.

Quarterly Contracted Monitoring Report (QCMR) Database. The QCMR collects quarterly, cumulative, program-specific data from each of the service providers contracted by the SMHA. This data protocol has been in existence at the SMHA since the 1980's. A primary function of the QCMR is to measure contracted program commitments, relative to actual quarterly outcomes (in terms of a myriad of units, such as numbers of consumers served, face-to-face contacts, etc). Top-performing and under-performing outliers can be identified with the QCMR. The QCMR is utilized for planning purposes and to fulfill federal reporting requirements for data that is required to be submitted for the Community Mental Health Block Grant, Data Infrastructure Grant, URS Data Tables, NOMs, and other numerous data requests that are received, and reports that are generated on a regular basis. The QCMR also provides data for determining cost-per-unit (of service) analyses in order to observe and compare provider efficiency. QCMR is a critical tool for performance-based contracting—and as such, is integral to the Wellness and Recovery goal of expanding data-driven decision making. Approximately 120 separate agencies provide QCMR data on roughly 630 separate program elements on a quarterly basis. QCMR data is aggregated on a provider-by-provider, and program-by-program basis; it does not provide client-specific information. The QCMR emphasizes agency/program process rather than consumer outcomes. The QCMR gives the SMHA the opportunity to observe service levels (e.g., how many consumers received how many units of service) but this system is not able (nor designed) to ascertain how many resources were provided to specific consumers.

In recent months two new developments have improved the QCMR: transfer to a web-based application, and the transfer of administrative oversight of the QCMR to the DMHAS Office of Research, Planning, Evaluation, Information Systems & Technology.

The IT initiative to convert the QCMR into a web-based .Net application with a SQL server backend is nearing completion. Annex A's (annual contract agreements) from 18 separate

program elements and quarterly reports from 16 program elements have been successfully programmed into the new system. (Only four more await completion.) The use of the new system has already greatly expedited data input/reporting and has also served as an invaluable 'beta test' to further improve performance of the new QCMR application. It was programmed using a three-tier architecture: a presentation layer for the GUI part, a business layer where all the business logic will occur and a data layer for all the database calls such as Inserting/Updating, etc. that pertain to data activity. This system was piloted with several agencies in the spring of 2013. If this pilot is acceptable, the system will be implemented for all agencies July 2013 to report the 4th quarter FY 2013 data that will be due.

This system is also being moved into a Virtual Machine (VM) environment, as are most of DMHAS' systems. The Office of Information Technology (OIT) at the Department of Human Services is spearheading this initiative and is currently creating the needed VMs for DMHAS. This new technological approach should be completed within the next few months. The QCMR pilot will be occurring within this new VM environment.

Administrative oversight of the QCMR was transferred from another unit to the DMHAS Office of Research, Planning, Evaluation, Information Systems & Technology in the fall of 2012. This represents a major improvement of the quality and veracity of the existing QCMR dataset, as personnel from this unit were able to use their combined expertise in data management and knowledge of the provider community to scrub the data and—when necessary, obtain more accurate data from providers that was previously incompletely or incorrectly submitted to the old QCMR.

Systems Review Committee (SRC) Datasets. Since the late 1980's each county convenes Systems Review Committee meetings for the purpose of sharing local (county-specific) information to stakeholders and the general public. To gain a systems-wide view across all 21 counties, administrators of contracted Short Term Care Facilities (STCFs) and Designated Screening Centers (DSCs) compile data on a one-page monthly MS-Excel spreadsheet. These data are aggregate and not client specific, which are then submitted to the SMHA central office for data scrubbing and aggregation into regional and statewide data. Admissions, discharges, referral sources and referrals for subsequent treatment are documented as aggregate data, however client level data is not available (i.e. demographics). SRC data is helpful for comparing system flow among agencies, identifying service gaps, and identifying efficiencies. Currently, the FY 2012 SRC dataset documents over 72,000 admissions episodes to DSCs and 15,800 admissions to STCFs.

Due to the labor intensiveness required to manage this system and the opportunity for user errors, plans are being discussed to develop the system into a web-based application that will provide error checking and eliminate the need to combine numerous spreadsheets each month. It is anticipated that the necessary programming will begin in SFY 2014, after the successful completion of the web-based QCMR, the revised USTF and the Bed Enrollment Data System (BEDS).

In January 2013 the DSC SRC dataset was used (in conjunction with QCMR and fiscal data) to complete a quarterly Screening Center Provider Performance Report (PPR). This 'dashboard'

report provides a visually-accessible summary of 17 key data fields, and compares the data from each screening center with statewide and regional averages.

Oracle Hospital Census Database: This extensive database is used at all four of New Jersey's state psychiatric hospitals to keep track of client admission episodes, demographic profile, clinical progress, dietary needs, medications, discharge preferences, legal status, and other factors. This dataset contains comprehensive data on all state hospital consumers. The average census of the state hospitals was 1,788 in FY 2011, including Ann Klein Forensic Center. The average number of admissions for these facilities was 2,331 in FY 2011 and the average number of discharges was 2,336 in FY 2011.

A major project that will be undertaken in FY 2014 is to redesign the system using .Net for the front end and replacing the current Oracle forms structure. This will allow for the development of a user friendly interface. Hospital and Central Office IT staff will work collaboratively on the redesign, along with key users from the business side of DMHAS.

POES. The use and prescription of medications at the state hospitals is to be tracked through Physicians Order Entry System (POES), a stand-alone application that interfaces with Oracle, through a shared unique client id POES is undergoing final testing/assessment at Greystone Park Psychiatric Hospital (GPPH). The POES application was originally designed and written within the Central Office and was deployed to GPPH in September 2009. The primary purpose of this application was to enable physicians to electronically submit medication orders and to track the current and historical medications administered to patients.

After two years of use, POES holds the records of over 250,000 medication orders, 1,500 patient allergies and suspected adverse drug reaction (SADR) events, 2,700 patient diet orders, 2,300 seclusion restraint orders, spanning 1,600 distinct consumers. POES manages all medications prescribed to 100% of our active patient population (approximately 450 patients per day). In addition, patient movements (locations and outside reasons – like Brief Visits, Medical/Surgical visits, etc), Seclusion/Restraint Orders, Diet Orders, Allergies, (suspected adverse drug reaction) SADR's, patient diagnosis, are all managed by POES.

Under the direction of the GPPH POES development team, new releases of POES have been successfully implemented with strong user acceptance, as each new build has brought meaningful change to patient care and to improving clinical processes. Upcoming releases include Oracle integration, preferred drug list management, and the Medication Administration Record (MAR). The feasibility of implementing this system at other state hospitals will be explored during FY 2014.

MEDITRAK. MEDITRAK is an electronic repository of client visit data to the state hospitals. It contains separate but linked modules on individual clients and episodes of care. MEDITRAK facilitates submission of consumer claims for reimbursement. MEDITRAK has been modified slightly at each state hospital due to the slightly different administrative needs at each of New Jersey's four psychiatric inpatient facilities. In order to improve data integrity and uniformity, these data structures will be consolidated with an improved data structure which is currently under development. The Medicare Billing System (MBS) is functionally similar to MEDITRAK

but is improved due to standardized structure, and its direct linkage to an ancillary patient billing records database (the Client Banking System (CBS)).

Advance Directives. The Advance Directives is a new web-based application that will be implemented at all the state hospitals initially, then at the Screening Centers and community providers, and finally made available to all residents of New Jersey. In accordance with N.J.S.A. 30:4-177.59, the DMHAS is required to develop a system to collect and gather information pertaining to advance directives in the state psychiatric hospitals. This application will allow state psychiatric hospital staff to directly input information into the database regarding whether a patient has an advance directive, the location of the advance directive, whether a patient wants to execute an advance directive, and other reportable data. The information obtained will enable the Division and the state psychiatric hospitals to obtain reliable data through a more efficient mechanism, which in turn will assist the Division and state psychiatric hospitals in submitting data to the DHS for the required annual report. Per the legislation, the next phase of the project will involve developing an internet registry for New Jersey. Hospital staff were trained on the new Advance Directives system in May 2013.

Mental Health and Addiction Focused Systems

BEDS. The Bed Enrollment Data System (BEDS) is a new system currently under development to track all residential beds and their utilization in DMHAS. It will be a web-enabled 'bed management' application to manage all the beds contracted with the provider agencies. Bed management is the provision and apportionment of community contracted beds. A "bed" is classified not only as a piece of furniture where a consumer sleeps but also where treatment and other services are performed that go into the behavioral health care that is provided by the facility. Currently, beds are managed using a manual process which is a combination of local bed tracking, meetings, phone calls and emails. The SMHA previously used an MS Access database called "Central Region Office Residential Database" to track beds, but it is no longer used nor is it updated. Quickly identifying bed vacancies in the communities has been a challenge. The ability for the DMHAS to confirm occupancy rates, satisfactorily manage beds, to collect accurate and real-time bed data is even more difficult.

In 2013, the total number of contracted community beds will be increased by 20%. The objective of BEDS development is to be a web-based system that allows DMHAS to accurately manage the status and availability of beds within the provider agencies. DMHAS requires a system to track all the beds in the community (Vacant, Occupied, Reserved and Referral Pending). Bed management will help providers reduce the number of manual tasks associated with bed placement by providing online bed availability and online views of bed status which will help streamline consumer placement, improve productivity, bed turnaround, and consumer satisfaction.

DMHAS Website. A project is now underway to merge the former DMHS website with the former DAS website. A new site is being designed with input from all the offices in DMHAS. Representatives from each office are working collaboratively on a development version of the website and including material to enhance its utility. The goal of this website is to provide consumers and other stakeholders with information that is timely and accurate. A review of

websites by the DMHAS website administrator of those states that have "merged" revealed that with few exceptions, most state websites still kept mental health and addictions information separate. The new website for DMHAS is intended to be integrated. Once agreement is reached, it is anticipated the new website will be live in early FY 2014.

The new merged website will provide the opportunity to showcase the Health Education Literacy Project (HELP) being developed with the assistance of the DMHAS' consumer Citizens Advisory Council (CAC) and will also serve as one vehicle for parity education.

3. Information regarding the State's Current Efforts to Assist Providers with Developing and using Electronic Health Records (EHRs)

New Jersey's efforts to assist healthcare providers with the implementation and use of certified Electronic Health Records is led by the New Jersey Health Information Technology Extension Center (NJ-HITEC). NJ-HITEC was awarded $23,048,351 by ONC as a part of the Regional Extension Center (REC) program. NJ-HITEC offers technical assistance, guidance, and information on best practices to healthcare providers in support their efforts to demonstrate meaningful use of Electronic Health Records (EHRs). Over 2,200+ healthcare providers are members of NJ-HITEC as of July 2011, and NJ-HITEC plans to reach 5,000 members by April 2012. More information on NJ-HITEC and its services can be found at: http://www.njhitec.org/.

New Jersey Health Information Technology Extension Center (NJ-HITEC) (see http://www.njhitec.org/about_us.html) is an affiliate of the New Jersey Institute of Technology, and is responsible for the dissemination of information on strategies and best practices necessary in the selection, implementation and use of EHR technology. HITEC provides a range of supports (live trainings, web-based forums) for a wide variety of stakeholders (hospitals, primary care providers, IT professionals) for the purpose of improving the quality and value of healthcare through improved data sharing.

DMHAS does not directly assist providers with developing agency specific EHRs. However, DMHAS has a contract with the New Jersey Association of Mental Health and Addictions Agencies (NJAMHAA) for an "IT Project". A key effort of this project is to assist publicly-funded behavioral health providers in NJ with selecting an EHR to fit their agency needs.

4. Potential Barriers the State Would Encounter When Moving to an Encounter/Claims Based Approach to Payment

The SSA does not envision any significant barriers when moving to an encounter/claims based approach to payment. In FY 2009 there was an Encounter Module programmed into NJ-SAMS for use by the providers that were participating in the Mobile Medication project. Providers were required to enter all encounters with clients, i.e., the actual service and the number of units. In FY 2010 the SSA launched its FFS billing system. The contract was awarded to the Computer Sciences Corporation (CSC) through an open competitive bid process handled by Treasury's Division of Purchase and Property. The CSC system is a web-based billing system for all of the SSA's FFS initiatives: Drug Court, MAP-SPB, MAP-DOC, SJI, MATI, DUII and the Co-Occurring Network. The amount of funding dedicated to these initiatives is approximately $40 million. All providers who are participants in these networks must submit their claims through

the CSC system for payment. CSC reimburses and/or notifies the agency of claim status within ten working days of receipt of the bill for all clients. Approximately 3,500 claims are processed per month. In summary, the SSA's providers are accustomed to submitting claims for payment and have had this experience.

However, upon the transition to the ASO/MBHO, the SMHA providers will likely encounter barriers, including but not limited to information technology, programmatic, and financial resources, etc. for implementation. The SMHA had previously requested technical assistance in this area.

5. Identify the specific technical assistance needs that the state may have regarding data and information technology.

DMHAS currently has several new information technology initiatives currently in place to enhance the reporting capabilities of the Division. As the Division moves toward implementing a FFS model, it will reassess its information technology and data needs including technical assistance needs.

6. Please provide an update of the state's progress for the areas above since the 2012/2013 in the above areas.

Update on SAMHSA Additional IT Questions From Prior Block Grant Application

For provider information, are providers required to obtain national provider identifiers, and does the system collect and record these identifiers?

For SSA provider information, providers are required to include their Federal Tax ID, Inventory of Substance Abuse Treatment Services (I-SATS) number or New Jersey Site License number, depending upon the application. The federally assigned I-SATS number is entered into NJ-SAMS and its related modules, CIMS and POMS. The Federal Tax ID appears in CIMS, the Prior Authorization interface to the CSC Billing system and POMS. The Site License number is included in NJ-SAMS.

For the SMHA, with the exception of MEDITRAK, providers are not required to obtain national provider identifiers, nor do systems collect and record such identifiers.

Does the system employ any other method of unique provider identification that provides the ability to aggregate service or other information by provider?

Yes, a Site License number is also included in NJ-SAMS for aggregation at particular sites within an agency. The USTF and QCMR include Project code so information can be aggregated at the provider level.

Does the system use a unique client identifier that allows for unduplicated counts of clients and the ability to aggregate services by client?

Yes, the SSA client information system (NJ-SAMS) utilizes a Unique Client Identifier that allows for unduplicated counts and the ability to aggregate services by level of care. In addition there is an ID Combo Identifier that allows us to track an entire episode of care for the client which includes all events, i.e., all level of care changes within that episode.

Similarly the SMHA client systems (USTF, MEDITRAK and Oracle Hospital Census) uses unique client IDs.

Are client-level data in the form of encounters or claims that include information on individual date of service, type of service, service quantity, and identity of individual provider?

For the SSA there is an encounter module that was developed in NJ-SAMS to capture this level of detail for clients enrolled in the Medication Assisted Treatment Initiative (MATI) which involves mobile medication units. Individual services, date, number of units and provider identity are captured. In addition, the CSC Billing System captures this level of detail on the SSA's FFS initiatives: Drug Court, MAP-SPB, MAP-DOC, SJI, MATI, DUII and the Co-Occurring Network. The amount of funding dedicated to these initiatives is approximately $40 million.

For the SMHA this type of information is only captured on state hospital patients through MEDITRAK.

Does the system comply with Federal data standards in the following areas (use of ICD-10 or CPT/HCPCS codes)?

The CSC Billing system uses CPT codes for services rendered. NJ-SAMS uses DSM-IV codes for psychiatric diagnoses. The SSA is planning to incorporate ICD-10 codes for physical conditions which are currently text fields in our Bio-psychosocial Assessment Module. Similarly, the SMHA will be planning to become ICD-10 compliant and complies with federal standards in the use of CPT/HCPCS codes.

Do provider and client identifiers in the behavioral health IT system allow for linkage with Medicaid provider identifiers that provides the ability to aggregate Medicaid and non-Medicaid provider information?

The DHS has a Shared Data Warehouse (SDW) in which Medicaid and the SSA participate. The SSA is able to link its client records with Medicaid claims data in order to provide aggregate Medicaid provider information. The social security number is the primary key used along with other demographic data. A commercial product that utilizes a "deterministic matching" algorithm provides this capability for the SDW.

However, the current data infrastructure for the SMHA does not permit expedient linkage between the current client-based mental health data base (USTF) with the state Medicaid recipient/claims data. Medicaid provides a shared data warehouse where the SMHA can look up client records for Medicaid claims.

Are Medicaid data or linked Medicaid-behavioral health data used to routinely produce reports?

The SSA linked Medicaid data are used to produce reports on an as needed basis. The SMHA routinely produces reports using Medicaid claims data to help ensure that contracted providers are correctly, accurately and appropriately billing the DMAHS (NJ Medicaid).

Does your State's IT division participate in regular meetings with Medicaid and other agencies to address mutual issues concerning system interoperability, electronic health records, Federal IT requirements or similar issues?

True interdepartmental collaboration among relevant state entities (e.g., NJ Office of Information Technology, NJ Medicaid, the SMHA and SSA) is still in its early stages, so at this point, meetings around the topic of system interoperability, EHRs and federal IT requirements occur on an 'as-needed' basis.

The SSA's information technology unit was not included in regular meetings with Medicaid, other state agencies or the state's HIT Coordinator to discuss system interoperability, electronic health records, federal IT requirements or similar issues; however, mental health staff have participated in the Electronic Healthcare Records Working Group . Senior staff from the SSA participated in the state's HIT Privacy and Security Working Group.

In December 2010, the SMHA began sending four representatives to participate in the Statewide Electronic Healthcare Records Workgroup. Membership of this workgroup includes representatives of other state agencies including: NJ Medicaid, Division of Military and Veterans Affairs, Department of Corrections, Office of Information Technology, DHS, Health Information Technology, Department of Health, and the Division of Developmental Disabilities. This workgroup researched and evaluated vendor products, explored unique requirements of each Department/Division, considered data exchange/transmission issues (and requirements), identified implementation and hosting methods, identified potential funding resources and formulated 'next steps'. On July 1, 2011 the recommendations from this committee were put forth to the State Health Information Technology Coordinator.

In December 2011, the SSA was invited to present to the state's HIT Commission and since that time, has been included in related meetings. During 2012, SSA/SMHA executive leadership participated in three work groups: Business Architecture, Information Architecture and Technical Architecture. Several sessions were held for each group. The DMHAS Assistant Director for Research, Planning and Evaluation was also a member of the NJ State Health Access and Record Exchange (SHARE) team.

Does your State have a grant to create a statewide health information exchange and does your agency participate in the development of the exchange and in issues concerning MH/SA data?

In January 2011, under the American Recovery and Reinvestment Act (ARRA) of 2009, and as part of the Office of the National Coordinator for Health IT (ONC) State HIE Cooperative Agreement Program (http://statehieresources.org/state-plans/), New Jersey was awarded $11,408,594. The overall purpose of this program and New Jersey's related grant funding is to

facilitate and expand the secure, statewide electronic movement and use of health information among organizations according to nationally recognized standards. The federal award would fund infrastructure projects for creating regional Health Information Exchanges (HIEs) and Electronic Health Records (EHRs) and will allow hospital providers, and health insurance companies to share electronic medical records in real time in secure networks.

The New Jersey Health Information Network (see this link for the RFP http://www.state.nj.us/treasury/purchase/pdf/NJHIN_RFI_2011-07-01.pdf) is intended to facilitate the creation and use of a robust and secure statewide interoperable state information infrastructure that will provide all stakeholders with health and healthcare and which will also provide a gateway to the national health information network (NwHIN). New Jersey HIN will provide access to a variety of state databases including the Medicaid Management Information System (MMIS), the Immunization Registry, Blood Lead Screening Registry and the Vital Statistics Registry.

Initially, New Jersey's SSA was not included in the development of the statewide health information exchange; however, participation has begun in these efforts as a result of the merger with the SMHA. New Jersey's SMHA is involved in the development of the statewide health information exchange, although initial implementation efforts are focused on enhancing the state's regional health information exchange organization capabilities, establishing the New Jersey Health Information Network (NJHIN), and defining the legal and financial sustainability frameworks for the entire health IT ecosystem. The SMHA will become more heavily involved as the state has more fully defined its technology infrastructure and more detailed plans are made to include health data from state data sources such as the DMHAS, DMAHS (NJ Medicaid), and Department of Health.

Is your State Medicaid agency engaging in or planning to improve its IT system? If so, is your agency included in such efforts for the purposes of addressing issues related to data interoperability, behavioral health IT system reform, and meeting Federal IT data standards?

Yes, NJ Medicaid is in the process of updating/re-procuring a number of IT systems. They are already in the DDI (Design, Development, Implementation) of a new eligibility system called Consolidated Assistance Support System (CASS). In addition, they are in the RFP development stage of an MMIS Re-procurement. As part of that effort, DMAHS (NJ Medicaid) hosted 70+ MITA sessions that included all their sister Divisions, and additional requirements meetings beyond that.

DMAHS (NJ Medicaid) has numerous IT system improvements in progress that include, but are not limited to:

- MMIS Replacement – Procurement and implementation of a new Medicaid Management Information System (MMIS) to support claims processing, information retrieval, and overall administration of the Medicaid program.
- Master Client Index (MCI) – A project intended to resolve duplicate records within and link recipients between New Jersey's Medicaid program, and the Department of Health's Immunization and Blood Lead Screening Registries.

- Version 5010 and NCPDP D.0 – Adoption of the new HIPAA standards for electronic healthcare and pharmacy claims.
- ICD-10 – Adoption of the new standard for clinical diagnosis and procedure codes.
- Consolidated Assistance Support System (CASS) – A project to integrate eligibility systems between Medicaid and the Division of Family Development programs.

DMAHS is focused on the issues of data interoperability and federal IT data standards, including the CMS Seven Conditions and Standards recently released. They are looking forward to continuing discussions with DMHAS to be sure they are covering all the needs of the Medicaid enterprise, especially as the Department is taking steps toward integrating behavioral health into some form of managed care.

DMAHS is undertaking three major initiatives to improve its IT system (HIT Operational Plan or view it at http://www.nj.gov/health/bc/documents/hitc10/hit_operational_plan_onc.pdf: the Master Patient Index (MPI), the NJ Enterprise Service Bus (ESB), and a pilot for FQHCs to access NJ Medicaid data directly from the New Jersey MMIS. These systems provide the baseline for the New Jersey Health Information Technology framework.

New Jersey has a Health Information Technology Commission that oversees interoperability, and devises fundamental methods and technologies that facilitate secure access and exchange of health information. For more information on New Jersey's health information technology efforts please see the following website http://www.nj.gov/health/bc/hitc.shtml .

While the SSA was not initially included in efforts for the purposes of addressing issues related to data interoperability, behavioral health IT system reform, and meeting federal IT data standard until now, participation in these efforts began as a result of the merger with the SMHA as it is partnering with Medicaid and the Office of the New Jersey Health IT Coordinator on interoperability of behavioral health information technology data in alignment with federal information technology data standards.

Division of Children's System of Care

Contracted System Administrator

DCSOC utilizes a CSA, PerformCare, to support care coordination, utilization management, quality management, and information management for the statewide System of Care. The CSA creates a virtual single point of processing that registers, tracks and coordinates care for all New Jersey children who are screened into the system at any level. Through the creation of a single electronic record the CSA provides DCSOC, the care management entities and other system partners with the information needed to manage the ISP process toward child and family satisfaction, quality outcomes, and cost effectiveness. The CSA provides data to DCSOC and providers through production and AdHoc reporting services. The CSA acts as an agent of state government contracted by and accountable to DCSOC to manage services. The CSA is not risk based and has no incentive to restrict care.

Functions of the CSA include:

- Providing 24-hour, seven-day-a-week customer service/call center support;
- Coordinating access to services for all children, youth and young adults;
- Facilitating access to specialized services for children, youth and young adults;
- Providing DCP&P dedicated staff to facilitate call center support and triage of youth and their families involved with the Child Welfare system;
- Providing care coordination, utilization management, and outlier management to ensure children and their families receive appropriate treatment for an appropriate length of time;
- Establishes access to same quality of services across the state;
- Identifying the different intensity of services given by providers and assists DCF to adjust reimbursement rates to reflect these differences;
- Reviewing children, youth and young adults receiving treatment in psychiatric hospitals to assure appropriate discharge planning and after care services are in place so that they are linked to a community network of care;
- Reporting on the effectiveness of services and child and family satisfaction;
- Implementing a complaints, reconsiderations and appeals process;
- Providing quality and outcomes management and a system measurement program that supports DCF/DCSOC's goal to promote best practices and assists the state in assuring compliance with state and federal guidelines; and
- Interfaces with Medicaid and other state systems to ensure that services are authorized and providers are paid regardless of whether a child is Medicaid/NJFamily Care eligible or not.

These administrative services are supported through a highly innovative and customized Management Information System (MIS) solution called Children and Youth Behavioral Health Electronic Record (CYBER). Embedded in CYBER are YouthLink and Outcomes Management - is a comprehensive child focused set of tools and reports that track and disseminates data gathered through the comprehensive assessment tools, allowing DCSOC to track outcomes, use of EBPs and to more fully manage performance and effectiveness of service delivery.

YouthLink identifies youth referred for out of home treatment services, and allows for their appropriate placement by accurately matching the intensity of service (IOS) needs, provider information and program capacity. YouthLink shows a Provider Queue that displays automated referrals and referrals that are assigned by the out of home provider. In addition, referral requests are displayed that match a providers' IOS or higher. The census displays a list of current admissions and complete admission history for youth within a facility.

Another feature of YouthLink is the Geo Map. This is a map of New Jersey that shows all the out of home treatment facilities by location using color-coded flags. A color key that represents each type of IOS is located on the right of the map. The Child's home or location is indicated by the address in CYBER. When considering a placement for a youth, the system calculates the youth's location and distance from a facility. Each flag will also display the name, address, contact information, number of beds, and the number of beds available in real time for each out of home location. The Geo Map is being expanded to include other types of providers that serve children including Intensive In-Community Services, Behavioral Assistance, Children's Crisis Intervention Services, Care management Organizations, Mobile Response and Stabilization

Services, Functional Family Therapy, Multi-Systemic Therapy, and Partial Hospitalization programs.

The CSA leverages multiple corporate and local communication systems including an integrated phone and data network, e-mail and intranet desktop solutions, tele- and video- and web-conferencing capabilities, and a best of breed information system to support their daily work.

PerformCare utilizes multiple methods for ensuring the accuracy of information given, proper call transfer, and timely response to calls requiring follow up. These methods include auditing of calls, supervision, training, use of satisfaction surveys from families and providers, meeting forums with providers, and use of internal reporting. Findings are used to track, trend, and report monthly performance at both individual and organization-wide levels.

Satisfaction surveys are also utilized to elicit feedback from callers, which include the performance indicator of accuracy of information provided. Multiple types of surveys are used. For families calling PerformCare the Quality Department telephones recent callers inquiring about their experience with the Call Center. Providers are given the opportunity to complete an electronic survey upon completion of a customer service request. Focused surveys are also administered to address specific needs, for example, an annual survey is administered for the DCP&P to measure satisfaction about the specialized DCP&P dedicated unit operated by the CSA.

The CSA holds numerous meeting forums with provider service lines statewide to both communicate new information but also to elicit feedback about CSA performance and operations for purposes of continuous improvement.

Additional enhancements to the CSA include:

- Development and implementation of the Adolescent Housing Hub managed by the Office of Adolescent Services under DCF. The program is a real-time database designed to assist youth with placement in a transitional or permanent housing program.
- Increased functionality to capture data specific to populations transitioning to DCSOC including children, youth and young adults with developmental disabilities as well as children, youth and young adults with substance use disorders.
- Increased outcomes management and outlier capacity, using newly developed tools available to every level of service delivery (Division Director and DCSOC staff through provider agencies and case management entities);
- Provider access to Data Dashboards;
- Enhanced reporting capacity and easy access to data and information by users through a web based application and the tools it provides;
- Simplification and easier navigation of electronic service plans; and
- Tracking eligibility to ensure more children gain access to public health insurance and ensure New Jersey maximizes federal dollars.

Daily communication and bi-weekly meetings with the CSA continue as new CYBER features and fixes and enhancements to existing features are released. The CYBER application can be

accessed from the CSA webpage at: http://www.performcarenj.org/. The website also contains useful information for families, youth and system of care providers. A Youth and Family Guide is available in both English and Spanish. It is here that parents and caregivers can learn how to obtain services and what can be expected when calling the CSA. A resource page is available as well as information on how families can file a complaint. Clinical criteria for each of the service lines (including CMO, Mobile Response, Family Functional Therapy, Multisystemic Therapy, Partial Hospitalization, Group Homes, Psychiatric Community Residence, Residential Treatment Center and Treatment Homes) are posted. The CSA uses the webpage as a means of providing reference guides, CYBER release updates, and training resources to help providers better understand how to navigate the electronic record.

DCSOC and the CSA will continue to improve and enhance the CSA program design and functions based upon the valuable feedback received from users, families, and providers.

A PowerPoint presentation, **"**The Division of Child Behavioral Health Services 10 Years of System of Care Implementation: *Letting the Data Tell the Story,"* can be accessed at: http://www.nj.gov/dcf/documents/home/childdata/behavioral/DCBHS10yrReview.pdf

DCF CAReS - The Department of Children and Families Consolidated Analytical Reporting System

DCSOC in conjunction with the New Jersey Office of Information Technology (OIT) has implemented a comprehensive data warehouse reporting solution that will meet the immediate data reporting needs of the DCSOC while laying an integration foundation to meet future integrated enterprise data information needs of the DCF. DCF is using the services of the Data Management Services (DMS) unit of the New Jersey OIT and the data architecture components of the New Jersey Common Information Architecture (NJCIA) to meet these objectives. The NJCIA provides design patterns, methodologies, technologies, reference data, and data facilities to achieve data integration.

In the past, DCSOC reporting approached was limited to receiving data via predefined data marts from PerformCare's CYBER and loading that data into a Microsoft Access database so reports could be produced. Perform Care's data was transformed, cleansed, formatted and loaded into a Microsoft Access database. This database was used to produce analytical reports. Some of these reports require extensive pre-processing to transform the data into the appropriate report format.

The DCF CAReS data warehouse solution provides a more flexible and user-friendly reporting approach. It standardizes the data transformations and improves overall report performance. It allows DCSOC and DCF to incorporate other data sources from within and outside of DCF into the solution. Most outside data sources are within other agencies in the Health and Social Services affinity group (line of business), such as various divisions within the New Jersey DHS.

DCF CAReS is being implemented in two phases:

The first phase, Initial Reporting (IR), which is currently implemented, deployed BusinessObjects (BO) as a reporting tool against the data currently in DCSOC' Microsoft Access

database. This data is hosted in an Oracle database. For DCSOC this is considered an independent data mart (not supplied through an enterprise data warehouse environment). The creation of an independent data mart is permitted as an interim solution during an enterprise data warehouse development effort.

The second track, the Consolidated Analytical Reporting Services (CAReS), has been initiated. Upon completion CAReS will create an enterprise DCF normalized data warehouse (integrated data store) for all social services data along with data marts (published data) as necessary to meet reporting needs. These data marts will be dependent, conforming data marts. They will be supplied from the enterprise data warehouse and will use conforming (standardized) reference data across data marts.

Data marts and BO universes will be created for each unique reporting need community/reporting need. Users may have different summary requirements or may need to see data aggregated in different ways. A data mart provides a user with the data in the form required, while other users have data marts in the form that they require. Because all data marts are sourced from the integrated data in the data warehouse, the answers generated across data marts will be consistent. The DCF CAReS track is the first step in a comprehensive data initiative compatible with and complementary to NJ-SPIRIT, the current DCF Child Welfare data system.

IV: Narrative Plan

R. Quality Improvement Plan

Narrative Question:

In the FY 2012/2013 Block Grant application, 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, that will describe the health of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that services, to the extent possible, continue reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements and garner and use stakeholder input, including individuals in 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. In an attachment, states must submit a CQI plan for FY 2014/2015.

Footnotes:

R. Quality Improvement Plan

The Division of Mental Health and Addiction Services (DMHAS)

When merged DMHAS integrated the quality activities from the processes which were previously in place for the separate divisions. The approach used for quality activities at the Division is to distribute quality processes throughout the various DMHAS offices:

- The Office of Prevention, Early Intervention and Community Services is responsible for monitoring the activities of community mental health and addiction providers and responsible for overseeing the Unusual Incident Reporting Management System (UIRMS) for community incidents at mental health providers;
- The Office of State Hospital Management and the Office of the Medical Director oversees quality assurance activities and the UIRMS for state hospitals;
- The Office of Research, Planning, Evaluation, Information Systems and Technology provides system level data and reports that inform the Division's continuous quality improvement activities; and
- The DHS Office of Licensing (OOL) reviews all DMHAS providers adherence to licensing regulations and the Central Incident Management Unit (CIMU) collects data on reportable incidents for addictions and mental health community providers and the state psychiatric hospitals. The state psychiatric hospitals manage their unusual incidents with DMHAS oversight and DMHAS manages the mental health community unusual incidents with assistance from CIMU. Current quality improvement strategies are described below for DMHAS and attached is the current Continuous Quality Improvement Plan for FY 2014/2015.

Quality Improvement Activities

The administrative operations and delivery of services for consumers with substance use and mental health disorders are based upon the principles of continuous quality improvement and total quality management through a systemic, data-driven approach to improved service delivery and achievement of future results. Reliable and valid data are used to identify and track critical outcomes and performance measures that describe the effectiveness of the system; continuously measure the effectiveness of services and ensure, whenever possible, that services reflect the evidence of their effectiveness. These processes incorporate some of the same consumer outcome and agency and systems performance data to identify opportunities for agency and systemic improvements in order to promote improved consumer outcomes. In addition to the processes described below, DMHAS implements the attached CQI Plan to monitor contracted agency performance, performance measures and response to emergencies, critical incidents, complaints, and grievances.

DMHAS has processes which are tracked at the state psychiatric hospitals and several clinical initiatives which are being done in collaboration with the state psychiatric hospitals and community. Each state psychiatric hospital has a Quality Plan and all community agencies licensed by DHS are required to have a Quality Plan.

Program and Contract Monitoring

The Office of Prevention, Early Intervention and Community Services is comprised of one statewide and three Regional offices that are primarily responsible for oversight of the operation of the community behavioral health system of care. On behalf of DMHAS, staff negotiates contracts with the community providers, as well as community hospitals, for the provision of prevention and early intervention services, as well as ambulatory outpatient and inpatient behavioral health care.

The Division relies on Service Contract Monitoring to continuously measure the effectiveness of services and supports and ensure that services, to the extent possible, demonstrate evidence of effectiveness. Staff oversees the implementation of the contracts to ensure that service commitments are met and that agencies are compliant with DHS/DMHAS program standards, state and federal statutes, as well as other applicable rules and regulations, policies, procedures and protocols. Staff also monitors agency operations to ensure that services are delivered within the context of a recovery oriented and culturally competent system. Staff participates in agency reviews conducted by the DHS OOL.

Addiction agencies have at least one formal contract monitoring site visit annually per calendar year for all prevention, treatment, and recovery support service contracts. More frequent reviews are conducted on an as needed basis for agencies identified as needing additional technical assistance or monitoring in response to identified deficiencies, technical assistance needs, or special contract requirements. The Annual Site Visit Monitoring Review Form addresses a minimum of five issues: Facility, Staff, Treatment or Service Records, Quality Assurance, Specialized Services, and Other Contract-Specific requirements.

Staff represent DMHAS at statewide, county and local forums where information sharing, technical assistance and state input for problem solving, program design, advocacy for consumer and families as well as where data collection and analysis is required.

Staff are available to assist consumers and families if there is dissatisfaction with services or difficulty in accessing or navigating the behavioral health system of care.

Health and Wellness

In addition, in collaboration with the Office of the Medical Director, the Office of Prevention, Early Intervention and Community Services collects data on mental health community consumer deaths. This includes: gender, age, county, program type, housing type, Axis I and Axis III diagnoses when available, cause of death. This information is gathered through the unusual incident reporting process and with cooperation from Department of Health Vital Statistics unit. This data is collected to track and trend deaths of consumers diagnosed with mental illness. This project began in April 2012 with the ability to track deaths systematically in UIRMS. Our hope is that by being aware of the causes of death we will be able to effectuate change using interventions such as training and education and by integrating physical health with mental health treatment for our state's consumers.

Provider Performance Reports

The Office of Research, Planning, Evaluation, Information Systems and Technology (ORPEIST) developed the "Provider Performance Reports" for all addiction treatment provider agencies funded by the DMHAS. The report includes: 1) statewide treatment data for all agencies, 2) admission and discharge data by modality for each specific agency, and 3) NOMS data for each modality an agency provides in comparison to statewide averages and peers. The outcomes in these reports include: abstinence from drug and alcohol use, increased employment, decreased criminal justice involvement, decrease in homelessness, and increased retention in substance abuse treatment. A measure on the percentage of clients successfully completing their treatment plan is also included. These reports were first produced in 2006 and are currently issued for the fiscal and calendar year, being sent to over 200 providers. In addition, county aggregate performance reports are produced that provide Local Advisory Councils on Alcoholism and Drug Abuse (LACADAs) and the County Alcohol and Drug Directors with profiles of the strengths and weaknesses of local systems of care. Statewide performance reports are also produced for the fiscal and calendar year and are posted on the DMHAS website.

Building upon the model of Provider Performance Reports for addiction treatment agencies, the ORPEIST is now in the process of developing Provider Performance Reports for community mental health agencies. Two programs that have been prioritized are the Designated Screening Centers and Supportive Housing. A template has been created for Designated Screening and reports were shared with Screening Directors in January 2013. The reports were well received by the agencies and will also be used to guide the selection of areas for improvement in the NIATx Project described below. A key driving force for the development of this report is to help Screening Centers prepare for the implementation of the ASO to manage behavioral health care in New Jersey.

NIATx Performance Improvement Initiatives

NIATx is a model of process improvement specifically for behavioral health care settings to improve access and retention in treatment. Improved access, engagement, retention, and consumer outcomes was the driving force behind the SSA to engage NIATx, in 2009 to deliver their learning collaborative model of process improvement to selected contracted substance use disorder treatment agencies in New Jersey. The goal of the NIATx Quality Improvement Capacity Building Program was to develop a core group of treatment agencies and staff that can provide leadership and serve as mentors for other New Jersey substance abuse treatment agencies that wish to improve performance and attain meaningful, client-centered treatment outcomes. The SSA also participated and implemented its own walk-through and change projects. Within six months of the program completion, two of the agency Change Leaders and one SSA staff were trained as NIATx coaches, and two of the participant agencies, in collaboration with the SSA, planned and delivered a one-day NIATx conference to the statewide provider community.

In 2009, the SSA initiated its first addictions performance-based contract. Through a competitive bidding process, residential treatment providers were contracted to provide treatment services to Drug Court participants. The contract included an opportunity to earn incentives for

meeting length of stay targets that are correlated with program engagement and retention. These targets were identified through a survival analysis of program encounter data. Contracted providers were required to participate in NIATx in order to improve their attainment of the performance targets and report data.

In 2010, DMHAS received support from the Nicholson Foundation to extend the NIATx Quality Improvement Capacity Building Program. Two additional learning collaboratives were launched. One collaborative invited FFS contracted providers to participate in program to implement the NIATx Process Improvement Model build their business systems and fully participate in third-party billing. Agencies were able to initiate change projects to implement and /or improve third-party billing systems and learn skills to develop a business practice dissemination plan. The second collaborative targeted agencies providing outpatient services for child-welfare-involved consumers and provided an opportunity for these agencies to improve their processes related to engagement and retention for this priority population. These collaboratives were led by Coaches trained in the first collaborative. DMHAS has continued to implement change projects related to improve its contract monitoring procedures and practices. The next change planned change project includes incorporating consumer input into contract monitoring site visits.

In 2010, DMHAS used the NIATx rapid cycle change project to design a uniform Plan of Correction (PoC) format for use by all funded agencies. The aim was to ensure that PoCs were completed in a uniform and consistent way and reviewed in the same manner. The areas identified as needing to be in an acceptable PoC were: 1) Identifying citation; 2) Plan of Correction; 3) Measurability; 4) Person(s) responsible; 5) Implementation date; and 6) Estimated completion/compliance. The PoC template was originally piloted on 10 agencies and it was compared to their 2009 PoCs. The key findings were as follows: 1) only 53% of the 2009 PoCs were fully and accurately completed and monitors were not reviewing PoCs in a uniform, consistent manner and 2) In 2010 97% of the PoCs were fully and accurately completed and monitors reviewed PoCs in a uniformed consistent manner

A new project that will be implemented during 2013 is the introduction of mental health providers to a NIATx performance improvement project for the 24 Designated Screening Centers in New Jersey. There will be an initial two-three hour meeting with the hospital CEO's and the screening center representatives. Programs can select up to three change projects which involve: increasing mobile outreach to individuals in crisis, decreasing wait time in the emergency room, and reducing the recidivism rate for individuals who return to the screening center within 30 days. Learning collaboratives will be formed which will meet monthly for nine months. A coach will facilitate the process. After seven or eight months, providers are expected to have made significant progress towards their aim.

BHbusiness Strategic Business Planning Learning Network Technical Assistance Initiative

In order to prepare providers to operate within the new environment of Medicaid reform in New Jersey and the managing of mental health and addiction services under the ASO, the DMHAS is participating in a technical assistance initiative.

"BHbusiness: Mastering Essential Business Operations", provided targeted training and other supports to ensure that behavioral healthcare providers are ready to meet the demand for services in the FFS environment. The learning networks will help behavioral health organizations improve their capacity to serve the new populations seeking mental health and addiction services coordinated by the State Associations of Addiction Services, funded by SAMHSA in collaboration with NIATx, the National Council for Behavioral Health (National Council), and Advocates for Human Potential (AHP) to administer the learning networks.

DMHAS is the convener of two learning networks to enhance provider's capacities in the critical area of Strategic Business Planning. Participants will learn how to: analyze their local healthcare market, define their value in the market, and identify potential market needs that they can address. The course will include: independent research, reading-learning, on-line discussions using social media tools, interactive webinars, and participation in a one-day regional workshop.

The course provides for mastery of business environment analysis and business planning tools such as: Strengths, Weakness, Opportunities and Threats, Market Analysis Plan, Customer Value Proposition, and Financial Modeling. Using the information identified in the analysis tools, providers will write a business plan that identifies three strategic business goals (short, medium, and long) and begin to develop strategies to enter new markets, develop new services, or increase market share.

Approximately 60 agencies participated in the Strategic Business Planning course, which was a six month course that began March 15, 2013 and concluded on August 31, 2013.

Unusual Incident Reporting

In April 2012, DMHAS began reporting community incidents into the DHS' Unusual Incident Reporting Management System (UIRMS). Prior to this, the mental health community unusual incidents were entered into a separate data base. The UIRMS was developed and first implemented with the state psychiatric hospitals reporting incidents into UIRMS since January 2003. Community incidents for the addiction community agencies have been reported for several years into the UIRMS database and is managed by the DHS.

Available canned UIRMS reports are limited and therefore, DMHAS has an arrangement with the DHS, where UIRMS resides, to receive nightly data downloads of all DMHAS unusual incident data. This allows the Division unlimited analytical capability to develop any needed reports. In addition, the UIRMS data are made available to the state hospitals for their own individualized analytical purposes.

DMHAS Central Office

DMHAS' Medical Director's Office and Office of State Hospital Management have specific quality activities for the state psychiatric hospitals.

1. **Patient Services Compliance Unit Site (PSCU) Visits -** The PSCU conducts announced and unannounced site visits at each state psychiatric hospital related to abuse and neglect

reporting and monitoring, clinical and direct care staffing, therapeutic programming, environment of care, special levels of observation, and other aspects which the Assistant Commissioner deems appropriate. Reports are sent to the facility for corrective action plans as necessary and completion of these plans are monitored by PSCU.

2. **PSCU Hotline Calls Related to Allegations of Abuse, Neglect, Mistreatment, Exploitation and Professional Misconduct -** Data regarding telephone calls received on the PSCU hotline is entered into a database and compared with the UIRMS at the end of each month. This reconciliation process ensures that, as appropriate, calls to the hotline receive a corresponding incident report and investigation. Outliers are brought to the attention of the specific hospital for follow-up. UIRMS allegations of abuse, neglect, mistreatment, exploitation and professional misconduct are also reviewed each month for closure to the incident report. These are closed as substantiated, unsubstantiated, or unfounded. There is follow-up with a particular hospital if there are any questions with a case closed as unsubstantiated or unfounded. Data is tracked and shared with the hospitals. A sampling of closed cases are reviewed during PSCU site visits on Abuse and Neglect Reporting and Monitoring. Cases of professional misconduct that are substantiated are tracked for reporting to the appropriate licensing board.

3. **Patient Safety Act Root Cause Analysis -** Any hospital sentinel event that falls under the Patient Safety Act requires completion of a root cause analysis by the respective hospital. The DMHAS Patient Safety Act Oversight Committee reviews each root cause analysis. Patient Safety Act events are reported within 24 hours of the event. Root Cause Analysis is received by the Division within 45 days. Root Cause Analyses are reviewed to determine if the criteria for thoroughness and credibility are achieved. Any reports that require further inquiry are returned to the respective hospital for further analysis. The Department of Health serves as the subject matter expert regarding the Patient Safety Act.

4. **Centralized Admissions -** Centralized Admissions was designed to serve as the clearing house and triage center for potential admissions to state psychiatric hospitals. In addition, for those persons not appropriate for admission to a state psychiatric hospital, the Centralized Admissions Unit diverts admissions to a lesser restrictive setting. Data is gathered regarding:

    - Length of time it takes for patients to be appropriately medically cleared for admission;
    - Length of time to address each referral for admission (target is same day)
    - Timeliness of triaging patients; and
    - Timeliness of addressing referrals from emergency rooms (24 hours is target).

5. **Clinical Initiatives -** The Medical Director's Office in conjunction with the Office of State Hospital Management has prioritized the following clinical performance improvement initiatives with each of the state psychiatric hospitals:

    - **Polypharmacy** - Decrease the use of antipsychotic medication in each of the following categories by 10%:

I. Intra-Class-Antipsychotic Polypharmacy Rationale: Increased drug interactions, side effects, cost and difficulties in dispensing multiple agents. No proven increased efficacy.

- two antipsychotics (percentage of patients with standing orders for any antipsychotic who have concurrent standing orders for any two antipsychotics)
- two atypical antipsychotics (percentage of patients with standing orders for any antipsychotic who have concurrent standing orders for any two atypical antipsychotics)
- three or more antipsychotics (percentage of patients with standing orders for any antipsychotic who have concurrent standing orders for three or more antipsychotics)

II. Inter-Class Polypharmacy Rationale: Increased drug interactions, side effects, cost and difficulties in dispensing multiple agents.

- Defined as five or more psychotropics (calculated as percentage of patients with standing orders for any psychotropic who have concurrent standing orders for five or more psychotropics, including nonpsychotropic agents that are used as psychotropics, such as hydroxyzine for anxiety.)

III. High Dose Antipsychotic Use Rationale: Use of dosages above the recommended dosages can increase incidence of the side effects, drug interactions and other adverse consequences, and does not necessarily increase drug efficacy.

- Total antipsychotic dosage(s) above maximum recommended dose (calculated by converting dosages of antipsychotics to chlorpromazine equivalents and taking the percentage of patients with high dose antipsychotics as a proportion of all patients receiving antipsychotics).

IV. Long Acting Injectable (LAI) Antipsychotic with Oral Antipsychotic Rationale: LAI antipsychotics are primarily used in patients who fail to take oral agents. Use of oral antipsychotics beyond the period of initial titration of the LAI should not be necessary with continued use and appropriate dosing of the LAI.

- Calculated by taking the percentage of patients with orders for any single LAI antipsychotic who have concurrent standing orders for the LAI antipsychotic and any oral antipsychotics)

- **Special Levels of Observation (Use of 1:1)**
  I. Reduce the use of 1:1 to critical behavioral situations
  II. Anyone on 1:1 for more than 5 days shall have interventions addressing behaviors in the treatment

- **Metabolic Syndrome** Ensure that treatment is being provided to patients with abnormal metabolic syndrome indices.
    I. 100% of patients are screened for Metabolic Syndrome according to the Administrative Bulletin
    II. Those patients with Metabolic Syndrome have interventions in their treatment plan addressing those positive indices; e.g.: diet if overweight, statin if dyslipidemia

State Psychiatric Hospitals

The four psychiatric hospitals support the SAMHSA National Consensus Statement on Mental Health Recovery: "Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential." As providers of inpatient mental health services, state psychiatric hospitals recognize that they are one important step in the continuum of care toward the recovery of the individuals we serve. Therefore, the state psychiatric hospitals incorporate recovery principles into every policy and program.

The state psychiatric hospitals utilize the following guiding principles to support the treatment and recovery of persons with severe and persistent mental illness:

- Leadership provides structure, accountability, resources, and services to support staff and facilitate patient recovery through a foundation of a caring and therapeutic relationship;
- Planning, implementation and provision of integrated, patient driven, recovery-focused treatment;
- Provision of strengths based, individualized, person centered care, encouraging patient involvement and peer support;
- Provision of a culture of nonviolence and safety, focused on mutual patient and staff respect;
- Hope, empowerment, empathy, and compassion are central to the hospital achieving its mission.

The primary goal of the Performance Improvement Program is to continually and systematically plan, design, measure, assess and improve performance of hospital-wide key functions and processes relative to patient care. To achieve this goal, the quality plans strive to:

- Incorporate quality planning throughout the facilities;
- Provide a systematic mechanism for the facilities' individuals, departments and committees to function collaboratively in their efforts toward performance improvement;
- Provide for hospital-wide programs that assures the facilities design processes (with special emphasis on design of new or revisions in established services) well and systematically measure, assess and improve its individual performance to achieve optimal patient health outcomes in a collaborative, cross-departmental, interdisciplinary approach. These processes include mechanisms to assess the needs and expectations of the patients and their families, staff and others;

- Focus upon what is performed and how well it is performed. To facilitate this goal, emphasis is placed upon "dimensions of performance". The dimensions of performance include:

    - Efficacy of the procedure or treatment in relation to the patient's condition;
    - Appropriateness of a specific test, procedure or service to meet the patient's needs;
    - Availability of a needed test, procedure, treatment or service to the patient who needs it;
    - Timeliness with which a needed test, procedure, treatment or service is provided to the patient;
    - Effectiveness with which tests, procedures, treatment and services are provided;
    - Continuity of the services provided to the patient with respect to other services, practitioners, providers and over time;
    - Safety of the patient (and others) to whom the services are provided;
    - Efficiency with which services are provided
    - Respect and caring with which services are provided.

DMHAS Performance Improvement Initiatives

Data collection, aggregation, analysis and reporting for these measures is the responsibility of the Office of Research, Planning, Evaluation, Information Systems and Technology (ORPEIST).

Core Measures – DMHAS collects data on the following core measures as outlined in the section "G. Quality" and the attached Quality Plan:

1. There is an increase of Level of Functioning (LOF) as self-reported in the Annual Consumer Perception of Care Survey.
2. There is an increase in the number of mental health consumers served by DMHAS by using the evidence based practice of supportive housing.
3. There is an increase in the quality and number of supportive relationships among the SMI population served by the DMHAS as self-reported on the Annual Consumer Perception of Care Survey.
4. Increase the number of adults with SMI or SED who are employed.

Other Performance Measures – DMHAS has identified three specific performance measures in addition to the Core Measures as listed above. These are further outlined in section "G. Quality" and the attached Quality Plan:

1. Supportive Housing
2. Suicide Prevention
3. Consumer Operated Services

State Hospital Performance Improvement Initiatives

1. Core Measures – Hospital Based Inpatient Psychiatric Services (HBIPS) - HBIPS is a major, national leadership effort to improve quality, safety, and performance of hospital-

based inpatient psychiatric services through the collaboration of hospitals, physicians, and consumers. Measures are collected and data is sent to the NASMHPD Research Institute, Inc. (NRI), which then forwards it on to The Joint Commission. NRI is a subdivision of the NASMHPD. All free-standing psychiatric facilities were required to begin reporting this data to The Joint Commission beginning January 1, 2011. The HBIPS Core Measure Set includes:

- HBIPS 1: Screening for risk of violence to self, risk of violence to others, substance use, psychological trauma history, and patient strengths
- HBIPS 2: Restraint hours
- HBIPS 3: Seclusion hours
- HBIPS 4: Patients discharged on multiple antipsychotic medications
- HBIPS 5: Patients discharged on multiple antipsychotic medications with appropriate justification
- HBIPS 6: Post discharge continuing care plan created
- HBIPS 7: Post discharge continuing care plan transmitted

Aggregate data is reviewed and outliers are assessed and corrective actions taken to increase scores.

Beginning August 15, 2013, each hospital's fourth quarter 2012 and first quarter 2013 HBIPS data on HBIPS - 2, 3, 4, 5, 6, 7 only will also be reported to the CMS via QNet. The financial impact is 2% of a facility's Annual Payment Update.

2. Inpatient Consumer Survey - As a recovery-oriented system, the hospitals strive to be inclusive and collaborative as well as to instill hope to patients. As expressed in the SMHA's Transformation Statement, each participant in the mental health system -- patients, primary support persons, hospital staff, and community providers -- is empowered and holds distinct and valuable knowledge and experience. One way of gathering this information is through an inpatient consumer survey originally started as one of the performance measures the hospitals used, collected data on and sent to the NRI. The hospitals have revised the form and began using the revised survey in November 2011. The survey is developed in .NET. After patients complete the survey it is entered into the application by hospital staff. As of April 2013 there were 1276 surveys entered into the system. Aggregate data is reviewed, outliers are assessed, and corrective actions taken to improve scores. Data is collected in the following areas:

- Patient Perception of Outcome of Care
- Patient Perception of Dignity
- Patient Perception of Rights
- Patient Perception of Participation in Treatment
- Patient Perception of the Facility Environment

3. Assaults (Patient-to-Patient and Patient-to-Staff) - State psychiatric hospitals collect data on patient-to-staff and patient-to-patient assaults. The purpose is to provide data about the incidence of patient-to-patient and patient-to-staff/other assaults at each hospital in order to facilitate performance improvement activities. This data is aggregated and

analyzed, looking for patterns and trends, and actions implemented in attempt to decrease violence. Individual cases of assault may need to be thoroughly analyzed in order to develop changes in a patient's treatment plan. Each hospital has a systematic process for reviewing monthly assault data at the respective Violence in the Workplace Committees In addition, the DMHAS has a Violence Reduction Committee whose task is to reduce violence at the state psychiatric hospitals.

4. **Falls -** Falls are a major concern in health-care-settings because they can lead to serious injury or worsen health problems. A Falls Risk Assessment is completed, at a minimum, on each patient upon admission, whenever there is a fall (un-witnessed or witnessed), yearly, and when falls precautions are ordered. Every hospital has a "Falls Committee" which is responsible for reviewing each and every patient fall, aggregating and intensely analyzing the data. Falls Risk Assessments are completed per each hospital's policy. For patients at high risk for falls, interventions are listed in the patient's treatment plan and implemented as per the plan.

5. **Grievances/Complaints -** Each hospital has a policy related to addressing patient complaints or grievances. Patient complaints are addressed by hospital policy. Patient grievances are addressed per hospital time frames.

6. **Evidence-based Treatment Interventions (training/programming) -** Illness Management and Recovery (IMR) and Dialectical Behavior Therapy (DBT) are groups run by hospital staff trained and supervised by on-site university consultants. Data is collected about the number of staff trained, the number of individual and groups sessions held, the Consumer Perception of Outcome of IMR groups and the percentage of IMR groups that have an average fidelity score of five (5).

7. **Family Monitoring Programs -** Unannounced visits, at the state psychiatric hospitals, are made periodically by family members and other interested parties to review the environment and therapeutic activities and findings reported to the hospital administration. The hospital addresses findings from family monitoring within 20 days. Hospitals meet at least quarterly with their family monitoring groups.

The Division of Children's System of Care (DCSOC)

Continuous Quality Improvement Processes Implemented by the Contracted System Administrator

PerformCare's CQI process first identifies key quality care and performance indicators and initiatives, both within the CSA and with individual providers in the service delivery network. Many of these indicators and initiatives are defined by contract and later enhanced as programs mature. This provides a framework for all Quality Improvement/Utilization Management (QI/UM) and Outlier Management activities using a balanced and well-integrated quality, cost, and risk perspective. Under every identified goal/objective (called Strategic CQI Initiatives), there are multiple indicators (Dimensions of Performance) that form the basis of an annual PerformCare QI/UM and Outlier Management Program Description and Work Plan. The Work

Plan outlines specific measures and reports that are monitored, evaluated, and then used to determine if quality initiatives are needed. A consistent structure and philosophy guides all of PerformCare's CQI efforts and is apparent within the Quality and Outcomes Management and Systems Measurement Program (QOMSMP) described below. Depicting the order of process graphically, PerformCare QI/UM and outlier management activities are structured as follows:

QOMSMP Strategic CQI Initiatives

⇓

Organization of QI/UM and Outlier Management Program Description, Work Plan, and Annual Program Evaluation

⇓

Organization of the QI/UM Committee Agendas, Minutes, Actions, and Reports

⇓

Organization of Responses to Requests for QI/UM Summaries from Stakeholders

The success of the QI/UM Committee is measured by the ability of PerformCare staff to administer systematic QI/UM policies and procedures, monitor and evaluate treatment delivered to children/youth/young adults and families according to predetermined standards, and ensure CQI.

The QI/UM Committee systematically monitors and evaluates the quality and safety of clinical care and service delivery by PerformCare's Care Coordinators/DCP&P Care Coordinators and Member Services Specialists as well as service providers. Quality of care is defined as the degree to which health care services for children/youth/young adults and/or their families increase the likelihood of desired health outcomes that are consistent with current professional knowledge. When a quality of care issue is identified through a routine call, complaint, reconsideration, appeal, or during the course of a CSA care coordination review, it is brought to the attention of the Clinical Manager or Director. The Clinical Manager or Director works with the reporter to determine priority and follow up needs. Non-urgent items are sent for review to the Quality of Care Council (QOCC) that meets regularly. The QOCC consists of the Medical Director, Clinical Manager or Director, and Director of Quality Improvement or designees. This group reviews the information and determines next steps as well as generates a report for the QI/UM Committee.

The following 10 Strategic CQI Initiatives serve as starting guideposts to provide a focus for all QI/UM and outlier management activities in the New Jersey System of Care.

1. **Access** – The degree to which appropriate care and services are accessible and obtainable to meet the child's/youth's/young adult's and family's needs.
2. **Appropriateness** – The degree to which the care and services provided are relevant to the child's/youth's/young adult's and family's clinical needs, given the current state of knowledge of best and promising practices, evidence-based care, and available resources.
3. **Competency** – The degree to which providers and PerformCare staff adhere to professional and/or organizational standards of care and practice.
4. **Child and Family Involvement** – The degree to which children/youth/young adults and families have an active role in the program.

5. **Continuity and Care Coordination** – The degree to which needed healthcare services for a child/youth/young adult or specified population are coordinated across levels of service intensity, organizations, child-serving systems, and across the coordination of physical and behavioral health systems.
6. **Diversity and Cultural Competency** – The degree to which providers and PerformCare staff understand and demonstrate respect for differences among cultural and ethnic groups that affect service delivery and clinical care.
7. **Outcomes and Efficacy –** The degree to which a treatment or service improves health status.
8. **Prevention and Community Outreach** – The degree to which PerformCare services promote health, prevent deterioration of emotional and behavioral health difficulties, and educate the community.
9. **Safety** – The degree to which risks of adverse outcome are reduced for children/youth/young adults, families, and others, including the service provider.
10. **Service Excellence** – The degree to which PerformCare meets established service standards and produces customer, provider, and child/youth/young adult and family satisfaction.

The framework for the activities of the QI/UM Committee is based on the Define/Measure/Analyze/Improve/Control (DMAIC) plan. This plan is defined as follows:

Define: Define the problem and costs/benefits to be realized.

⇓

Measure: Establish measurement with objective quality indicators and data.

⇓

Analyze: Analyze collected data, root causes, and processes.

⇓

Improve: Implement system interventions to achieve improvement.

⇓

Control: Develop ongoing monitoring to sustain gains and control processes.

A. Quality and Outcomes Management and System Measurement

PerformCare, as the CSA, is committed to offering the highest quality of services by actively exploring and taking action on opportunities for improvement. As areas of improvement are identified, PerformCare will implement new or different practices to achieve the goal of utilizing a data-driven system. Such improvements will increase efficiency, accuracy, timeliness, accountability, communication, and satisfaction by all users of CSA services. More specifically, the QI/UM and Outlier Management Programs monitor:

- Call center performance in answering calls: PerformCare will monitor all phone statistics and submit reports to the Director of Quality Improvement for review in QI/UM meetings.
- Child/youth/young adult and family/caregiver satisfaction: Satisfaction is a key indicator that services are or are not working for the people using the system. PerformCare will

work with DCF/DCSOC to implement existing satisfaction measurement tools or review and determine most appropriate tools.

- Reliability and timeliness of service delivery: Though an authorization is approved by PerformCare, it is only through this monitoring that the company truly knows what is occurring in service delivery. Data like this assists Care Coordinators/DCP&P Care Coordinators in the re-authorization process and understanding the speed or lack thereof in outcomes and functional improvement.
- Decision making process: Timeliness and consistency.
- Service utilization: This includes trends, outliers, length of stay by service and by provider, racial and ethnic disparities, and disproportionality. This data is used to assist in the assignment of Enhanced Care Coordination and to explore the disparity and disproportionate use of services by certain groups as well. Sharing this information in the QI/UM Committee allows members to have the opportunity for input. It also enhances discussion with DCF/DCSOC to help design the intervention and monitoring through a CAP.
- Network adequacy: Information regarding timely access to services wait times and partial service delivery assists the PerformCare and DCF/DCSOC to address network issues. The MIS can produce geo-mapping technology that allows for the determination of what type of service line is inadequate, as well as where the inadequacies lie. The QI/UM Committee and/or DCF/DCSOC will continue to monitor reported inadequacy through a CAP.
- Costs of services provided: This can be outlined by type, average cost per child/youth/young adult, and in aggregate.
- Outcomes measurement: The positive attainment of outcomes by service line and system-wide, including clinical and functional outcomes and system-wide outcomes such as OOH services.

B. CAPs

Written CAPs include specific action(s) taken or to be taken, timeframes for initiation and completion, person(s) responsible, and follow-up activities to be implemented to ensure effectiveness of the action. CAPs may include additional staff and system partner training, technical assistance, and revisions in or development of new policies and procedures. The effectiveness of CAPs requires continual monitoring and evaluation to identify measurable changes and improvements. Measuring and evaluating CQI efforts helps to ensure:

- measurable improvement of the desired change,
- that improvement is maintained over a specified time period,
- that improvement in the quality of treatment and/or service is continually reflected in daily operations,
- that improvements continually meet the requirements of the standards outlined in the action plan, and
- that there is supporting documentation of the required outcomes and improvements.

PerformCare, through the QI/UM and Outlier Management programs and regular monitoring, develops CAPs anytime performance standards are not met. These CAPs are submitted to

DCF/DCSOC for review and feedback, and performance improvement is monitored by supervisors and through the QI/UM Committee.

C. Delegation of Quality Improvement and Utilization Management Program Activities

PerformCare does not delegate any QI/UM and Outlier Management Program activities. In the event that PerformCare delegates any of these functions to another entity, such as a subcontractor, the QI/UM Committee will ensure the following:

- There is a written description of the delegated activities. This description will include the delegate's accountability for these activities and the frequency of reporting to the QI/UM Committee.
- PerformCare's program has written policies and procedures monitoring and evaluating implementation of delegated functions and verifying the quality of care provided.
- There is evidence of continuous ongoing evaluation of delegated activities including approval of the entity's annual QI/UM and Outlier Management Program Description and Work Plan and regular specified reports.

D. The Quality Improvement/Utilization Management (QI/UM) Committee

The QI/UM Committee is established to provide administrative oversight of the QI/UM and Outlier Management Program and as carried out by the Work Plan. The Work Plan is a document developed and updated at least annually to identify the specific indicators, measures, and timeframes of the QI/UM and Outlier Management Program for that year.

The QI/UM Committee assesses pertinent utilization and trended data to ensure that appropriate care and interventions will be implemented along with assessing organizational functions for improvements. The QI/UM Committee assures that the QI/UM and Outlier Management Program seizes opportunities for clinical and service improvement by embedding the principles of CQI into the process and then implements the change necessary to improve outcomes. The principal responsibility of the QI/UM Committee is to monitor the utilization and quality of both clinical and non-clinical services offered to the children/youth/young adults and their families served by the CSA.

The QI/UM Committee meets on a minimum of a quarterly basis. Committee meetings are internal to PerformCare and will focus on monitoring internal processes and post go-live implementation activities. The Medical Director serves as PerformCare's designated behavioral healthcare practitioner and co-chairs the QI/UM Committee. The Director of Quality Improvement serves as Chair. Committees generally operate by consensus, but sufficient representation by voting members must be present to vote on resolutions or actions. Sufficient representation is defined as a quorum and occurs when two-thirds of voting members are in attendance.

The QI/UM Committee may add, as appropriate and in consultation with DCF/DCSOC, to its ad hoc membership by including other necessary members such as PerformCare management and line staff, providers, family members (including priority population representatives), and others.

Ad hoc members are approved by the Committee Chair prior to attending meetings and are non-voting, but are subject to the same committee rules as voting members. The QI/UM Committee is comprised of representatives from all of the service delivery components of the organization including administration, care coordination, and member services. Interested healthcare practitioner representatives may attend and participate in the committee meetings, with an emphasis on improvements in clinical behavioral health care and service. Under the direction of DCF/DCSOC, the QI/UM Committee may include youth, young adults, families, providers, and other stakeholders.

PerformCare solicits and supports provider participation in the QI/UM process through opportunities for provider participation in provider-specific meetings, trainings, and ongoing communication in the course of normal operations. The standing membership of the QI/UM Committee includes the following:

Voting Members

- Chair: PerformCare Medical Director or physician designee.
- Co-Chair: PerformCare Director of Quality Improvement.
- PerformCare Clinical Manager or Director.
- Possible external DCP&P and DCF/DCSOC representatives, providers, child/youth/young adult and family stakeholders are to be determined under the direction of DCF/DCSOC

Consistent with PerformCare's commitment to CQI, the Director of Quality Improvement, in consultation with the Medical Director and under the direction of the QI/UM Committee, formulates the QI/UM and Outlier Management Program Description and Work Plan for the upcoming year. The contents of the program include:

- goals and objectives for the upcoming year;
- program scope;
- specification of indicators to be monitored in the coming year, including a brief outline of the methodology, timeline, and party(ies) responsible for monitoring each indicator;
- an outline of scheduled projects and activities designed to address issues identified through evaluation of the previous year's report, including the quality and safety of clinical care and quality of service;
- timeframe within which each activity is to be achieved;
- identification of priority areas of program focus, including variables to be explored through focused Performance Improvement Projects (PIPs); and
- planned evaluation of the QI/UM and Outlier Management Program.

The QI/UM Committee fulfills its purpose through the following activities:

- Annual review, revision, and approval of all policies and procedures.
- Annual review, approval, and implementation of the QI/UM and Outlier Management Program Description, Work Plan, and Program Evaluation.
- Analysis and evaluation of the results of QI/UM activities, quality indicators, current goals, and recommended modifications to the Work Plan. This monitoring includes

reviewing data and reports to identify trends and any necessary organizational corrective action(s).

- Ensuring practitioner participation in the QI/UM and Outlier Management Program through planning, design, implementation, or review.
- Monitoring the implementation and effectiveness of remedial/corrective actions.
- Determining the need for PIPs beyond standardized monitoring and evaluation.
- Monitoring implementation and review findings of these PIPs.
- Reporting to the PerformCare Board of Directors and DCF/DCSOC conclusions and necessary actions and follow-up as appropriate to meet the goals of the QI/UM and Outlier Management Program.
- Submitting a QI/UM and Outlier Management Annual Program Description to the PerformCare Board of Directors and DCF/DCSOC for recommendations regarding any necessary changes to the program.

The QI/UM Committee meets at least quarterly to accomplish the annual goals and oversee, coordinate, implement, evaluate, and modify the Work Plan.

1. Documentation

The QI/UM Committee protocol for documenting activities, findings, recommendations, and actions is as follows:

- All meetings and activities of the QI/UM Committee are documented using committee minutes and a written agenda. Minutes are typed, reviewed, dated, and signed by the committee chair/co-chair, and distributed to committee members. Final adopted documents (including reports that are adopted with or without changes) are provided to the QI/UM Committee after the monthly meetings.
- Minutes follow a consistent format that identifies:
    - topics discussed;
    - findings, supporting data, documentation, and recommendation(s) for problem resolution, service/system enhancements, and opportunities for improvement; and
    - a written action plan to include specific action(s) taken or to be taken, timeframes for initiation and completion, person(s) responsible, and follow up activities to be implemented to ensure effectiveness of above action.
- Minutes of the previous meeting are reviewed, amended as needed, and approved as the first order of business in the next consecutive meeting.
- Committee meeting minutes, reports, summaries, reviews, monitoring/evaluative data, and any other documentation and information (in part or complete) are confidential and proprietary in nature. Distribution is made according to an established approved distribution list. All committee members (standing and ad hoc), participants, and/or observers on a regular or ad hoc basis are required to sign a statement agreeing to abide by all standards, rules, regulations, and guidelines regarding confidentiality and the handling of proprietary information.

2. Accountability to the Governing Body

The QI/UM Committee is assigned oversight responsibilities for the QI/UM and Outlier Management Program by the PerformCare Board of Directors. The PerformCare Board of Directors reviews and approves the QI/UM and Outlier Management Program Description on an annual basis. Prior to implementation, the Program Description and Work Plan are also submitted to DCF/DCSOC for review and approval annually, no later than January 30 of each calendar year. The QI/UM Committee provides administrative direction and direct oversight for all processes and activities of the QI/UM and Outlier Management Program. The QI/UM Committee is accountable to the PerformCare Board of Directors and DCF/DCSOC. The QI/UM Committee is actively involved in the design, development, and implementation of the QI/UM and Outlier Management Program and the monitoring and evaluation of all quality improvement activities.

3. Medical Director as Designated Practitioner

Responsibility for medical policy pertaining to the quality of behavioral health care is assigned to the PerformCare Medical Director. The Medical Director is the designated behavioral healthcare practitioner with overall oversight of the QI/UM and Outlier Management Program. The Medical Director, who is a Board Certified Psychiatrist, is an active participant in the QI/UM Committee. The Medical Director oversees clinical activities and provides clinical supervision/consultation of all personnel. The Medical Director retains the final authority for recommendations for professional clinical review of credentials, medical necessity, and appropriateness or quality of care.

4. Annual Work Plan

The QI/UM Committee provides oversight approval of the QI/UM and Outlier Management Program Description, Work Plan, and Annual Program Evaluation. All three documents are developed by the QI/UM Committee and annually evaluated and approved by the PerformCare Board of Directors and DCF/DCSOC. As a CQI document, the Work Plan evolves and changes as new issues develop and revised priorities are established to monitor care and service quality. The content of the Work Plan will change annually in response to the changing needs of the organization, children/youth/young adults and their families, and other customers. Continuous evaluation and reporting by the QI/UM Committee, entities, and/or individuals will identify the necessity for adding new information or adjusting the existing information during the program year. The continuous review and analysis of information serves to improve quality of outcomes, services, clinical care coordination, and reinforces PerformCare's commitment to quality.

The Work Plan identifies specific data collection procedures and on-going evaluation of clinical and administrative functions. Data is used to review progress towards implementation and accomplishment of QI/UM and Outlier Management Program goals and objectives; identify problems for resolution; determine effectiveness of remedial/corrective actions; modify services/systems within the organization; and re-evaluate performance standards and thresholds to ensure the implementation of a continuous quality improvement process throughout the clinical, administrative, and operational functions.

As part of the Work Plan, PIPs may be identified during the course of the year that can have a favorable effect on health outcomes and child/youth/young adult and family satisfaction. If identified, the NCQA Quality Improvement Activity format or other agreed upon mechanism will be used to develop measurements and interventions that will be reported to the QI/UM Committee. These projects may include Quality Planning, Quality Improvement, and Quality Control/Measurement activities focused on:

1. measurement of performance, using objective quality indicators,
2. implementation of system interventions to achieve improvement in quality, and
3. evaluation and initiation of activities for increasing and sustaining improvement.

Certain areas are targeted for PIPs. Projects include activities focused on:

- performance measurement, using objective quality indicators to be monitored with an emphasis on indicators that provide efficient, accurate, and reliable means of monitoring quality of services and treatment in targeted areas;
- identification of research methodology, reporting mechanisms, and timeframes for data collection for each PIP;
- appropriate data collection methods, including scheduled audits, focused studies (i.e., studies by population, diagnostic group, or service type), standardized outcomes measurement, and routine analysis of treatment-generated data;
- comparison of PerformCare's performance data with benchmarking data, professional standards, and internal baseline data to establish performance thresholds and guidelines;
- analysis of collected data for root causes, barriers to improvement, and to identify opportunities for intervention and improvement;
- development and implementation of system interventions to achieve improvement;
- evaluation of improvement activities to ensure that identified problem areas are effectively addressed; and
- provision of ongoing evaluation to PerformCare, DCF/DCSOC, DCP&P, and other system partners as appropriate.

5. Annual Program Evaluation

During the fourth quarter of each year, the Director of Quality Improvement begins the process of preparing an annual summary and evaluation regarding the quality and effectiveness of improvement activities from the previous year. The outcomes and results of all quality improvement activities will be summarized and reported annually in the QI/UM and Outlier Management Annual Program Evaluation. The Program Description and Work Plan are submitted for approval no later than January 30 of each calendar year. This report evaluates the continuity and effectiveness of the QI/UM and Outlier Management Program for the previous year. The contents of the report include:

- a description of completed and ongoing QI/UM and outlier management activities that address the quality and safety of clinical care and quality of service;
- analysis of the results and summaries of QI/UM and outlier management initiatives, including barrier analysis and interventions;

- trending of clinical and administrative quality and safety of clinical care and quality of service indicators and performance data, including aggregate data on utilization and inter-rater reliability documentation;
- areas of deficiency/corrective action recommendations;
- progress towards and achievement of Work Plan annual goals and objectives; and
- evaluation of overall effectiveness and continuity of the QI/UM and Outlier Management Program.

6. Resources

Guided by the QI/UM and Outlier Management Program Description and the annual Program Evaluation, PerformCare is committed to continuous evaluation and analysis of outcome and performance information. The review and analysis of process and outcome data is critical to identifying and resolving QI/UM issues that affect all aspects of the organization and its operations. This quality improvement initiative is a shared responsibility, requiring commitment from not only across departments but by all staff. However, particular PerformCare staff members are charged with the responsibility of overseeing daily QI/UM activities to meet the goals of the program.

Administrative responsibility for the QI/UM and Outlier Management Program is assigned to the PerformCare Director of Quality Improvement who works in consultation with the Medical Director or other qualified appointee. The Director of Quality Improvement is responsible for ensuring there are adequate resources to operate the QI/UM and Outlier Management Program. To this end, the Director of Quality Improvement, in coordination with the Chief Executive Officer and Chief Financial Officer, is responsible for the development and submission of an annual budget. The budget includes provisions for sufficient material resources, adequate staffing, and the provision for necessary education, experience, and/or training to effectively carry out QI/UM and Outlier Management Program activities. PerformCare works to ensure the availability of sufficient staff, data sources, and analytical resources to complete all program activities in a competent and timely manner. In addition, PerformCare has designated staff with statistical expertise that has the ability to design sound studies, apply statistical analysis of data, and derive meaning from the statistical analysis.

7. PerformCare Care Coordination and UM Monitoring Process

PerformCare's New Jersey QI/UM and Outlier Management Program includes clearly defined processes to manage mental health care utilization for children/youth/young adults involved in the System of Care. The program includes procedures to evaluate medical necessity criteria information sources, clinical appropriateness, and review and determination processes for behavioral health services. The QI/UM and Outlier Management Program provides the operational structure and processes necessary by which utilization decisions are made so that DCF/DCSOC and PerformCare can continuously evaluate program effectiveness and quality.

The goal of the QI/UM and Outlier Management Program is to determine the appropriate intensity of service for children/youth/young adults accessing behavioral health services and

evaluating the continuity, effectiveness, and quality of care. The QI/UM and Outlier Management Program for New Jersey centers on the following critical elements:

- utilization management services;
- single telephonic point of access;
- focused, outcome-oriented care for children/youth/young adults and their families/caregivers;
- utilization of cost-effective, least restrictive care;
- detection of over- and under-utilization;
- timeliness of UM decision-making, including initial assessment for service needs and continued stay; and
- consistency of UM decision-making based on DCF/DCSOC guidelines, policy, and medical necessity criteria including a comparison of actual decisions to DCF/DCSOC established algorithms for referral.

Ongoing monitoring of care coordination and continuity of care is one of PerformCare's Strategic Clinical Quality Improvement Initiatives and is incorporated into the QI/UM and Outlier Management Program Description and Work Plan. Coordination and continuity of care is defined as:

> The degree to which needed healthcare and other services for an enrollee or specified population are coordinated across levels of care, across organizations, and across care of physical and behavioral health services. Treatment services and supports are coordinated on both the local system level and on an individual child/youth/young adult and family basis in order to reduce fragmentation and to improve efficiency and effectiveness with service delivery. Coordination includes linkages with children/youth/young adults, families, advocates, and professionals at every level of the System of Care. Care Coordinators/DCP&P Care Coordinators are accountable for facilitating this coordination and to monitor appropriate performance based on established standards of practice.

Monitoring activities related to coordination of care include, but are not limited to, tracking and reporting on the following:

- readmission rates;
- coordination efforts with the DDD;
- coordination efforts with DCP&P; and
- coordination efforts with Family Courts and the JJC.

Data is collected from a variety of sources, including:

- assessment and UM and authorization data from PerformCare's MIS,
- outcomes data
- Care Coordinator/DCP&P Care Coordinator documentation audits and inter-rater reliability studies,
- retrospective (post-utilization) reviews, and

- outlier management data.

8. Review of Information Management Decision Support (IMDS) Tools, Medical Necessity, and Level of Need Criteria

The IMDS tools, medical necessity, and level of need criteria (DCF/DCSOC approved criteria), review guidelines, and standards are reviewed and evaluated on an ongoing basis by the Medical Director under the direction of DCF/DCSOC, its designated committees, and in consultation with the QI/UM Committee and other identified professionals. A formal review of all IMDS tools, medical necessity, and level of need criteria guidelines and standards is completed on an annual basis to ensure criteria remain relevant, valid, and consistent with the literature pertaining to the determination of medical necessity. The medical necessity and level of need criteria is also formally reviewed and approved annually by the QI/UM Committee.

By applying IMDS tools, medical necessity, and level of need criteria, the Care Coordinator/DCP&P Care Coordinator determines the following:

- The child/youth/young adult is receiving services in the least restrictive, least intensive, and most clinically appropriate level of service intensity required by his/her emotional and/or behavioral challenges and level of function.
- Current and requested treatment and ancillary services are consistent with the child's/youth's/young adult's clinical stability, complexity, and severity of symptoms.
- The child/youth/young adult is responding or can reasonably be expected to respond to the prescribed plan of treatment.
- Behavioral healthcare services continue to meet medical necessity.

While medical necessity criteria assists in establishing the intensity and mix of services most suited to the child/youth/young adult and family's condition, the criteria does not provide for specific individualized services. For this reason, PerformCare includes the assessment of the appropriateness of services and quality of care beyond the mere intensity of service. The PerformCare Medical Director and clinical team utilize best practice standards and clinical practice guidelines in assessing evaluations and provider practices.

The Director of Quality Improvement, in collaboration with the QI/UM Committee and Medical Director, ensures data interpretation and the use of medical necessity criteria are informed by best practices in the field of behavioral health. Current research in the field, clinical practice guidelines published by relevant professional organizations (i.e., American Medical Association, American Psychiatric Association), and guidelines established by licensing and accrediting bodies will be referred to in the development of recommendations for enhancements to medical necessity criteria and practice standards.

9. Complaints, Reconsiderations, and Appeals

The ability to effectively manage complaints, reconsiderations, and appeals for children/youth/young adults and their families in service is essential to the provision of

uninterrupted care and the ability of the child/youth/young adult to achieve stated treatment goals. Effective care coordination should minimize the need for extensive complaints as it is the responsibility of PerformCare to not only assure its own staff is responding effectively, but also to provide the appropriate training and expertise needed in the provider community to minimize the need for such complaints. PerformCare has established guidelines and a uniform process to resolve complaints, reconsiderations, and appeals in full compliance with all mandates, such as Medicaid-related procedures, including Fair Hearings and External Reviews. These processes include multiple review levels, as necessary, all designed to assure that children/youth/young adults and families are receiving the right services at the right time to achieve stated goals.

Documentation regarding each initial complaint and subsequent resolution captures data that demonstrates PerformCare's actions, the actions of the provider as reported, and the ability to monitor quality, focusing on:

- number and type of complaints, reconsiderations, or appeals received;
- timely decision-making and action plans;
- timely and accurate notification of resolution to all parties; and
- final outcomes of complaints, reconsiderations, or appeals (upheld, overturned, withdrawn, or pending status).

The QI/UM Committee monitors required timelines for resolution of complaints, reconsiderations, and appeals. All PerformCare staff understands that children/youth/young adults and their families are entitled to the best possible services from all entities within the System of Care and strive to reach timely resolutions. The family burden often experienced of managing complex issues should not be exacerbated by unresolved complaints. Any complaint related to quality of care or care coordination is documented and addressed by the Clinical Manager or Director. PerformCare ensures the determination and assurance of continuation rights (continuing current services) during the complaints, reconsiderations, and appeals processes.

Required data for every complaint is captured in the MIS that allows for reporting and monitoring of each complaint, reconsideration, and appeal until resolution. The MIS provides for real-time data analysis; monitoring the status of any complaint, reconsideration, or appeal at any time during the process; and accurate reporting of this information to all required parties including DCF/DCSOC. The recovery of all gathered information inclusive of that related to complaints, reconsiderations, and appeals is managed through a redundant, multifaceted backup system that ensures the integrity of the data. Backup media is stored on and off-site (in two separate off-site locations) and is readily available for restoring the data in a timely manner should the need arise. Additionally, backup servers are maintained on and off-site in a replicated arrangement assuring that information is obtainable in a near online state should the need arise.

Information about complaints, reconsiderations, and appeals processes (including clear and concise policies and procedures) are widely distributed through multiple channels including:

- the Youth and Family Guide,
- family and provider orientations and training, and

- the PerformCare web site.

In addition, PerformCare staff is required to verbally advise each child/youth/young adult and his/her family/caregiver of their rights and responsibilities should resolution of any complaint, reconsideration, and/or appeal be a suspension of the requested service level. Staff is trained to use language and terminology appropriate to the understanding of the child/youth/young adult and family when explaining the process. Staff is also trained to offer information about Family Support Partners and other peer resources should the family/caregiver be interested in obtaining such assistance. All employees, regardless of position, receive training on complaints, reconsiderations, and appeals policies and procedures during initial orientation. Refresher training is provided at least annually. Compliance documentation and other complaint, reconsideration, or appeal information will be available as required. Monthly compliance reporting is reviewed by the QI/UM Committee and Corporate Compliance Committee to assure that multiple departments are monitoring the company's performance. The Director of Quality Improvement is responsible for the implementation and management of complaints, reconsiderations, and appeals in conjunction with the Clinical Manager or Director.

A. Complaints

A parent/legal guardian, young adult, emancipated minor, or authorized representative may file a complaint. The complaint is referred to the Community Outreach Liaison who logs the relevant complaint information into the database. The Quality Improvement Coordinator verifies with the parent/legal guardian, young adult, emancipated minor, or authorized representative whether or not s/he first attempted complaint resolution through the local level process. If not, s/he is encouraged to seek local level complaint resolution first. If s/he tried local level complaint resolution or s/he insists upon complaint resolution through PerformCare, the Quality Improvement Coordinator Community Outreach Liaison proceeds with complaint resolution. If the complaint is of a sensitive nature or requires expertise in a given area, the complaint is referred to a supervisor or a staff member with expertise in the subject matter. If the complaint is regarding service quality, the complaint is brought to the attention of the Director of Quality Improvement and Clinical Manager or Director for intervention who will initiate the quality of care committee review process.

Resolution for complaints is completed within five business days from receipt of the complaint. A letter is sent to the parent/legal guardian, young adult, emancipated minor, or authorized representative and provider within 48 hours of this decision. If the parent/legal guardian, young adult, emancipated minor, or authorized representative does not accept the first attempt at complaint resolution, the appeal process is followed. All information collected for the processing of the complaint is documented in the complaints/reconsiderations/appeals database.

B. Reconsiderations

Any parent/legal guardian, young adult, emancipated minor, or authorized representative of a parent/legal guardian, young adult, or emancipated minor may request a reconsideration of a level of care determination when notified of that action. The reconsideration is referred to the Quality Improvement Coordinator who logs the relevant information into the database. The

Quality Improvement Coordinator verifies with the parent/legal guardian, young adult, emancipated minor, or authorized representative if s/he first attempted resolution through the local level process. If not, s/he is encouraged to seek local level resolution first. If s/he tried local level resolution or s/he insists upon resolution through PerformCare, the Quality Improvement Coordinator proceeds with reconsideration and coordinates the process as follows:

- review by the Clinical Manager or Director is completed;
- review by the Medical Director is completed;
- the first attempt at resolution of the reconsideration is within five business days of the reconsideration request;
- if the parent/legal guardian, young adult, emancipated minor, or authorized representative does not accept the first attempt at resolution, the appeal process is followed;
- until the reconsideration/appeal is finalized, the intensity of service prior to reconsideration will be continued;
- when the resolution is finalized, appropriate services are authorized and all documentation regarding the reconsideration is entered into the database;
- a letter is sent to the parent/legal guardian, young adult, emancipated minor, or authorized representative and provider within 48 hours of this decision;
- all information collected for the processing of the reconsideration is documented in the complaints/reconsiderations/appeals database.

C. Appeals

Any parent/legal guardian, young adult, emancipated minor, or authorized representative of a parent/legal guardian, young adult, or emancipated minor may request an appeal of the resolution regarding a level of care reconsideration. If the appeal is regarding a level of care determination then, until the appeal is finalized, the level of care prior to reconsideration/appeal is continued.

For individuals eligible for Medicaid and Medicaid-administered health benefits programs including, but not limited to, NJ FamilyCare-Children‘s Program Plan A, NJ KidCare, Medicaid Special Eligibility, Medicaid Only, Medically Needy, and Special Medicaid Programs for the Aged, Blind and Disabled, appeals are conducted in accordance with the Medicaid Fair Hearing procedures set forth in N.J.A.C. 10:49, et seq. For individuals eligible for NJ FamilyCare-Children‘s Program Plan B, C, or D, appeals are conducted in accordance with the grievances and appeals procedures set forth in N.J.A.C. 10:79-6.5, et seq. For individuals not eligible for Medicaid, NJ FamilyCare, or any other Medicaid-administered health benefits program, appeals are conducted in accordance with the dispute resolution procedures as follows:

- The request must be made within 30 days of notice of the resolution or within 30 days of learning that the resolution notice was not received.
- If these timeframes are not met, the appeal request may be denied.
- The parent/legal guardian, young adult, emancipated minor, or authorized representative of a parent/legal guardian, young adult, or emancipated minor must submit a written request for an appeal and must include the following:
    - name and address of person filing the appeal,
    - name and address of the individual receiving services,

    - a brief statement of the matter under appeal,
    - a list of involved parties and /or potential witnesses, and
    - any information that would support the request.
- The DCF/DCSOC Director or designee conducts a record and document review in lieu of having the parties present unless the DCF/DCSOC Director or designee determines that an in-person meeting or teleconference is necessary.
- Within 30 days of the receipt of the written request and at least 5 business days prior to the review, DCF/DCSOC sends the parent/legal guardian, young adult, emancipated minor, or authorized representative written notification of whether the review will be in person, telephonic, or a record review. The notice includes the issues to be considered and the method in which the review will be conducted (in-person meeting, document review, or telephone meeting), and includes the time and location of the review if it is a meeting.
- The appeal process (whether in-person, telephonic, or a record review) is completed within 60 days from the date the written request for an appeal was received.
- A postponement request for the review will be granted only for good cause and includes the parent's/legal guardian's, young adult's, emancipated minor's, or authorized representative's need for additional time to provide necessary information.
- Unless delayed for reasons beyond the control of the parent/legal guardian, young adult, emancipated minor, or authorized representative, a failure to appear for the scheduled review is considered as a withdrawal of the appeal.
- When the outcome of an appeal will have a direct impact on the child/youth/young adult, the DCF/DCSOC determines whether, and in what manner, the child's/youth's/young adult's position on the appeal will be ascertained and the nature of his/her participation in the appeal process.
- Prior to the review, the DCF/DCSOC Director or designee conducting the appeal, at his/her discretion, may consult with the staff members who have information related to the issue being appealed.
- The appeal review includes the following:
    - summary of the factual basis for DCF/DCSOC action;
    - the relevant rules and policy;
    - a review of the information gathered through the prior consultation with staff, information presented orally or in writing by witnesses, supporters, or representatives; and
    - questions asked during the appeal process.

The DCF/DCSOC Director or designee conducting the appeal makes a decision based on the record and the information presented at the appeal or during consultation with other staff. DCF/DCSOC forwards written notification of the decision of the appeal to the parent/legal guardian, young adult, emancipated minor, or authorized representative within 30 days of the completion of the appeal. The notification shall include notice of whether the parent/legal guardian, young adult, emancipated minor, or authorized representative has the right or opportunity to appeal further and directions on how to initiate this process and whom to contact.

DCF/DCSOC may deny any appeal opportunity that has not been exercised in accordance with established timeframes except in cases where the parent/legal guardian, young adult, emancipated minor, or authorized representative was delayed for reasons beyond his/her control.

If the parent/legal guardian, young adult, emancipated minor, or authorized representative does not request further dispute resolution within 20 days of notification of the appeal decision, or is ineligible for further dispute resolution, the appeal decision will be considered final. All actions taken during the appeal process are fully documented in the complaints/reconsiderations/appeals database.

10. Auditing and Audit Reviews

A. Financial

PerformCare will have an independent financial audit performed annually and submitted to the state within 120 days of the end of PerformCare's fiscal year.

B. Information System

PerformCare will conduct an annual or periodic examination of the controls within its Information Technology infrastructure.

C. Operational

PerformCare will have an independent operational audit of CSA operations performed annually.

D. General

PerformCare complies with all state and federal audit review requirements or requests. DCF/DCSOC may conduct its own audits whenever it chooses and PerformCare cooperates in facilitating access to the facility and system at any time, with or without prior notice, to state, federal, or other personnel authorized by DCF/DCSOC for site inspections, audits, or other purposes. These authorized personnel have unlimited access to all systems, records and areas, and personnel of PerformCare.

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Division of Mental Health and Addiction Services

Quality Improvement Plan

FY 2014 – FY 2015

"Quality is never an accident; it is always the result of high intention, sincere effort, intelligent direction and skillful execution. It represents the wise choice of many alternatives." Willa A. Foster

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, treatment and recovery services delivered by a culturally competent and well trained workforce.

DMHAS Vision

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

DMHAS Values

DMHAS' work is driven by its values. Staff with the Division and its partner agencies value:

- consumers' dignity and believe that services should be person-centered and person-directed;
- the strength of consumers, their families and friends because it serves as a foundation for recovery;
- the commitment of its partner agencies to professionalism, diversity, hope and positive outcomes;
- evidence-based practices that show consumer-informed and peer-led services improve and enhance the prevention and treatment continuum; and
- the public trust and believe that it is essential to provide effective and efficient services.

INTRODUCTION

Continuous Quality Management (CQI) is an approach to improving and maintaining quality that emphasizes regular, internally driven assessments of potential causes of quality defects, followed by action aimed at either avoiding a reduction in quality or correcting the quality defect at an

early stage. Related to CQI is the broader management approach of Total Quality Management (TQM), which is a process for creating organization-wide participation in planning and implementing continuous improvements in quality. TQM emphasizes the need for all members of a unit or team to understand the needs and desires of consumers or ultimate users of the service or product; use of data-related techniques to assess and improve the quality of the team's output. The Division of Mental Health and Addiction Services uses this approach to quality planning and the Quality Improvement Plan serves as the framework for quality improvement activities.

The Quality Improvement Plan is dedicated to improving consumer care, safety, and values of service and thereby the performance of all professionals. In doing so, the provision of the highest quality and most appropriate care is achieved. The scope of the Quality Improvement Plan covers all aspects of the organization. Occurrences that are outside of our expected performance standards will be evaluated. These will also include evaluations of sentinel and adverse clinical events.

The Quality Assurance Plan for the Division of Mental Health and Addiction Services focuses on those indicators that systematically measure the achievement towards the Division's Mission, Vision, Values and Strategic Plan. The following criterion is used to base priority for measurement:

- High risk
- High-volume
- Problem prone
- Sentinel events
- Processes related to consumer needs, expectations, and satisfaction
- Strategic goals
- Resource availability, The Operating Budget
- Regulatory Compliance
- Staff and Staffing Issues

Continuous quality improvement is not something performed by an individual or a group of individuals----it is a part of our everyday activities. Senior Leaders have committed to excellence in performance and quality improvement through the Strategic Planning activities which included several days of brainstorming sessions and communicating the focus areas to the workforce and stakeholders for their input. In addition to Division-wide priority setting by Senior Leadership, units also set priorities to initiate their own improvement activities based on documented need within their work unit.

Much of the planning related to Quality Improvement resulted from review of SMHSA's Framework for Quality Improvement by the Outcomes Workgroup under the direction of the Behavioral Health Stakeholder Steering Committee during the development of the Medicaid Comprehensive Waiver; Appendix A.

PURPOSE

The purpose of the Division of Mental Health and Addiction Services' Quality Improvement Plan is to continuously improve New Jersey's system of behavioral health that will lead to improved quality of services and outcomes for individuals, families and communities. A key component of this is the collection of data that will inform policy and measure program impact. This plan demonstrates the Division's activities to assess and improve key processes and outcomes to enhance provider efficiency and effectiveness in achieving service objectives. In addition, the plan is utilized to enhance the Division's operational practices that ultimately affect services delivered to mental health and substance abuse consumers. Components of the plan include:

1. Determination of priorities for improving systems, processes, and consumer safety and satisfaction.

2. Identification of a framework for improving and sustaining performance of Division-wide systems and processes through a planned systematic approach of plan, design, measurement, analyzes and improvement of services provided.

3. Support of the concept that, through collaboration, systems will be more effective, staff will have greater skills, and patient outcome components will be improved.

4. Ensure that the best possible care and services are provided within available resources, while being consistent with the mission, vision, values, goals and objectives, and plans of the organization.

GOAL

To provide a framework and motivation for improvement of consumer health outcomes and customer satisfaction by design of effective, organization-wide processes followed by measurement, assessment, and improvement of those processes.

As such, there are key areas that were assessed as critical during the Division's Strategic Planning Activities:

- Assessment and Treatment in the Least Restrictive Setting
- Enhancement of Therapeutic Programs
- Safe and Therapeutic Housing
- Decrease in the Morbidity and Mortality of Consumers with Severe and Persistent Mental Illness
- Enhancement of Staff Skills and Competencies
- Improve Medication Management Process including the use of methadone
- Movement Towards a Managed System of Care

OBJECTIVES:

- To establish data systems that will allow scientific measurement of the improvement processes, outcomes of the actions taken and reporting this information by aggregate or individual analysis
- To continue to provide staff education regarding the principles and tools of Continuous Quality Improvement
- To provide criteria for identifying and prioritizing improvement
- To involve all services, staff and stakeholders in improvement activities
- To synthesize information obtained from performance outcome data when determining priorities for improving systems/processes
- To provide the framework for planning, directing, coordinating and improving consumer care and consumer safety for psychiatric and addiction services for Inpatient, Outpatient, and Partial Programs and behavioral/rehabilitation services for Residential programs.
- To support the design of new processes, assist in the implementation, determine criteria for assessment of effectiveness

METHODOLOGY

The Division of Mental Health and Addiction Services utilizes various techniques to determine what should be measured and how it should be measured. In addition, data is regularly assessed and decisions made regarding improvement activities. This process includes the PDCA cycle: Plan, Do, Check, Act which is described below pictorially and in a narrative.

Plan–Do–Check–Act Process

1. **Plan** - Recognize an opportunity and plan a change.
2. **Do** - Test the change. Carry out a small-scale study.
3. **Check** - Review the test, analyze the results and identify what you've learned.
4. **Act** - Take action based on what you learned in the study step: If the change did not work, go through the cycle again with a different plan. If you were successful, incorporate what you learned from the test into wider changes. Use what you learned to plan new improvements, beginning the cycle again.

Activities that contribute to this quality improvement plan:

- **Stakeholder Engagement**

  The Division engages stakeholders through its frequent meetings with various stakeholders and inclusion of stakeholders in its strategic planning activities and attending stakeholders' meetings and conferences such as the COMHCO (Coalition of Mental Health Consumer Organizations) conference. Such meetings include Mental Health Planning Council (includes families and consumers), Quarterly Stakeholder meeting, Quarterly Addictions Provider meetings, Quarterly Addictions Medical Directors meetings, Citizens Advisory Council, Addictions Professional Advisory Committee (meets every other month). Refer to Appendix B.

  Quality activities are also addressed at Systems Review Committee meetings.

- **Strategic Planning**

  The Division recently underwent strategic planning brainstorming activities and is in the process of obtaining staff and stakeholder input through focus group activities in order to develop clearly defined goals, objectives. Each work unit will ask "What do we need to do to reach our goal?" and develop action plans to achieve the stated goals and objectives. Resources will be allocated appropriately in pursuit of these goals and objectives.

- **Evidence Based Practices**

  The Division supports evidence-based services. Examples of evidence based services:

  - Supported Employment – Monitored through QCMR and quarterly meetings are held with supervisors to go over issues and discuss policy changes; Fidelity Scale used to self-rate and submit annually
  - Supported Education - Monitored through QCMR and quarterly meetings are held with supervisors to go over issues and discuss policy changes; Fidelity Scale to be developed
  - Medication Assisted Treatment - Medication Assisted Treatment (MAT) is an evidence-based practice that combines pharmacological interventions with substance abuse counseling and social support. Through funding legislated through the Bloodborne Disease Harm Reduction Act, the SSA has developed the Medication Assisted Treatment Initiative (MATI). This initiative includes mobile medication units with corresponding outreach, office based services and case management, as well as supportive housing, sub-acute enhanced medically managed detoxification, vouchers for other treatment services, and

an evaluation of the project. The mobile medication units prioritize the provision of pharmacological treatment to individuals in cities and towns that have no access and/or limited access to methadone and suboxone treatment, and to clients referred through the Sterile Syringe Exchange Programs

Injectable naltrexone has been funded through a pilot initiative that ensures patient informed choice and allows medical services for the induction and up to five additional monthly injections for people with alcohol or opioid dependence who have had a conviction for Driving Under the Influence and could benefit from medically managed treatment for substance use. The Division is expanding these medical services to other funding sources for opioid dependent persons who are in need of detoxification from illicit opioids and want to remain abstinent without maintenance medications, or who are seeking medically supervised withdrawal from maintenance medication.

- Justice Involved Services (JIS – jail diversion and jail reentry programs) – Monitored through QCMR and program observation conducted every 3 months, but no form used to rate observations
- Integrated Dual Diagnoses Treatment (IDDT)
- Program of Assertive Community Treatment (PACT) – monthly report submitted to the Division that includes: 1) program inputs (e.g. contracted staff, actual staff fill rate); 2) program outputs (e.g. caseload, hours of service delivered by the team); and 3) consumer outcomes (e.g. % of caseload that is employed)
- Illness Management and Recovery (IMR) – number of trainings are tracked
- Wellness Coaching - number of peer wellness coaches trained are tracked

- **Community Performance Measures**

Core Performance Measures:

1. Increase in Level of Functioning – There is an increase of Level of Functioning (LOF) as self-reported in the Annual Consumer Perception of Care Survey. The targets below were derived from the previous 3 years of surveys.

   Numerator = # of valid respondents who answered affirmatively

   Denominator = Total # of consumers to respond about their level of functioning as measured by questions 29-32 on the 2006 MHSIP Consumer Survey

- SFY 2014 – 95% of consumers completing the Annual Consumer Perception of Care Survey will either "agree" or "strongly agree" that their level of functioning is satisfactory.
- SFY 2015 – 96.2% of consumers completing the Annual Consumer Perception of Care Survey will either "agree" or "strongly agree" that their level of functioning is satisfactory.

2. Stability in Housing – There is an increase in the number of mental health consumers served by DMHAS utilizing the evidence based practice of supportive housing. Data will be collected though the Quarterly Contact Monitoring Report (QCMR), the USTF database and the URS Data Table 16 ("Profile of Adults with Serious Mental Illnesses….")

   Numerator - # of adults with mental illness receiving supportive housing

   Denominator – Total # of unduplicated adults with severe mental illness served.

   - SFY 2014 – Increase by 4%
   - SFY 2015 – Increase by 4.2%

3. Increase in Supportive Relations - Increase in the quality and number of supportive relationships among the SMI population served by the DMHAS as self-reported on the Annual Consumer Perception of Care Survey.

   This will be measured by the questions related to "Social Connectedness" included in the 2014 and 2015 Consumer Perception of Care Surveys utilizing the MHSIP (Mental Health Statistical Improvement Program) surveys.

   Numerator = # of valid respondents who answer affirmatively

   Denominator = Total # of valid respondents

   - SFY 2014 - 92% of all respondents to the relevant survey questions will either "agree" or "strongly agree" that their level of social connectedness is satisfactory.
   - SFY 2015 – 92.4% of all respondents to the relevant survey questions will either "agree" or "strongly agree" that their level of social connectedness is satisfactory.

4. Supportive Employment - Increase the number of adults with SMI who are employed as measured by consumer employment status on the USTF (Unified

Services Transaction Form) Client Registry Database collected on consumers enrolling in and discharging from state-funded, community-based mental health programs and URS Data Table 4 ("Profile of Adult Clients by Employment Status").

Numerator = # of adult consumers competitively employed full or part time, including supported employment

Denominator = Total # of persons employed (as defined above) Plus the number of persons unemployed plus the number of persons not in the labor force (e.g.: retired, student, volunteer, disabled, etc.)

- SFY 2014 – 29%
- SFY 2015 – 29.5%

- **State Outcome Measures (SOMs)**

The DMHAS has implemented Provider Performance Reports which are sent to all addiction treatment agencies twice a year. Agencies utilize these reports to inform their Continuous Quality Assurance processes and to gauge their performance relative to the State average and to their peers' performance within specific levels of care. These reports capture information on five key State Outcome Measures (SOMs) which are listed below and are reported for every level of care. An example of performance for standard outpatient care for CY 2012 is presented below.

1. Abstinence from Alcohol
   94% were abstinent from alcohol use at discharge, an improvement of 25%.

2. Abstinence from Other Drugs
   88% were abstinent from drugs, an improvement of 18%.

3. Employment
   49% were employed, an increase close to 10%.

4. Arrests in Prior 30 Days
   There was slight decrease in this measure (-.9%).

5. Homelessness
   There was a slight decrease in homelessness (-.3%)

Positive changes were observed from admission to discharge for clients entering substance abuse outpatient treatment, which accounted for 28% of admissions during CY 2012. A similar pattern was also observed for individuals entering intensive outpatient care (22% of admissions).

- **Other Performance Measures**

  DMHAS has identified three specific performance measures in addition to the Core Measures as listed above. These are further outlined in section "G. Quality" and the attached Quality Plan:

1. Supportive Housing - The relevant data includes observation of:
   - The numbers of consumers served annually,
   - The numbers of community-based housing opportunities (a.k.a. 'beds") developed annually, and
   - The number of workforce development trainings facilitated by the SMHA

   The data from each of these will come from the QCMR database, fiscal/contracting data and SMHA workforce development records, respectively.

2. Suicide Prevention - The relevant data for Suicide Prevention will include the call record datasets provided to DMHAS by the National Suicide Prevention Lifeline Network (NSPLN). Specifically the SMHA will be looking to see what proportion of calls transferred by the Lifeline and originating in New Jersey are answered by the DMHAS-funded suicide prevention hotline during times when the NSPLN is closed or experiencing heavy call volume.

3. Consumer Operated Services - The relevant data for Consumer Operated Services will include data on the use and participation in wellness and recovery activities provided to consumers at Self Help Centers, vis-à-vis the SHOUT™ self-help center electronic utilization and outcome record system. In addition, electronic surveys will be administered annually with self-help center members and in combination with SHOUT utilization data in order to assess performance against the stated indicator.

- **Contract Monitoring/Utilization Review**

  Contract monitoring/utilization review occurs both in addictions and mental health programs. Each of these will be described below:

  Addictions

  DMHAS relies on Service Contract Monitoring to continuously measure the effectiveness of services and supports and ensure that services, to the extent possible, demonstrate evidence of effectiveness**.**

  DMHAS conducts at least one formal contract monitoring site visit annually per calendar year for all prevention, treatment, and recovery support service contracts. More frequent reviews are conducted on an as needed basis for agencies identified as needing additional technical assistance or monitoring in response to identified deficiencies, technical assistance needs, or special contract requirements.

A contracted agency is notified in writing at least one week in advance of a scheduled site visit (site visits can be unannounced). Prior to the site visit, Addiction Programmatic Monitoring Officers (APMOs) review the most recent listing of agency personnel and reviews the last monitoring site visit report for renewal contracts to ensure follow-up for any previous citations is incorporated into the upcoming review. Once onsite, the APMO tours the facility, reviews relevant components of the policy and procedure manual and individual client files, if appropriate for the contracted service, for compliance with contractual agreements, Federal Block grant requirements, and licensure requirements. Each review is conducted and recorded using a standardized Annual Site Visit Monitoring Review Form as a guide. The Site Visit Monitoring Form is used to document adherence or non-adherence to contract deliverables, service requirements, service levels, and contracted outcomes. The APMO selects a random sample of client files from the active client roster for a detailed review of requirements including use of placement criteria, treatment planning and progress documentation, and delivery of specific client services. Rosters are reviewed to monitor utilization for slot-funded services. Fee-for-service claims reports are compared to individual client records. At the conclusion of the site review, the APMO conducts an exit conference with agency representatives.

The Annual Site Visit Monitoring Review Form addresses a minimum of five issues: Facility, Staff, Treatment or Service Records, Quality Assurance, Specialized Services, and Other Contract-Specific requirements. Facility questions pertain to the facility's interior and exterior appearances, facility accessibility, and the proper posting of licenses and certificates. Staff questions pertain to personnel policies, staff meetings and training, and staff certification. Treatment Record questions pertain to the counselors' procedures, availability of medical and clinical services, the client roster, and maintenance of client files for treatment services; for prevention and recovery support services, this section of the monitoring form documents fulfillment of other specific contract deliverables and requirements. Quality Assurance questions pertain to the agency's Quality Assurance plan and quality of care, and to contract-specific performance targets. Specialized Services questions pertain to child care, transportation and gender specific treatment. Other questions pertain to management and administrative matters.

During the annual site visit the APMO will notify the Monitoring Unit Supervisor immediately if he/she finds that the clients and/or staff are at immediate risk due to life safety concerns such as lack of facility maintenance; construction being done on site, or other possible dangers, including numerous citations for contractual or licensure non-compliance or other issues of concern. The

Monitoring Unit Supervisor immediately notifies the appropriate DMHAS Senior Staff so that a determination can be made regarding the need for immediate and appropriate actions.

After the site visit has been completed, which can take anywhere between 1-5 days depending on the agency size and their funded treatment modalities, the APMO then completes the Annual Site Monitoring Review Form and cover letter. The APMO then gives a copy to the Monitoring Unit Supervisor for review prior to mailing it to the agency. The Monitoring Unit Supervisor reviews the findings, if a finding is a serious and/or extreme violation of a contractual and/or licensure requirement, the Monitoring Unit Supervisor informs the DMHAS Senior Staff who may require agency representatives to come to DMHAS in Trenton to meet with program representatives regarding a required plan of correction and/or the frequency of monitoring may increase.

When an agency receives the site visit report, the agency is then required to respond with a plan of Corrections (PoC) if they were found to be out of compliance with the Annex A requirements. Once a PoC is received it is then reviewed by the APMO. The APMO will either accept the PoC or reject the PoC. If a PoC is rejected a letter goes out to the agency indicating what components of the submitted PoC were rejected and the agency must submit a new/revised PoC. The APMO will provided technical assistance and this process will continue until an acceptable PoC is submitted. If after several attempts for any reason an agency is unable to submit an acceptable PoC, the monitoring unit supervisor is notified by the APMO and the issue will be brought to PIC for review and discussion.

Mental Health

Agencies are required to submit data quarterly (called Quarterly Contract Monitoring Reports – QCMRs) to the Division of Mental Health and Addiction Services. This data is critical to assess agency performance with their respective contracts. Agencies that do not meet the service utilization level for which they are contracted will be closely monitored to determine patterns of underutilization.

Regional staff oversees the implementation of the contracts to ensure that service commitments are met and that agencies are compliant with DHS/DMHAS program standards, state & federal statutes, as well as other applicable rules and regulations, policies, procedures and protocols.

Staff also monitors agency operations to assure that services are delivered within the context of a recovery oriented and culturally competent system.

Regional staff participates in agency reviews conducted by the Departments Mental Health Licensing Unit (MHL), Medicaid and DHSS

- MHL conducts triennial reviews of mental health programs, to assure the agencies' adherence with regulatory standards for their respective licensed programs.
- MHL provides the agency with a licensing review outcome report that outlines any cited deficiencies that are discovered by MHL and Regional staff during the visit.
- Agencies must submit a plan of correction that specifies dates for completion of deficiency corrections.
- MHL & Regional staff also conduct announced and unannounced visits to agencies on an ad hoc basis to address reports of concern such as allegations of abuse or unqualified staff delivery service.

In addition, the Fiscal Office reviews variance reports (both dollar and percent) to identify any variances not explained by the accompanying narrative provided by the agency. Variances that exceed 10% +/- are assessed to determine if the impact is noteworthy given the overall size of the contract provider. If so, these variances are brought to the attention of the regional offices for their input and potential follow-up with the provider.

- **Unusual Incident Reporting**

There is a process for the community to report unusual incidents. The addictions' community utilizes "211" to report incidents and these have been entered into the Department of Human Services' (DHS) Unusual Incident Reporting Management System for many years. The unit which is responsible for this resides with the Department of Human Services. Incidents and data are reviewed at this level for addictions' community incidents and jointly with DHS and DMHAS for mental health community incidents.

The mental health community has a process for reporting critical unusual incidents through the respective regional offices. These incidents were logged and kept in a separate database for review. A pilot began on April 1, 2012 during which the DHS Critical Incident Management Unit (CIMU) has been entering unusual incidents occurring in mental health community agencies into this same data base. This process is being further refined to: 1) expand the reporting categories; 2) have DMHAS staff enter data into the database; 3) revise current forms; 4) alert the community to the changes; 5) change contracts to include the revised processes; 6) refine the process of closing out all incidents; and 7) aggregate and analyze data to include trend reports.

- **Consumer Complaints/Grievances**

  For purposes of this section, term complaints and grievances is used interchangeably. The addictions' community utilizes "211" to report any complaints or grievances and these are handled through the DHS Office of Program Integrity and Accountability Unit (OPIA). On the other hand, mental health community complaints and grievances which come into the Division are referred to the Regional Offices to work with the providers and consumer to resolve these issues. The complaint and grievance procedures are outlined below.

  Licensure regulations, N.J.A.C. 10:37-4.6, all state-funded mental health programs to establish consumer complaint procedures which are subject to Division review and approval at the time of the agency's annual request for state funding. Each consumer is made aware of the existence of a complaint procedure at second, non-emergency contact. Under all circumstances, consumers not accepted for services shall be informed immediately of the State-wide advocacy services available to them. Agency Directors are to designate a staff person to function as Agency Ombudsperson on as needed basis. The responsibilities of the Agency Ombudsperson shall be:

  - To receive consumer complaints;
  - To act an advocate for consumers who make complaints; and
  - To attempt to negotiate resolutions of issues raised by consumers (complaints shall be investigated and negotiated within five working days) /grievance processes.
  - Submit a written report of findings, resolutions and/or recommendations to the Agency Director and to the consumer within seven working days of the complaint. If the complaint has been resolved to the consumer's satisfaction, the grievance process shall end at this point.

  Most complaints and grievances are resolved at the treatment provider/agency level. The consumer may request review by the Agency Director. The Director shall make the final Agency-level decision regarding the complaint, in a due process manner, as quickly as possible.

  If the complaint has still not been resolved to the consumer's satisfaction, the consumer may request a review by the County Mental Health Board. The County Mental Health Board, through its Administrator, shall receive and review complaints referred from Agency Directors within five working days. The County Mental Health Board shall make its findings and recommendations known to the Agency Director and consumer within seven working days of the complaints.

If the consumer is not satisfied with the recommendation of the Board, or the Agency's response to these recommendations, the consumer may request review by the Division.

Consumers may request a review by the Division directly, and in confidence, at any time. However, consumers are encouraged by the Division to seek an Agency-level review first and will be asked to justify the omission of an Agency or a County-level review. The Division will advise the Agency and the County Mental Health Board of all complaints received directly, unless the consumer, on notice, refuses to consent to such a disclosure.

The Division may convene a Professional Review Committee, when needed, consisting of an interdisciplinary team appropriate to the subject of the complaint. The designees shall receive and review complaints referred by consumers within five working days and shall submit a written report of its findings and recommendations to the Assistant Commissioner within two more days.

The Assistant Commissioner shall review this report and submit recommendations to the Agency Director and the consumer within seven working days. The Division shall determine if any formal State remediation/funding compliance action is necessary based on the Agency's response to these recommendations.

- **Response to Emergencies**

Response to emergencies is dependent upon the type of emergency:

- DMHAS has a Disaster and Terrorism that has the capability and authority to deploy certified Disaster Response Crisis Counselors (DRCC). DRCCs can be deployed for any crisis or emergency as determined by the Disaster and Terrorism Coordinator or at the request of the DMHAS Assistant Commissioner or the DHS Commissioner. In addition, 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 Assistant Division Director for the Office of Early Intervention, Prevention and Community Services is the state-wide contact for addictions' "211" incidents. This person is available 24/7 to receive information on emergencies and critical incidents and they are individually handled as the situation warrants.

- For community mental health emergencies, the Assistant Division Director for the Office of Early Intervention, Prevention and Community Services as well as the DMHAS Assistant Commissioner and the Commissioner for the Department of Human Services are available 24/7 should the need arise to contact them and they are individually handled as the situation warrants. All DMHAS Executive Staff are available via cell phone in the case an emergency warrants contacting them.

- For community emergencies involving clients receiving methadone treatment, the Office of Research, Planning, Evaluation, Information Systems and Technology has developed an IT system, the Guest and Emergency Medication System (GEMS), which will allow clients to receive their medication at any available methadone clinic in New Jersey. In addition, there is a Disaster Coordinator in this Office who assists methadone clinics with the activation of their Continuity of Operations Plan (COOP) and provides support using GEMS, if needed.

- **Consumer Satisfaction**

  Consumer satisfaction with the services provided by DMHAS contracted agencies is measured via the Annual *Consumer Perception of Mental Health Care Surveys* which provides consumers with an avenue in which to report their reactions to the services that they are receiving, and a window through which DMHAS may evaluate itself and its contracted providers.

  The DMHAS Annual Consumer Perception Mental Health Care Survey is a self-reporting tool consisting of no fewer than 62 items on various topics shaped to convey consumer's reflections of their current mental health service, treatment, assessments of their primary health and basic demographic information. The core of the survey instrument is the *Mental Health Statistics Improvement Program's (MHSIP) Adult Survey*[1]--used it in its entirety (48 questions), supplemented by ten questions related to primary health, from the Behavioral Risk Factor Surveillance System (BRFSS) survey[2] . These tools are recommended for use by the National Association of State Mental Health Program Directors (NASMHPD)/National Research Institute (NRI). The consumer survey dataset yielded by the survey instrument provides perspective in addressing:

*What are some of the basic demographics of the consumers of mental health services?

[1] See http://www.nri-inc.org/projects/SDICC/Forms/MHSIP_Adult_Survey2.doc
[2] See http://www.cdc.gov/brfss/questionnaires/pdf-ques/2011brfss.pdf

*Is there a difference between agencies with relation to reported satisfaction?

*Does satisfaction differ between domains of responses?

*What is the overall response of consumers to our mental health services?

*What are the average responses from consumers about mental health service?

Methodology:

Survey Domains

The majority of the response values for the MHSIP questions are set on a 5-point ordinal (e.g., "Likert") scale, with responses ranging from, "Strongly Disagree" to, "Strongly Agree". These MHSIP questions are aggregated into eight analytical 'domains. These domains are General Satisfaction; Access to Services; Quality & Appropriateness of Services; Participation in Treatment Planning; Outcomes, Functioning, Social Connectedness and Legal Challenges. Brief definitions of each domain are as follows:

General Satisfaction (items 1-3) is intended to illustrate a consumer's general approval of a program. This is in response to the choices and services offered to a consumer. These responses provide essential data for URS Tables 11 (Summary Profile of Client Evaluation of Care) and 11a (Consumer Evaluation of Care by Consumer Characteristics) and also provides the basis for National Outcome Measure (NOM) 12, "Client Perception of Care".

Access to Services (items 4-9) includes responses based on the consumer's accessibility to the program's location, services, staff and psychiatrist. Responsiveness of staff is also considered under this domain. These responses provide essential data in URS Tables 11 (Summary Profile of Client Evaluation of Care) and 11a (Consumer Evaluation of Care by Consumer Characteristics).

Quality, Appropriateness of Services (items 10, 12, 13, 14, 15, 16, 18, 19 and 20) focuses on consumer responses with relation to program staff. These include staff personal and professional behavior. An emphasis on the consumer/staff relationship is explored with the items within this domain. These responses provide essential data in URS Tables 11 (Summary Profile of Client Evaluation of Care) and 11a (Consumer Evaluation of Care by Consumer Characteristics).

Participation in Treatment Planning (items 11 and 17) relate to a consumer's treatment plan. Responses relating to locus of control with respect to one's treatment plan are the scope of this domain. These responses provide essential data in URS Tables 11

(Summary Profile of Client Evaluation of Care) and 11a (Consumer Evaluation of Care by Consumer Characteristics).

Outcomes (items 21-28) indicate the consumer's perception of the effectiveness of the services that they are receiving. Self-reporting of symptom reduction and relationship strength are the focus of this domain. These responses provide essential data in URS Tables 11 (Summary Profile of Client Evaluation of Care) and 11a (Consumer Evaluation of Care by Consumer Characteristics).

Functioning Outcomes (items 29-32) presumes the residual outcomes of mental health services has an effect on a consumer's overall social skills and symptom reduction. Similar to the Outcomes domain, Functioning is tangential to the effects of services. Diversely, this domain emphasizes functioning in the midst of adversity and quality of life. These responses provide the data necessary to answer URS Table 9a (Social Connectedness & Functioning) as well as NOMs 17, "Improved Functioning".

Social Connectedness (items 33-36) consists of items relating to a consumers social stability. This domain centers on relationships between consumers connectedness to their support network as well as their community. These responses provide the data necessary to answer URS Table 9a (Social Connectedness & Functioning) as well as NOMs 16, "Improved Social Connectedness"

Legal Challenges (items 39-41) involves consumers' response to the criminal justice programs provided by the New Jersey Division of NJDMHAS. Items 39 and 40 are nominal responses. Item 41 requires an ordinal scale response unique to this item. The goal of this domain is to record the response of those consumers enrolled in a criminal justice program for less than 1 year. These responses form the basis of URS Data Table 19a (Criminal Justice) as well as NOMs 14, "Criminal Justice Involvement".

Sampling:

The survey is administered to a stratified random sample of consumers of all non-acute, community based mental health services.

The sampling strata are agency-specific, program elements. For example, if one agency has three program elements (Outpatient, PACT and Partial Care) then that agency would be given three separate survey packets, and a representative, random sample is drawn separately from consumers of *each* of the three program elements. Each such packet is uniquely coded so that DMHAS can determine which agency and which program element a survey questionnaire was distributed to. The selection of these particular sampling stratum help to mitigate against the consumers of a specific program element (or a specific agency) from being disproportionally represented in the overall sample.

The size of each sample depends on the estimated size of the consumer population in a given year, as indicated by current QCMR data. The sampling ratios of these larger, more inclusive surveys have been at 5.9%, a value which was based on considerations of desired error ranges and confidence levels. In 2011 and 2012 over 8,000 and 6,000 surveys (respectively) were distributed.

Dissemination of Surveys

Each year prospective respondents are randomly selected (among their cohorts enrolled in the same program element, administered by the same provider) to be given the annual survey questionnaire.

Agency CEOs and Program Coordinators alike are given explicit instructions that consumer participation in the survey is optional, anonymous, and a consumer's decision to participate in the survey (or not) should in no way adversely impact the delivery of future services. Further, program coordinators are instructed to distribute the survey and explain its use to consumers only when assistance is requested (due to considerations of literacy, developmental impairment, etc.). The objective of promoting survey participation in a manner with the least amount of possible feedback from service providers was to foster a more candid response from the participant.

Surveys are mailed via USPS and respondents are given at least two weeks to participate in the survey. Responses are then received by DMHAS, processed and analyzed, with the results forming the basis of the aforementioned URS Data Tables and National Outcomes Measures for the Implementation Report of the Community Mental Health Block Grant.

Survey Analysis

Each year's survey responses are collected, analyzed, cleaned, reviewed and analyzed. Responses were scanned; reviewed for errant data and inserted into an Access table. Analysis of much of the data was completed using MS-Excel 2010 and SPSS/PASW Statistics 18.

For each survey domain, the mean score of its questions are calculated as a mean domain response. This mean domain response is taken as a proxy of that consumers overall impression of their mental health services along that specific domain. However, a small quantity of survey questionnaires were either illegible, contained a majority of user errors with regards to response coding, or had a preponderance of or missing responses to items. To address this DMHAS follows the SAMMHSA/CMHS guidelines mandating that when the questions for a specific domain are missing 33% or more responses, then that participant's mean domain response for that domain is to be excluded from analysis (as reported in the URS tables).

Survey Results

The Annual Consumer Survey yields helpful data for the URS Data Tables and the National Outcome Measures. These results are reported to the NJ Mental Health Planning Council for comment, review and discussion.

In addition, a wealth of additional inferences are gleaned from the Consumer Survey data—depending on Division imperatives and available research resources. A partial list of the phenomena brought into greater clarity with the survey results include: demographic composition (i.e., age, gender, race, ethnicity, marital status) of mental health consumers, composite 'strength' of responses (e.g., to what extent consumers 'strongly' agree with survey statements), response rates per county, response rates per program elements, mean domain scores by county, mean domain scores by program element.

Conclusions

The DMHAS Annual Consumer Perception of Mental Health Care Survey provides the Division with a consistent set of measures by which it may look at the degree to which consumers feel well-served by contracted providers, and to the extent that consumers are satisfied with the overall level of care furnished by the Division. Due to the standardized nature of the survey format, DMHAS may look back longitudinally at these results to observe change through time.

The respectable sample sizes of these surveys, along with the coding mechanisms that allow for the identification of specific providers enables the Division to look at an impressive number of issues and domains of service. Results can be cross-tabulated in ways that allow detailed examinations of differential consumer perception of mental health care within (and between) specific agencies, specific program elements, specific counties and demographic groups.

- **Service in the Least Restrictive Setting**

  The Division is committed to the treatment and service of our consumers in the least restrictive setting. As such, resources have been given to the development of affordable housing in the community and the timely discharge of patients from our state psychiatric hospitals who are designated CEPP.

- **Deaths**

  The Division collects data related to deaths which occur with our consumers, both in the state psychiatric hospital system and community. Cause of death and demographic information is obtained for each death reported. The Division plans on instituting prevention to decrease the incidents of early death in our consumers. This includes

suicide risk assessment training and suicide prevention as well as interventions related to physical health such as smoking cessation and metabolic syndrome tracking and monitoring.

- **Violence Reduction**

  Suicide prevention is the focus of violence reduction in the community. The DMHAS' Suicide Prevention Committee is currently working on a state-wide with the following goals:

  - Promote awareness that suicide is a public health problem that is preventable
  - Develop broad-based support for suicide prevention
  - Improve and expand surveillance systems
  - Develop and implement strategies to reduce the stigma associated with being a consumer of mental health, substance abuse and suicide prevention services
  - Strengthen and expand community-based suicide prevention and postvention programs
  - Implement education for recognition of at-risk behavior and delivery of effective treatment
  - Develop and promote effective clinical practices to reduce suicide attempts and suicide in the least restrictive setting
  - Improve access to community services for persons with mental health and substance use disorders
  - Improve reporting and the depiction of suicide, suicide behavior, mental illness and substance use in the electronic and print media
  - Promote and support research on adult suicide and suicide prevention and its dissemination and incorporation into clinical practice and public health efforts

- **Hospital Core Measure Data**

  Specific to state psychiatric hospitals, the Division collects data from the hospitals on Core Measures from the Behavioral Healthcare Performance Measurement System (BHPMS) which are sent to NRI (The National Associate of State Mental Health Program Directors Research Institute, Inc.) and then to The Joint Commission and will soon be sent to The Centers for Medicare and Medicaid Services. These measures include:

- Screening for Violence Risk, Substance Use, Psychological Trauma History, and Strengths
- Seclusion and Restraint Events and Hours
- Polypharmacy at Discharge
- Justification for Polypharmacy
- Post Discharge Continuum of Care Plan Complete
- Post Discharge Continuum of Care Plan Transmitted to Next Level of Care

_NIA_Tx Performance Improvement Initiatives

In addition to ongoing activities, the Division also supports specialized performance improvement teams or activities such as with *NIA*Tx performance improvement projects. *NIA*Tx is a model of process improvement specifically for behavioral health care settings to improve access and retention in treatment.

The DMHAS has used the *NIA*Tx model for several initiatives and has continued to implement change projects related to improve its contract monitoring procedures and practices. The next change planned change project includes incorporating consumer input into contract monitoring site visits.

A new project that will be implemented during 2013 is the introduction of mental health providers to a *NIA*Tx performance improvement project for the 24 Designated Screening Centers in New Jersey. There will be an initial 2-3 hour meeting with the hospital CEO's and the screening center representatives. Programs can select up to three change projects which involve: increasing mobile outreach to individuals in crisis, decreasing wait time in the emergency room, and reducing the recidivism rate for individuals who return to the screening center within 30 days. Learning collaboratives will be formed which will meet monthly for nine months. A coach will facilitate the process. After seven or eight months, providers are expected to have made significant progress towards their aim.

MEASUREMENT/ TOOLS and TECHNIQUES

Any number of tools and techniques can be used for this including flowcharting, cause and effect diagrams, consumer surveys, self-assessment, audits and statistical process control.

Examples of tools include:

- flowcharting
- statistical process control (SPC)
- Pareto analysis
- cause and effect diagrams
- employee and consumer surveys

Examples of techniques include:

- benchmarking
- cost of quality
- quality function deployment
- failure mode effects analysis
- design of experiments

EVALUATION and CONTINUOUS IMPROVEMENT

After using the tools and techniques the Division establishes the degree of improvement made or needed is evaluated. If expectations are not met an action plan is devised and implemented and measurement continuously occurs. If the action plan has resulted in improvement that action plan continues and becomes part of regular processes. If the action plan does not result in improvement, the action plan is reviewed to ascertain if it was implemented as designed or if there needs to be a different action plan developed. Data is obtained to assess if action plans are working towards improvement and the process continues.

The DMHAS Quality Improvement Plan is, itself, continuously being evaluated and revised as necessary, but at least every two state fiscal years. The evaluation summarizes the goals and objectives of the Division's Quality Improvement Plan, the quality improvement activities conducted during the past year, including the targeted process, systems and outcomes, the performance indicators utilized, the findings of the measurement, data aggregation, assessment and analysis processes, and the quality improvement initiatives taken in response to the findings. Based upon the evaluation, actions are developed to improve the effective of the Plan.

Strategic Plan 2012-2014

VISION&MISSION

Vision:

To ensure a better today and even a greater tomorrow for every individual we serve.

***Mission*:**

In partnership with New Jersey's communities, DCF will ensure the safety, well-being, and success of New Jersey's children and families.

STRATEGIC PRIORITIES

Seamless System of Care	Performance Management & Accountability	Partnerships	Communication	Organizational Development

STRATEGIC GOALS

To provide ease of access to care for children, youth and families	To ensure the integrity and quality of DCF's system of care	To collaborate with stakeholders and community partners to improve outcomes for New Jersey children, youth and families	To enhance the effectiveness of communication with employees, partners, the media and the general public	To continually examine and prepare the organization structurally, in alignment with the mission and strategic plan

OBJECTIVES

☐ Ensure excellent customer service so that anyone can easily find and access services when needed ☐ Provide strengths-based services that result in positive experiences for children, youth and families ☐ Align services with local and regional needs ☐ Ensure that services are provided in a culturally competent manner and evolve based on family need ☐ Include providers / partners in efforts to improve navigability and accessibility of services	☐ Ensure that services are informed by outcomes and aligned with community needs and the DCF mission to promote healthy, safe and stable children and families ☐ Use data outcomes to inform decision making and to support DCF as a Learning Organization, self-correcting as needed ☐ Foster transparency and accountability ☐ Continue to improve the significant progress made by DCF under the Modified Settlement Agreement ☐ Sustain and enhance system reform through self-directed initiatives that support the Department's vision and mission	☐ Foster a mutual understanding of the roles and competencies of DCF and its external stakeholders ☐ Ensure DCF and external stakeholders have a shared sense of trust, respect and responsibility to the accomplishment of DCF goals ☐ Strengthen and broaden DCF's stakeholder base ☐ Ensure sustainability of partnerships	☐ Ensure the accuracy and timeliness of communication ☐ Identify strategies to increase public awareness of DCF services and how these can be accessed ☐ Ensure communication efforts are multi-lingual and culturally informed ☐ Provide mechanisms for two-way communication	☐ Provide training and employee development designed to produce employees capable of delivering organizational goals and objectives ☐ Expect and plan for change within the organization ☐ Evaluate the organizational structure on an on-going basis and modify as needed

IV: Narrative Plan

S. Suicide Prevention

Narrative Question:

In the FY 2012/2013 Block Grant application, SAMHSA asked states to:

- Provide the most recent copy of your state's suicide prevention plan; or
- Describe when your state will create or update your plan.

States shall include a new plan as an attachment to the Block Grant Application(s) to provide a progress update since that time. Please follow the format outlined in the new SAMHSA document Guidance for State Suicide Prevention Leadership and Plans available on the SAMHSA website at here.

Footnotes:

S. Suicide Prevention

Division of Children's System of Care (DCSOC)

Traumatic Loss Coalition (TLC) for Youth

Suicide is the fourth leading cause of death for New Jersey's youth. DCF/DCSOC is dedicated to the prevention of youth suicide. New Jersey's primary youth suicide prevention program is the Traumatic Loss Coalition for Youth funded by DCF/CSOC. The Traumatic Loss Coalitions (TLC) for Youth Program at University Behavioral HealthCare is an interactive, statewide network that offers collaboration and support to professionals working with school-age youth. In 1999 the TLC for Youth Program was created to establish TLCs in each of New Jersey's 21 counties and to provide ongoing technical assistance to communities in crisis. The dual mission of the TLC is excellence in suicide prevention and trauma response assistance to schools following unfortunate losses due to suicide, homicide, accident and illness. This is accomplished through county, regional and statewide conferences, training, consultation, onsite traumatic loss response, and technical assistance. The purpose is to ensure that those working with youth from a variety of disciplines and programs have up-to-date knowledge about mental health issues, suicide prevention, traumatic grief, and resiliency enhancement. 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.umdnj.edu/brti/tlc/.

In July 2012, the U.S. Department of Health and Human Services' SAMHSA awarded a $1.4 million Garrett Lee Smith youth suicide prevention grant to the TLC for Youth–University Behavioral HealthCare in partnership with the New Jersey DCF. Following is the Program Description:

The New Jersey Youth Suicide Prevention Project (NJYSPP) targets youth between the ages of 10 and 24 who are at risk for suicide through a comprehensive initiative that trains gatekeepers and clinicians in suicide prevention and intervention, establishes school and community screening to identify at-risk youth, reaches youth directly via a social media campaign, and leverages positive peer messaging to change dangerous norms around codes of silence and stigma around help-seeking for suicide, mental health, and substance abuse. Programs are embedded in an existing statewide infrastructure of community partnerships. Advancing five of the 10 goals of the NJ State Youth Suicide Prevention Plan, the NJYSPP targets high-risk youth including LGBTQ youth, Latina adolescents, African American male youth, survivors of suicide loss, as well as youth in colleges and universities, the juvenile justice system, and out of home placements.

Using information from the New Jersey Violent Death Reporting System (NJVDRS), the six counties with the highest incidence of completed suicides for ages 10-24 during the years 2007-2009 have been targeted for specific attention. An integrated training approach using evidence-based and best practice programs includes the following components: Connect Prevention/Intervention trains individuals to identify at-risk youth and link youth to services, with 1,425 individuals projected to be trained by the end of the third year; Connect Postvention

will train at least 1,425 professionals by the end of the third year to provide an integrated community response in the aftermath of suicide, reduce risk of contagion and promote healing; and Assessing and Managing Suicide Risk trains clinicians in the core competencies necessary to work with suicidal clients, with at least 450 clinicians will be trained by the end of Year 3. Trained trainers in these curricula will ensure sustainability.

To enhance gatekeeper training initiatives, New Jersey integrates Sources of Strength peer leader training to increase the number of youth receiving suicide prevention and strengths-based messaging, reverse norms of silence, increase help-seeking and connect at-risk youth with trusted adults. By Year 3, there will be 16 peer leader teams, 500 peer leaders, and 80 adult advisors. The NJYSPP also includes implementation of the Teen Screen program in schools and primary care. The goal is to increase the number of schools and physicians using Teen Screen and referring at-risk youth for services. A total of 36 schools will implement teen screen by Year 3. The last component is a statewide Social Media Campaign to develop a social media strategy using Facebook, Twitter, and blogs to reach a potential 1.6 million New Jersey youth with suicide prevention messaging, linkages to New Jersey suicide prevention programs and to encourage use of the NJ Second Floor Helpline and the National Suicide Prevention Lifeline.

The New Jersey Youth Suicide Prevention Advisory Council (NJYSPAC)

The New Jersey Youth Suicide Prevention Advisory Council (NJYSPAC) was formed under legislation signed into law in January 2004. The Council meets monthly to examine existing needs and services and make recommendations to the DCF for youth suicide reporting, prevention and intervention. The members of the council are appointed by the Legislature and the Governor and meet monthly to examine existing needs and services and recommendation to the DCF for youth suicide reporting, prevention, and intervention. A key responsibility of NJYSPAC and its members is the creation of the Youth Suicide Prevention Plan. The most recent Plan, written in March 2011 covers the years 2011 through 2014. The Council also advises DCF on the content of informational materials to be made available to persons who report attempted or completed suicides. Along with the Council, DCF works to develop and publicize public awareness campaigns on youth suicide prevention and intervention, and to compile data about reported attempted and completed suicides by youths in the State, without identifying any individuals involved. A report by DCF is also issued annually to the council, the Governor and the Legislature containing a summary of the data compiled by the Division that includes aggregate demographic information about youth who attempt or complete suicide. In 2012 two reports were issued. The enabling legislation charges the NJ Youth Suicide Prevention Advisory Council with making formal recommendations to DCF for the development of the New Jersey Youth Suicide Prevention Plan, which outlines the goals, rationale, objectives and strategies for increasing the prevention effort throughout the state.

In March 2011, the NJ DCF/DCSOC released its Youth Suicide Prevention Plan 2011-2014 (see attached).

In June and November 2012, DCF/DCSOC released the following reports on Youth Suicide:

- Adolescent Suicide Report: A Data Overview and Prevention Activities Report on Youth Suicide in New Jersey

(see http://www.nj.gov/dcf/families/csc/prevention/documents/AdolSuicideRpt_6_1_12.pdf); and

- Updated 2012 Adolescent Suicide Report: A Data Overview and Prevention Activities Report on Youth Suicide in New Jersey (see http://www.state.nj.us/dcf/news/reportsnewsletters/dcfreportsnewsletters/NJ%20ANNUAL%20ADOLESCENT%20YOUTH%20SUICIDE%20REPORT%2011%2029%202012.pdf).

- Additionally, DCF, in coordination with the DHS, released a report entitled The Effectiveness and Sufficiency of Services Provided by the New Jersey-Based Suicide Prevention Hotlines (see http://www.state.nj.us/humanservices/news/reports/NJ%20HOTLINE%20SURVEY%20REPORT%2011%2028%2012.pdf).

2NDFLOOR – New Jersey's Youth Helpline/Suicide Hotline
The New Jersey Statewide youth helpline/hotline, 2NDFLOOR, is available 24-hours a day, seven days a week to youth and young adults ages 10-24 to help find solutions to the problems they face at home, school, or play.

Youth can either call the helpline/hotline, 1-888-222-2228, or access the interactive Web site www.2NDFLOOR.org. The helpline/hotline is supervised at all times by a mental health professional. Youth are provided with relevant and appropriate linkages to information and services to address their social, emotional, and physical needs. Calls to the 2NDFLOOR youth helpline/hotline are anonymous and confidential except in life-threatening situations.

2NDFLOOR is certified by the American Association of Suicidology as a statewide suicide hotline.

Jersey Voice
This peer-to-peer Web site, Jersey Voice - www.jerseyvoice.net - helps to promote suicide prevention and encourages youth and young adults to communicate creatively about the difficult times they are experiencing so their messages can help peers encountering similar problems.

Society for the Prevention of Teen Suicide
The Society for the Prevention of Teen Suicide (SPTS) was started in 2006 by two fathers who had lost teenaged children to suicide. This Web site includes information for teens, parents and educators, including a video, *Not My Kid: What Every Parent Should Know*. This short video asks and answers questions about whether or not your child may be at risk for suicide. More importantly, it demonstrates how to ask those questions - and keep asking - until you get answers that help you understand whether or not your child is at risk....and what to do about it.

Division of Mental Health and Addiction Services (DMHAS)

DMHAS works collaboratively on a statewide level to help reduce suicides and attempts among all segments of New Jersey's population. The Division is a participant and collaborator with the NJYSPAC. The Council's oversight covers youth through age 24. Through its participation in

the NJYSPAC in helping to coordinate the NJ Youth Suicide Prevention Plan, DMHAS strives to reduce suicides and attempts among individuals aged 18 to 24.

Leveraging the momentum created by the Youth Suicide Prevention Plan, DMHAS began to review its own service system in relation to the suicide prevention recommendations included in the Youth Plan. Much of this review included assessments of strengths and weaknesses within the systems and opportunities for improvements. In addition to the needs of young adults through age 24, the DMHAS also had a responsibility to develop an Adult Suicide Prevention Plan to meet the needs of adults throughout all the Life Stages served within the DMHAS systems of care. Beginning in December 2011, an internal workgroup of DMHAS staff began regular meetings to first concentrate on developing strategies to meet recommendations outlined in the Youth Plan, and then to develop an Adult Suicide Prevention Plan that could complement that Plan through the other Adult Life Stages. That workgroup completed a draft Adult Suicide Prevention Plan in December 2012 which is currently under review with DMHAS leadership.

Following initial review of that Adult Suicide Prevention plan, the Division collaborated with Dr. Kelly Posner, Ph.D. (a nationally-renowned mental health expert on suicidality and its prevention) to train mental health and addictions treatment staff to use the Columbia-Suicide Severity Rating Scale (C-SSRS). Dr. Posner provided four half-day training sessions in May 2012 which was attended by 319 participants from all areas of the state. The audience included a wide variety of disciplines from all across the state, and included psychiatric emergency service screeners, mental health (both adult and child) clinicians, school-based personnel, and state officials. In the autumn of 2012, in coordination with SAMHSA Administrative Staff, DMHAS was able to provide intensive Mental Health First Aid Training for 48 individuals. The evaluations of these sessions, and discussions with the trainers themselves have been used to improve the content and setting for subsequent trainings that will be scheduled in SFY 2014.

In addition to the development of New Jersey Suicide Prevention Plans for Youth and Adults, another significant issue has been identified to both DHS-DMHAS and DCF by the NJYSPAC. That issue is the significant number of calls originating in New Jersey to the National Suicide Prevention Lifeline 800 # that cannot be answered in NJ and therefore must be answered out of state. It should be noted that only three agencies in NJ had agreed to answer NJ Lifeline calls and did so without any additional funding (beyond the $2,500 Lifeline annual stipend) and they were: CONTACT We Care, CONTACT of Mercer Co, and CONTACT of Burlington Co. Long before the Lifeline system existed, NJ had invested significant funding in local (county-based) mental health emergency service hotlines and psychiatric screening centers in addition to several specific typed of hotline systems, such as: the UMDNJ Cop 2 Cop 24/7 Helpline; the UMDNJ Vet 2 Vet 24/7 Helpline; a UMDNJ Mom 2 Mom 24/7 Helpline (provides peer support for mothers of children with special needs); the DMHAS 2-1-1 Addiction Information and Referral Hotline; and the MHA-NJ Mental Health Cares Information and Referral Helpline. While these investments most probably have done much to continue NJ's historically low per capita suicide completion rate, the overall number of NJ calls to the Lifeline system continues to increase and with it the number of Lifeline calls not answered in NJ also increase.

In reaction to the NJ Lifeline concerns mentioned above and recent legislation passed by the NJ Legislature for DCF and DHS to study the status of New Jersey based suicide prevention

hotlines, the DMHAS and DCF collaborated in completing a report to the New Jersey Legislature titled, "The Effectiveness and Sufficiency of Services Provided by the New Jersey Based Suicide Prevention Hotlines." In addition to this report, DHS-DMHAS and DCF worked with UMDNJ and the MHANJ to provide excess capacity that they identified in their internal hotline systems to become credentialed Lifeline Crisis Centers for New Jersey. Both agencies agreed to assist Lifeline in New Jersey without any new funding provided by the DMHAS. One of the chief outcomes of the above report was that even with the additional assistance provided by two additional NJ agencies joining the New Jersey Lifeline system, none of the agencies had the resources to provide 24/7 services and therefore, no New Jersey Lifeline calls could be answered in New Jersey after 11PM on any night.

On December 13, 2012, the DHS-DMHAS issued a RFP "To Implement a Statewide Suicide Prevention Hotline and Coordinate Call Response with the National Suicide Prevention Lifeline to Increase Suicide Prevention Efforts for Youth and Adults in New Jersey." That RFP addressed Goal #8 of the NJ Youth Suicide Prevention Plan as it promotes access to mental health and substance abuse services and Objective 8.5 which challenges us to increase the number of NJ Lifeline calls answered in NJ. The RFP made $674,000 available on an annual basis. In Q3 of SFY 2013, the RFP was awarded to the University Behavioral Healthcare (UBHC) The phone number was launched on May 1, 2013 and is 855—NJHOPELINE (855-654-6735).

The New Jersey HOPELINE adds the following capacities:

- Provides 24/7 Hotline services.
- Collaboration and communication with other New Jersey Lifeline providers, New Jersey Designated Screening Service agencies and additional adult and child mental health, substance abuse, and other providers.
- Provides specific training for all volunteers, offers peer positions, and volunteer opportunities.
- Ability to accept warm transfers from and to other behavioral health & social service organizations.
- Has a clinical supervisor assigned to each shift.
- Have plans for meeting demand from youth and others who wish to access the proposed suicide hotline serve via text messages, chat and/or social media.

The implementation of this expanded new hotline/Lifeline service will significantly increase the capability of the DMHAS system to expand and coordinate suicide prevention services statewide and throughout all the child and adult life stages.

The DMHAS Disaster and Terrorism Branch also identified additional issues and challenges that may arise in New Jersey as a result of the destruction and personal tragedies cause by Superstorm Sandy. Studies following the destruction caused by Hurricane Katrina appear to indicate a significant spike in suicides could occur approximately six months following a severe storm disaster such as Katrina or Sandy. The DMHAS will continue to improve ways to monitor and respond to such a situation should it occur in New Jersey.

The New Jersey State Epidemiological Outcomes Workgroup (SEOW), which was initially convened in 2006, was charged with collecting and analyzing epidemiological data to assess the magnitude of substance use-related consequences and substance use patterns related to these consequences. The aim is to profile population needs, resources, and readiness to address the problems and gaps in service delivery. The SEOW has begun compiling a comprehensive list of behavioral health indicators that indicate the presence or absence of a behavioral health problem. Suicide rates, trends, and related information are among the data the SEOW now includes in its analyses.

The Governor's Council on Mental Health Stigma has been working with a variety of community partners on suicide prevention efforts, utilizing our "A Community Effort" model for public awareness and education. "A Community Effort" is based on a philosophy of community connectedness, connecting all the audiences in the community in prevention efforts. "A Community Effort" public awareness campaigns target audiences that include Individuals and Families, Youth, Educators and Students, Employer and Employees, Veterans and Military, Law Enforcement, Multicultural Communities, Communities of Faith and Providers. "A Community Effort" aims at stigma by sending the message that "we all have mental health."

Specifically in regard to youth, the Council is represented on the Monmouth County Suicide Task Force and Monmouth County Emergency Response Committee. Through both of these endeavors, the Council utilizes "A Community Effort" to "market" prevention and break down the "silos" that exist not only in Monmouth County but across the State.

The Council also facilitated a partnership with the New Jersey Council of County Colleges to create the first ever statewide Mental Health Awareness Day at all 19 New Jersey Community Colleges that occurred October 6, 2011. This is part of an already existing partnership with Bergen, Cumberland, Mercer, and Sussex Community Colleges, as well as work with Ramapo and Felician Colleges and Princeton University.

The Council is working with the New Jersey Youth Development Council to create a public awareness campaign in the youth voice. The Youth Development Council comprises youth who have been through New Jersey's systems of care. Part of the goal of the Youth Development Council is to strengthen and elevate the youth voice to inform systems of care and engage peers in awareness and prevention. The Council will also be working with the New Jersey DCF on an initiative to provide information and resources to pediatricians, pediatric nurses and families receiving treatment at pediatric offices. A member of the Youth Development Council is also part of the New Jersey Mental Health Planning Council.

State of New Jersey
DEPARTMENT OF CHILDREN AND FAMILIES

CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

ALLISON BLAKE, PH.D., L.S.W.
Commissioner

July 5, 2012

To the Residents of New Jersey,

A law passed earlier this year —Public Law 2011, Chapter 166 (N.J. Stat. § 30:9A-29) — requires the Department of Children and Families to adopt a statewide youth suicide prevention plan. DCF has determined the requirement is best satisfied by the readoption of the *New Jersey Youth Suicide Prevention State Plan 2011-2014.*

The 2011-2014 plan was published less than a year prior to the enactment of P.L. 2011, C. 166 and its implementation is already well underway. After thorough review and consultation with outside experts and advocacy groups—including the Department of Human Services and the New Jersey Youth Suicide Prevention Advisory Council—DCF has concluded that the plan both satisfies the intent of the legislature, and remains an appropriate guide for the state's youth suicide prevention efforts.

The scope of efforts in this area cannot, however, be limited by the contents of a plan. Based on valuable feedback received over the course of the past year, DCF makes the following additional commitments:

1. DCF will report on the progress of the implementation of the prevention plan to the Governor and Legislature in July, 2013.
2. DCF will continue to issue an annual youth suicide prevention data report which will review the youth suicide data and prevention activities for each year.
3. DCF will require its lead youth suicide prevention program to add an outcome survey component to its trainings to obtain feedback on usefulness of trainings from participants.
4. DCF will review the New Jersey Youth Suicide Prevention Plan and consider updates when the new National Strategy for Suicide Prevention is released.
5. DCF will continue to promote the use of best practices and evidence-based approaches in its youth suicide prevention efforts.

We look forward to continuing to work with the residents of New Jersey to prevent youth suicide. We were pleased to see a decrease in the numbers of New Jersey students reporting they had attempted suicide in the Youth Risk Behavioral Survey released by the CDC last month and believe we can continue to have a positive impact. New Jersey has a

comprehensive youth suicide prevention program in place statewide and we are constantly building upon that infrastructure to improve and enhance our efforts.

Preventing youth suicide is a collaborative effort and we look forward to working in partnership with our communities to move this plan forward. We welcome your comments or questions at cbh_dcf@dcf.sate.nj.us.

Sincerely,

Jeffrey J. Guenzel, MA, LPC
CSOC Director

Allison Blake, Ph.D., L.S.W
Commissioner

New Jersey Youth Suicide Prevention Plan 2011 – 2014

New Jersey
Department of Children and Families
Allison Blake, Ph.D., L.S.W
Commissioner

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Introduction

In 2008, sixty-eight individuals aged 24 years and younger completed suicide (New Jersey Office of the State Medical Examiner). This number places youth suicide as the fourth leading cause of death for New Jersey's youth (National Center for Injury Control and Prevention, Centers for Disease Control).

The New Jersey Department of Health and Senior Services, reports:

- Every month seventy New Jersey youth make a suicide attempt serious enough for hospitalization.
- Over forty percent of the suicide attempts by minors are subsequent to previous suicidal behaviors.
- Suicide attempts result in significant medical and non-medical costs and include physical, emotional, and psychological damage to the victims as well as to their families and friends.
- Clusters of suicide attempts and deaths of youth have been reported in New Jersey.

NJ Suicide Statistics Relative to Other States

Relative to other states, New Jersey has low suicide rates at all ages. New Jersey has ranked as one of the four lowest states for suicide rates in the country (Thomson Healthcare). The reasons for New Jersey's relatively good standing can be attributed in part to the implementation of state regulations, policies, guidance, and resources identified in the professional literature to successfully prevent youth suicide (Cecil G. Sheps Center).

NJ's Suicide Prevention Activities

There are many factors and actions that have aided the suicide prevention efforts in New Jersey. New Jersey has had strict laws restricting minor's access to guns. The State has mandated staff training in schools for suicide prevention and the detection of warning signs. New Jersey has mandated the establishment of psychiatric screening centers in every county that include crisis hotlines staffed 24 hours a day, seven days a week. In addition, beginning in 2001, New Jersey has developed a state-wide Mobile Response and Stabilization System (MRSS) for youth available in every county in the State. This program provides 24/7 in community crisis intervention in situations where there may not yet be suicidal gestures, but there are often significant risk factors. The MRSS program is also able to provide up to eight weeks of immediate in-home/in-community therapeutic interventions.

These efforts regarding New Jersey's suicide prevention activities were noted as a "promising practice" in a 2004 report by the Cecil G. Sheps Center at the University of North Carolina at Chapel Hill. The report also indicated that New Jersey has a high degree of collaboration among state and local organizations as exemplified by the makeup of the New Jersey Youth Suicide Prevention Council (NJYSPAC) which includes representatives from the New Jersey Department of Health and Senior Services, the Department of Children & Families, the

Department of Education, the Department of Human Services, the Division of Mental Health Services, and the Juvenile Justice Commission.

New Jersey's lead State agency for youth suicide prevention is the Department of Children and Families (DCF). As of the writing of this plan, DCF's lead youth suicide prevention program is the Traumatic Loss Coalition for Youth at the University of Medicine and Dentistry – University Behavioral Health Care. This program is funded by the Department of Children and Families – Division of Child Behavioral Health Services.

The Traumatic Loss Coalition (TLC) has operated as a county-based collaborative since the year 2000. Each county employs a Coordinator who conducts meetings throughout the year bringing together school personnel, mental health clinicians, juvenile justice personnel, law enforcement officials, social service agencies, child welfare workers and many others who work closely with youth. The meetings are effective forums for reviewing traumatic loss events, identifying service needs, and providing professional development through the inclusion of an educational component. Speakers for the educational component are experts in topics related to the needs of youth. The Coordinators often collaborate with other agencies in their respective counties to co-sponsor workshops and conferences focused on issues pertinent to the mental health of the youth.

The Coordinators also work within their counties to direct a Lead Response Team (LRT) to assist schools when needed following a traumatic loss event, or as in the case of several counties, support the director of an existing team. Post Traumatic Stress Management (PTSM) training is provided for members of these teams.

The State report completed by TLC in 2010 indicated that in the 18 month period ending March, 2010:

- **3,991** individuals received on-site trauma response assistance to schools and communities including postvention after a death by suicide, homicide, accident or illness, and other critical incidents;
- **9,740** individuals attended training programs on mental health disorders and suicide prevention for youth-serving individuals and groups; and
- **2,448** individuals attended training programs for school and community personnel who must respond to the needs of youth in the aftermath of suicide, homicide, accidental death, and other critical incidents such as a natural disaster or terrorist strike (postvention).

The Traumatic Loss Coalitions for Youth Program has created an expanding statewide network that effectively works to prevent suicide and promote healing and resiliency in the aftermath of traumatic loss (UBHC, UMDNJ, Traumatic Loss Coalitions for Youth, 2010).

NJ Youth Suicide Prevention Advisory Council

In January of 2004 due to an overwhelming concern about youth suicide, The State of New Jersey created through legislation (N.J.S.A. 30:9A-22 et seq.) the New Jersey Youth Suicide Prevention Advisory Council (NJYSPAC). This purpose of the NJYSPAC is to examine existing needs and services and make recommendations to the Department of Children and Families for youth suicide reporting, prevention, and intervention; advise the Department of Children and Families on the content of informational materials to be offered to persons who are required to report attempted or completed suicides; and to advise the Department of Children and Families on the development of regulations pursuant to the act which created the NJYSPAC.

Everyone is affected by suicide. Council members are dedicated to youth suicide prevention and give freely of their time and commitment to developing strategies for suicide prevention and intervention.

This plan is dedicated to the youth and families whose life has been touched by suicide.

Council Members and Contributors to the State Plan 2010

***Organizational affiliations are those at the time of the individual's involvement.**

Leadership

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CEO, CGS Family Partnership, Inc.

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New Jersey's Youth Suicide Prevention Plan

In 2001, the U.S. Department of Health and Human Services released a report entitled, "National Strategy for Suicide Prevention: Goals and Objectives for Action." This report described suicide as a serious public health problem throughout the United States, and introduced a blueprint for addressing suicide prevention. The Surgeon General also recommended that each state adopt a youth suicide prevention plan that would incorporate the national recommendations.

This New Jersey Youth Suicide Prevention Plan seeks to build on the existing efforts in New Jersey by remaining focused on the risk and protective factors associated with the prevention of suicide in children, youth, and young adults. The plan outlines goals, rationale, and objectives for increasing the prevention effort throughout the state. Achieving these goals will require the continued partnership and collaboration among all stakeholders. Accountability for the goals will necessitate that all stakeholders work in concert with each other focused upon the needs of our children, youth, young adults, their families, and support networks.

The plan presents the overall goals for the prevention of suicide and is broken down into ten sections. Found within each section are specific objectives. The sections and format of the plan were not arbitrary. Rather the plan was modeled in content and in form after the 2001 National Strategy for Suicide Prevention and the joint Suicide Prevention Resource Center and SPAN USA 2010 Progress Review of the National Strategy.

New Jersey's Youth Suicide Prevention Plan Goals

	Goals
1	Improve and expand surveillance systems;
2	Promote awareness that suicide is a preventable public health problem;
3	Develop broad-based support for youth suicide prevention;
4	Develop and implement strategies to reduce the stigma associated with needing and receiving mental health, substance abuse, and suicide prevention services;
5	Strengthen and expand community-based suicide prevention and postvention[1] programs;
6	Implement professional training programs for those who are in regular contact with youth at-risk for self-injury or suicide;
7	Develop and promote effective clinical practices to reduce suicide attempts and completions;
8	Promote access to mental health and substance abuse services;
9	Improve reporting and portrayals of suicide, mental illness, and substance use in the electronic and print media; and
10	Promote and support research on youth suicide and suicide prevention, its dissemination and incorporation into clinical practice and public health efforts.

[1] A strategy or approach that is implemented after a crisis or traumatic event has occurred

Goal # 1: Improve and expand surveillance systems.

Rationale

The quality of surveillance data on completed suicides is relatively high in New Jersey due to our state's participation in the CDC-funded National Violent Death Reporting System. The New Jersey Violent Death Reporting System (NJVDRS) is a detailed surveillance system of all violent fatalities, which integrates medical examiner, death certificate, and law enforcement data to provide accurate and timely data on all suicides. Additionally, the NJVDRS provides detailed information about suicide circumstances, and how they differ for adolescents as compared with those in other age groups. Despite this, death certificates sometimes fail to correctly identify suicides as the cause of the death. Information on completed suicides is obtained from the New Jersey Department of Health and Senior Services, Vital Records, as coded by medical examiners on death certificates. A problem arises in those ambiguous youth deaths where suicide is suspected, but no clear evidence is available to make a definitive statement of this specific cause. In those cases, the medical examiners will enter another code based on secondary circumstances surrounding the death (e.g., substance abuse, motor vehicle accident, undetermined, unintentional). This problem leads to potential under-reporting of youth suicide.

Data on suicide attempts or ideation are lacking and are similarly affected by some of the same surveillance challenges noted above. These data are expected to be collected by mental health providers, screening centers, and emergency room personnel. But there are gaps in how these data are collected and made available for further review by prevention initiatives.

A related issue is the extent to which information on youth suicide from schools is utilized regarding broad-based prevention efforts. The New Jersey Board of Education requires public middle and high school students to complete the New Jersey Student Health Survey, which is administered periodically to middle and high school students in the state. This survey asks about depression, suicide plans, ideation, and attempts. However there is an enormous discrepancy between the prevalence of self-reported attempts and the prevalence as captured by hospital discharge data, suggesting that the majority of these self-reported attempts are relatively low in terms of lethality. As adolescents age, their rate of reporting suicidal plans and attempts declines, while the rate of actual attempts increases. This is a serious problem as a 2009 nationwide survey of youth in grades 9-12 in public and private schools in the United States (U.S.) found that 13.8 % of students reported seriously considering suicide, 10.9 % reported creating a plan, and 6.3 % reported trying to take their own life in the 12 months preceding the survey (CDC Youth Risk Behavior Surveillance).

Objectives:

1.1 The Department of Children and Families will publish an annual report on suicide in New Jersey that integrates data from multiple state data management systems.

1.2 Improve coordination of data collection regarding suicide investigations with state, local agencies, and their partners.

1.3 Establish surveillance mechanisms across entities that track the use of mental health services as well as suicide attempts.

1.4 Establish a mechanism for systematic collection and analysis of suicide attempt data.

Goal # 2: Promote awareness that suicide is a preventable public health problem.

Rationale

Many individuals are not aware that suicide is the fourth leading cause of youth death in New Jersey. Therefore, enhanced awareness that suicide is a serious public health issue is expected to influence people to be more vigilant about identifying the risk of suicide in themselves, peers, and others.

Increased awareness should result in more caregivers of children, youth and young adults to seek assistance when there is a risk of suicide. Awareness among policy makers may result in efforts to modify policies and to allocate resources toward suicide prevention efforts.

Objectives

2.1 Develop and implement a public information campaign that explains that suicide in youth is preventable and is related to mental health, substance abuse and other at-risk behaviors.

2.2 Establish and enhance existing mechanisms and structures for suicide prevention designed to foster collaboration with stakeholders and the general public on prevention strategies across disciplines.

2.3 Increase the number and quality of both public and private institutions that are involved in collaborative and complementary dissemination of current suicide prevention information on the Internet.

2.4 Promote awareness of youth suicide as a public health issue in communities through community-based organizations.

2.5 Increase awareness of suicide risk and prevention strategies for all providers of DCF out-of-home services including resource homes, treatment homes, and various residential placements.

Goal # 3: Develop broad-based support for youth suicide prevention.

Rationale

Because youth suicide and attempts are the result of complex, multidimensional biological and psychosocial factors, the prevention of suicide requires an ecological, multidisciplinary approach. Similar collaborative efforts will be required at the state and local levels in New

Jersey. These collaborative efforts like NJYSPAC will need public and private partnerships at the local, state and national level to generate the greatest impact regarding suicide prevention.

The National Strategy for Suicide Prevention supports the development of collective leadership and of increasing the variety of groups working to prevent suicide. This effort applies to the state and local level. The development of broad-based support for suicide prevention will require ready access to information, research, literature resources, best practices, and program models. This effort will include the identification of multiple sites that can disseminate these resources.

Objective

3.1 Encourage agencies and organizations involved in suicide prevention to work within a collaborative framework at the state and local level.

3.2 Promote access to materials such as monographs, periodicals, videos, outreach posters, information pamphlets, electronic communication and related materials on suicide prevention in New Jersey.

3.3 Increase the number of state, local, professional, volunteer, and other groups that can integrate suicide prevention activities into their ongoing programs and activities.

3.4 Include suicide prevention information on the DCF website and encourage DCF contracted agencies to include suicide prevention information on their websites.

Goal # 4: Develop and implement strategies to reduce the stigma associated with needing and receiving mental health, substance abuse and suicide prevention services.

Rationale

Harris and Barraclough, 1997, found that sixty to ninety percent of all suicidal behaviors are associated with some form of mental illness and/or substance use disorder (National Strategy for Suicide Prevention). The negative stigma of mental illness and substance abuse prevents many children, youth and young adults from seeking assistance and has contributed to the silence and shame associated with mental health problems and suicide. Family members of those surviving a suicide attempt often hide the behavior from those that could help or provide support, believing that it reflects badly on their own relationship with the suicide attempter or that attempting suicide is shameful or sinful (National Strategy for Suicide Prevention).

Objective

4.1 Increase coordination among state agencies and entities such as the Governor's Anti-stigma Council and DCF to decrease stigma.

4.2 Increase public knowledge that mental health and physical health are intertwined components of overall health.

4.3 Increase public knowledge that mental illness and substance abuse, similar to physical illness, respond to specific treatments.

4.4 Increase public knowledge that consumers of mental health, substance abuse, and suicide prevention services are pursuing fundamental care and treatment for their overall health.

4.5 Encourage professional groups, associations, and individuals to address the issue of stigma associated with using mental health and substance abuse services.

Goal # 5: Strengthen and expand community-based suicide prevention and postvention programs.

Rationale

Effective suicide prevention requires a broad-based community commitment. Although there is not any one "suicide type," there are youth who are at a higher risk based on particular risk factors. To help youth in need, community professionals and organizations must mobilize resources, identify risk and protective factors, and bring focused attention to the issue of suicide.

Successful suicide prevention, intervention and postvention strategies are based on the public health approach. Evidence-based methods are needed. Evaluations are also needed as programs are developed and implemented. The science of suicide prevention is still developing. Therefore, emerging strategies, promising practices, and other strategies with a foundation based in best practices may be used in addition to existing evidence-based strategies. These programs require an even more rigorous evaluation process to measure effectiveness.

Objectives

5.1 Expand and improve training efforts in suicide prevention to increase knowledge regarding best practices for suicide prevention, intervention and postvention for community-based organizations and schools.

5.2 Improve coordination with cultural and faith-based entities to share resources and information on issues of suicide.

5.3 Focus specific suicide prevention and postvention efforts towards higher risk populations such as adolescents, college students, gay/lesbian/bisexual/transgender youth, immigrants, non-English speaking youth, those addicted to and/or abusing substances, and youth in the correctional/juvenile justice system or other out-of-home settings.

Goal # 6: Implement professional training programs for those who are in regular contact with youth at-risk for self injury or suicide.

Rationale

There are many different settings where trained personnel can intervene with youth at-risk for self-injury or suicide. Pirkis & Burgess, 1998, found that approximately 45 percent of all individuals who die by suicide have had some contact with a mental health professional within the year of their death (National Strategy for Suicide Prevention). Trained personnel who come into contact with youth at risk for suicide are referred to as "key gatekeepers." Key gatekeepers include, but are not limited to, teachers, clergy, police, resource parents, physicians, nurses, and therapists. Providing appropriate training for this broad array of key gatekeepers is an opportunity to enhance suicide prevention efforts.

Objectives

6.1 Maintain and expand key gatekeeper suicide prevention training programs in New Jersey to ensure adequate recognition and treatment of youth who are at-risk for suicide.

6.2 NJYSPAC will make concrete and specific recommendations to DCF about the adequacy of existing training for DCBHS and DMHS providers and about improvement, including specific curricula, which are preferable.

6.3 Maintain training programs in the recognition and treatment of risk factors associated with suicide across disciplines, including physical and mental health and substance abuse systems, legal systems, the education systems, and religious organizations. These trainings should include instruction on the identification of persons at risk, appropriate counseling, and referral to community-based services.

6.4 NJYSPAC will make specific recommendations to DCF:

> 6.4.1 That identifies who the "key gatekeepers" are; determine how they are organized across the state; recommend engagement strategies for each group; and suggests courses of action for engagement in youth suicide prevention efforts.
>
> 6.4.2 That identify preferred youth suicide prevention training strategies for key gatekeeper groups; training strategies will be cognizant of and sensitive to the particular mission, goals, needs, and organizational structures of each group.

Goal # 7: Develop and promote effective clinical practices to reduce suicide attempts and completions.

Rationale

For every youth who completes suicide there are many others who have made non-lethal attempts. Professionals in the health and mental health/substance abuse fields, clergy, education, and law enforcement are involved in the identification and referral of people at–risk for suicide. Service referrals should be made to programs evidencing high quality services , best practices and evidence based treatments when possible and appropriate. The quality of treatment for at-risk youth will be improved by the identification and implementation of these effective clinical practices. It is essential that all referral sources know how and where to locate providers whose practices are evidence based and reliant upon best practices. It is necessary that individuals at risk for suicide are engaged in prompt and effective treatment.

Objectives

7.1 DCF will facilitate interdepartmental collaboration to develop and promote best practice on the recognition of the antecedents of suicidal behavior.

7.2 Identify, disseminate and train the various provider groups on evidence-based and best practice guidelines in the diagnosis and treatment of suicide and self-injury . The primary audiences for this effort may include emergency care providers, primary care providers, mental health care providers, substance abuse providers, juvenile corrections personnel, school personnel, clergy, and other professionals who work with youth at-risk for suicide. Training should support providers efforts to treat youth at high-risk for suicide, youth that attempt suicide, and families, friends and those likely to be affected by a suicide or suicide attempts.

7.3 Promote, and support evidence-based and best practice guidelines for prevention and treatment of suicide or self-injury.

7.4 Facilitate the training of providers who treat children, youth, and young adults who are suicidal in best practices and evidenced based treatments.

Goal # 8: Promote access to mental health and substance abuse services.

Rationale

Youth with untreated mental health and substance abuse problems are at high risk for suicide; therefore, access to high quality mental health and substance abuse services is critical. Barriers to access should be reduced and linkages among various community agencies, mental health, and substance abuse treatment programs need to be enhanced. Where possible, services should be integrated and coordinated to avoid conflicting policies from potential funding sources.

Objectives

8.1 Identify and address barriers to mental health and substance abuse services.

8.2 Increase community awareness of risk behavior and increase awareness of culturally competent and linguistically relevant services.

8.3 Work with all appropriate state departments to increase access to an integrated network of effective, efficient, culturally competent and linguistically accessible mental health and substance abuse services that include suicide prevention and counseling services.

8.4 Promote DCF's youth helpline, "2nd Floor." Continue to enhance this helpline's ability to respond to youth at risk and explore potential for this helpline serving as a National Suicide Prevention Lifeline networked hotline.

8.5 Increase the number of calls answered in New Jersey from New Jersey residents that call the National Suicide Prevention Lifeline. Identify, coordinate, and prepare New Jersey based hotlines to serve as a recipient of National Suicide Prevention Lifeline calls.

8.6 Encourage all DCF contracted agencies to promote NJ Mental Health Cares helpline as a resource for families seeking mental health services.

Goal # 9: Improve reporting and the depiction of suicide, mental illness, and substance use in the electronic and print media.

Rationale

Media representations of suicide can potentially influence the suicidal thoughts and actions of youth. The collaborative efforts of the American Foundation for Suicide Prevention, American Association of Suicidology, and Annenberg Public Policy Center with support from the Centers for Disease Control, National Institute of Mental Health, Office of the Surgeon General, and Substance Abuse and Mental Health Services Administration have issued guidelines for reporting on suicide.

Objectives

9.1 Disseminate information on nationally recognized guidelines for reporting about suicide with an effort to reduce the stigma and prevent future suicides.

9.2 Utilize the nationally recognized guidelines outlined in the Reporting on Suicide: Recommendations for the Media (Annenberg Public Policy Center 2001) for reporting on suicide and local experts on suicide and suicide prevention for consultation and training with the media and academic programs in journalism.

9.3 Work with New Jersey academic journalism programs to include guidance on the appropriate depiction and reporting of mental illness, suicide and self-injury in their curricula.

Goal # 10: Promote and support research on youth suicide and suicide prevention and its dissemination and incorporation into clinical practice and public health efforts.

Rationale

Suicide prevention is a growing field, with an expanding knowledge base. More youth suicide prevention programs have been evaluated and resources are available to help community-based programs evaluate their suicide prevention efforts. Additional research on suicide prevention efforts and information from an increased number of evidence-based practices needs further systematic replication and evaluation.

Suicide prevention efforts at the state and local program level can be strengthened by promoting research-based strategies, using research in program planning and development, collection of data on process and outcome and an evaluation component for each program. There is a need for more training in evaluating suicide prevention efforts.

Objectives

10.1 Promote ongoing dissemination of evidence-based suicide prevention models and use of research-based strategies for suicide prevention.

10.2 Encourage all New Jersey suicide prevention programs to review best-practice and evidence-based research and to include an evaluation component that demonstrates outcome effectiveness.

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10.3 Increase the number of suicide prevention programs that conduct program-specific research or participate in research and evaluation efforts of others.

10.4 Establish and maintain a directory of suicide prevention programs with demonstrated effectiveness as recognized by best-practice.

Next Steps

This plan is a three (3) year plan; however it is designed to be a base for longer range planning as well. Not all of the objectives listed in this plan will be able to be met within three years and will carry over to future plans. It is the hope of DCF that the NJYSPAC will provide ongoing recommendations for suicide prevention and planning and this State plan may be amended as often as annually. At a minimum, the plan will be fully reviewed and updated every three (3) years.

DCF will continue to accept and review all advice and recommendations provided by the NJYSPAC. The NJYSPAC will meet on a regular schedule and DCF will provide a liaison to the NJYSPAC.

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IV: Narrative Plan

T. Use of Technology

Narrative Question:

In the FY 2012/2013 Block Grant application, SAMHSA asked states to describe:

- What strategies the state has deployed to support recovery in ways that leverage ICT;
- What specific application of ICTs the State BG Plans to promote over the next two years;
- What incentives the state is planning to put in place to encourage their use;
- What support system the State BG Plans to provide to encourage their use;
- Whether there are barriers to implementing these strategies and how the State BG Plans to address them;
- How the State BG Plans to work with organizations such as FQHCs, hospitals, community-based organizations, and other local service providers to identify ways ICTs can support the integration of mental health services and addiction treatment with primary care and emergency medicine;
- How the state will use ICTs for collecting data for program evaluation at both the client and provider levels; and
- What measures and data collection the state will promote to evaluate use and effectiveness of such ICTs.

States must provide an update of any progress since that time.

Footnotes:

T. Use of Technology

Overview

In order to better understand the use of ICT among substance abuse prevention and treatment providers, the SSA sent a brief web-based survey to all providers in July 2011. Responses were received from 130 providers. Results of the survey indicated that some providers (30) were using ICT. Most used ICT for text messaging and outreach, followed by recovery tools, emotional support, case management support and prompts. Some were using it for appointment reminders, confirmation, telemedicine and social media (Facebook, Twitter) for information dissemination. Telemedicine was being used to evaluate/screen psychiatric patients and for commitment hearings.

A new survey was sent out to both mental health and addiction providers in March 2013. There were 99 respondents. Results indicated that 39% were using this technology, an increase of 10% since the last survey. The most frequent use was for text messaging (50%), followed by outreach and case manager support. Telemedicine was being used by 21% of the respondents, a slight increase since the last survey.

a. What strategies has the State deployed to support recovery in ways that leverage Interactive Communication Technology?

The SSA employs other strategies (e.g., peer support, follow-up phone calls) to support recovery rather than leveraging ICT for this purpose. The SMHA is anticipating that the use of ICTs will increase upon the implementation of the Electronic Health Record and the web-based, client-level database. This is an area where technical assistance is requested by both the SSA and SMHA.

The SMHA has allowed several provider agencies to conduct telemedicine in several Designated Screening Centers Telemedicine is permitted by providers who have obtained written waivers to do so from the SMHA. The increased affordability of telemedicine makes it attractive in locales where traditional medical settings are cost-prohibitive. Currently telemedicine is conducted primarily in central New Jersey (e.g., Warren, Mercer, and Middlesex Counties), and the southern region (e.g., Gloucester and Camden Counties).

The DCF “Transitions for Youth (TFY)” is a multifaceted statewide initiative that utilizes a positive youth development framework to address the complex needs of youth transitioning to adulthood, particularly those who are aging out of foster care or who were involved with New Jersey's juvenile justice or behavioral health systems. TFY is funded primarily through the DCF Office of Adolescent Services (OAS) and is coordinated by the Center for Nonprofit Management and Governance, The School of Social Work at Rutgers, The State University of New Jersey. The goal of this initiative is to ensure that youth develop essential skills and competencies in education, employment, daily living, decision-making, and interpersonal communication. All TFY programs are rooted in best practices and integrate Positive Youth Development, a model for improving outcomes for youth by addressing the following domains: housing stability; improved academic functioning; job-readiness skills; financial literacy;

emotional regulation and physical wellness; and peer, adult and community partnerships. TFY utilizes the following ICT:
Facebook at http://www.facebook.com/pages/Transitions-for-Youth/202831964660;
YouTube at http://www.youtube.com/user/TransitionsForYouth1?feature=mhum; and
flickR at http://www.flickr.com/groups/1498471@N25/.

The New Jersey Statewide youth helpline/hotline, 2NDFLOOR, is available 24-hours a day, seven days a week to youth and young adults ages 10-24 to help find solutions to the problems they face at home, school, or play. Youth can either call the helpline/hotline, 1-888-222-2228, or access the interactive Web site www.2NDFLOOR.org. An interactive message board is available for youth who have questions and concerns but are not yet ready to place a phone call to the helpline. The helpline/hotline is supervised at all times by a mental health professional. Youth are provided with relevant and appropriate linkages to information and services to address their social, emotional, and physical needs. Calls to the 2NDFLOOR youth helpline/hotline are anonymous and confidential except in life-threatening situations. The American Association of Suicidology recently certified 2NDFLOOR as a statewide suicide hotline. 2NDFLOOR utilizes the following ICT:
Facebook at http://www.facebook.com/2ndflooryouthhelpline; and
YouTube at http://www.youtube.com/watch?v=eL8yP7_Qy6I.

Jersey Voice is a peer-to-peer website that helps to promote suicide prevention and encourages youth and young adults to communicate creatively about the difficult times they are experiencing so their messages can help peers encountering similar problems. The website was organized with the assistance of the Traumatic Loss Coalition for Youth program as well as the NJ DCF. TLC partnered with Emotion Technology to develop this site that combines a focus on suicide prevention and intervention with social media outlets to reach youth and young adults where they live and communicate. Audio, image, interactive, text, and video technologies are utilized, including Facebook, Twitter, Vimeo and YouTube. Jersey Voice can be accessed at www.jerseyvoice.net

b. What specific application of ICTs does the State plan to promote over the next two years?

The SSA would like to explore the use of e-therapy in rural areas where access to substance abuse treatment is limited. A discussion on the use of e-therapy was held with the SSA's Professional Advisory Committee approximately two years ago and was acknowledged as an area needing further exploration. Also, New Jersey was awarded a Strategic Prevention Framework State Incentive Grant (SPF SIG) several years ago. Several of the grantees had plans to use social media as part of their prevention strategy.

Another area the SSA wishes to explore is the use of Short Text Messages (STMs) using mobile devices to engage and retain clients in treatment and support their recovery. The SSA has provided a letter of support for the National Council on Alcoholism and Drug Dependence (NCADD) in New Jersey, who is partnering with Columbia University and applying for a grant to improve methadone treatment outcome and reduce HIV risk behaviors. Based on NCADD's pilot trial using texting messaging with individuals in MAT and their work developing a mobile

intervention for addiction continuing care, they have a firm foundation for a larger randomized controlled trial. The study sample will come from several methadone clinics in New Jersey.

The SSA is also interested in ICT as a means of information dissemination and promoting health literacy over the next few years. Within the next two years, the SMHA envisions the implementation of Personal Health Records (PHRs), the use of e-apps, and exploring new uses of telemedicine.

The DMHAS Medical Director is interested in a pilot to test the use of mobile technology with 50 discharged State hospital patients to help them remember appointments, take medication, etc. Efforts will be undertaken to secure funding for this pilot study with the goal of applying for a grant to implement this technology on a larger scale. Also, several staff attended a presentation on using mobile technology to deliver a program to assist with depression called "Beating the Blues" that may have applicability in New Jersey.

DCSOC is exploring its options in this area of technology.

c. What incentives is the State planning to put in place to encourage their use?

The SSA does not provide incentives for ICT use nor is planning to do so in the near future, due to limited funding availability.

The SMHA does not provide incentives for the use of ICTs at this time. There are some provider agencies that have begun to develop/implement ICTs; one of these agencies recently was awarded the Primary and Behavioral Healthcare Integration Grant, and recently applied for the Supplement for that Grant (Primary and Behavioral Healthcare Integration Grant for Health Information Technology).

DCSOC has not yet explored providing incentives for the use of ICT.

d. What support system does the State plan to provide to encourage their use?

The SSA is always available to provide technical assistance to its providers when rolling out new initiatives. It makes frequent use of webinar technology to educate providers and eliminating the need for travel and securing meeting space.

Another support is DMHAS' contract with the New Jersey Association of Mental Health and Addiction Agencies (NJAMHAA) IT Project, which assists agencies in their use of technology. DMHAS requested that the IT Project begin to promote and support the use of ICT among providers, since this also emerged as an area of interest in a survey NJAMHAA conducted. Based on feedback from DMHAS, a session on ICT was included in the NJAMHAA IT Conference held in March. The session included two presentations: "Beating the Blues" and "A-Chess." "Beating the Blues" treats depression and anxiety by using Cognitive Behavioral Therapy and consists of eight weekly online treatment sessions, 50 minutes each. "A-Chess" is a mobile phone-based relapse prevention system that offers support to alcohol dependent people

when and wherever it is needed. It offers Social Support, Virtual Counseling, Education, Location Tracking, Assessments, and Alerts.

DCSOC has not yet explored supports to encourage the use of ICTs within the Children's System of Care.

e. Are there barriers to implementing these strategies? Are there barriers to wide-scale adoption of these technologies and how does the State plan to address them?

The SSA has concerns regarding the security of these technologies and potential liability issues for clinicians who utilize e-therapy. Appropriate privacy protection must be incorporated into the design of the ICT, particularly when dealing with consumers who have substance use disorders. Since most SSA clients are indigent, many may lack easy access to the internet or cell phones. This barrier is also noted by the SSA's Citizens Advisory Council (CAC).

SSA providers surveyed have also identified a variety of barriers in the use of this technology. Some do not use ICT to communicate with clients due to concerns about information security and confidentiality. Others identified lack of funding to hire appropriate technology staff or acquiring the needed equipment. Lack of reimbursement for services such as e-psychiatry and telemedicine were seen as obstacles. Agencies were also restricted by system firewalls or county policies and procedures. Other barriers are clients' phone numbers change or are disconnected, if an answering machine picks up, there is no confirmation, clients are charged for cell phone and texting minutes, client literacy issues, and lack of knowledge by providers about how to use these systems. This is an area requiring further education.

The SMHA may face the following barriers during its implementation of ICT strategies: inadequate funding necessary for the development and maintenance of related ICT technology (e.g., personnel costs related to the development of such technologies and hardware expenditures) and complications arising from the interface of a myriad of unrelated data structures.

Funding to implement exploration and wide-scale implementation of ICTs is not available to DCSOC at this time.

f. How does the State plan to work with organizations such as FQHCs, hospitals, community-based organizations and other local service providers to identify ways ICTs can support the integration of mental health services and addiction treatment with primary care and emergency medicine?

The SSA and SMHA will be looking closely at the use of ICTs as it moves towards the development of Behavioral Health Homes to support integration of services and for monitoring consumer and provider outcomes.

These areas have not yet been explored by DCSOC.

g. Will the State use ICTs for collecting data for program evaluation at both the client and provider levels?

At present, the SSA will not use ICT for collecting data for program evaluation at both the client and provider levels since there are existing web-based client and provider level reporting systems that are used by the SSA for this purpose.

These areas have not yet been explored by DCSOC.

h. What measures and data collection will the State promote for promoting and judging use and effectiveness of such ICTs?

If the SSA were to move in this direction, it would want to assess the effectiveness of this technology in reducing no shows and improving client engagement and retention. It will also look at the effectiveness of this technology in supporting a client's recovery.

Although the SMHA will institute formal evaluation protocols closer to the final implementation of ICTs, the following indicators for evaluating the use and efficacy of ICTs may include: improved no-show rates for community services, decreased hospital readmission rates, and improved health and behavioral health outcomes.

These areas have not yet been explored by DCSOC.

IV: Narrative Plan

U. Technical Assistance Needs

Narrative Question:

States shall describe the data and technical assistance needs identified during the process of developing this plan that will facilitate the implementation of the proposed plan. The technical assistance needs identified may include the needs of the state, providers, other systems, persons receiving services, persons in recovery, or their families. Technical assistance includes, but is not limited to, assistance with assessing needs; capacity building at the state, community and provider level; planning; implementation of programs, policies, practices, services, and/or activities; evaluation of programs, policies, practices, services, and/or activities; cultural competence and sensitivity including how to consult with tribes; and sustainability, especially in the area of sustaining positive outcomes. The state should indicate what efforts have been or are being undertaken to address or find resources to address these needs, and what data or technical assistance needs will remain unaddressed without additional action steps or resources.

1. What areas of technical assistance is the state currently receiving?
2. What are the sources of technical assistance?
3. What technical assistance is most needed by state staff?
4. What technical assistance is most needed by behavioral health providers?

Footnotes:

U. Technical Assistance Needs

The State Mental Health Authority (SMHA)/ The Single State Authority on Substance Abuse (SSA)

The SMHA/SSA would benefit from technical assistance in the following areas:

1. Implementation of Interactive Communication Technologies (ICTs) such as e-apps and telemedicine. In surveying SSA providers about their use of ICT it became apparent that many providers did not know much about this area and were interested in learning how these technologies could be helpful. The SSA is interested in the use of e-therapy in our more rural locations where there is limited access to transportation. Also, the SSA would like to understand how professional liability, security, confidentiality and reimbursement issues are addressed. Another area the SSA would like to learn more about is how these technologies can be used to increase client engagement and retention and support recovery. The SMHA is also interested in exploring these technologies with interest in the prevention of suicide and depression.

2. Mental Health Prevention – this will be the first year that the SMHA has utilized CMHBG funding for Mental Health Prevention services as we will be funding a Statewide Suicide Prevention Hotline. The SMHA would like to further its Mental Health Prevention efforts in the state and welcome technical assistance in this area.

3. Transforming the Planning Council from a Mental Health Planning Council to a Behavioral Health Planning Council – New Jersey submitted a grant application for Technical Assistance in February to assist in these efforts but was notified in March that it was not awarded. Guidance in clarifying the regulations regarding membership composition (percentage requirements) in light of the move to a merged behavioral health council is needed.

Division of Children's System of Care (DCSOC)

During the process of developing this State Plan, DCSOC identified the following Technical Assistance needs:

- Technical assistance in the provision of evidence-based treatment options for youth with co-occurring mental illness/developmental disabilities.

  DCSOC developed a comprehensive, organized DD/MI training curriculum and technical assistance program in coordination with the University Behavioral Health Care that provides that assists DCSOC system partners, DDD, community providers, family members, and other stakeholders in working effectively with the dually diagnosed population. The training curriculum includes:

1. Parent/Caregivers Strategies for Shaping Behavior & Implementing a Behavioral Plan of Care for Youth with both Developmental Disabilities and Mental Health Challenges;
2. Understanding Youth with Co-Occurring Developmental Disabilities and Mental Health Challenges;
3. Assessment, Diagnosis & Psychotherapy for Youth with Intellectual Disabilities;
4. Developing an Individualized Education Program (IEP) for Achievement (includes expanded focus on youth with developmental disabilities & mental health challenges);
5. Developmental Tasks of Childhood and Adolescence; and
6. Supporting Youth with Co-Occurring Developmental Disabilities and Mental Health Challenges.

Despite this robust curriculum, technical assistance on the provision of evidence-based programs for this population is limited.

IV: Narrative Plan

V. Support of State Partners

Narrative Question:

The success of a state's MHBG and SABG 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. States should identify these partners in the space below and describe how the partners will support them in implementing the priorities identified in the planning process. In addition, the state should provide a letter of support indicating agreement with the description of their role and collaboration with the SSA and/or SMHA, including the state education authority(ies), the State Medicaid Agency, entity(ies) responsible for health insurance and health information marketplaces (if applicable), adult and juvenile correctional authority(ies), public health authority (including the maternal and child health agency), and child welfare agency. SAMHSA will provide technical assistance and support for SMHAs and SSAs in their efforts to obtain this collaboration. These letters should provide specific activities that the partner will undertake to assist the SMHA or SSA with implanting its plan.[45] This could include, but is not limited to:

- The State Medicaid Agency 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 the expanded Medicaid population.
- The state justice system authorities that will work with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with mental and substance use disorders who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment.
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective actors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and substance use disorders, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements.
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system. Specific service issues, such as the appropriate use of psychotropic medication, can also be addressed for children and youth involved in child welfare.
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities.

45 SAMHSA will inform the federal agencies that are responsible for other health, social services, and education

Footnotes:

V. Support of State Partners

Joint SSA and SMHA Partnerships with Other State Partners

New Jersey has been fortunate to have several Health Homes initiatives that have developed at the grass roots level. Two New Jersey providers are implementing SAMHSA-funded Behavioral Health Home Pilots. In addition, the Nicholson Foundation, through a public-private partnership, has provided funding to two FQHCs to implement health homes providing integrated behavioral health care. There is also a privately funded Behavioral Health Home implemented by UMDNJ in both Newark and New Brunswick. New Jersey DMHAS and the Division of Medical Assistance and Health Services (Medicaid) have been at the table to help these efforts overcome obstacles created by the current regulatory and funding mechanisms.

New Jersey's Medicaid Waiver Application includes a proposal under Section 2703 of the ACA to include Health Homes as part of its Medicaid State Plan, thereby becoming eligible to receive additional Federal funds (90/10 match) for Health Home services in the first two years after implementation. This component of the waiver includes provisions for Behavioral Health Homes (BHHs) for people with SMI. To fully implement this service, New Jersey will be submitting a Medicaid State Plan Amendment for BHH services.

Upon approval from CMS, care coordination services in the health home model, consistent with federal CMS, guidelines under Section 2703 of the ACA, will be reimbursed as a new service at an enhanced rate for up to two years. DMHAS has received technical assistance from SAMHSA on financing models and the development of the State Plan Amendment. Currently New Jersey plans to implement the service regionally with each new SPA creating the service in a new region thereby creating a new two year enhanced funding clock.

DMHAS and Medicaid have been partnering to develop these services. In addition to the Waiver proposal regarding BHHs, Medicaid and DMHAS are partnering to assist the HMOs that manage the primary care for Medicaid clients to develop Health Home services that include bidirectional behavioral health and primary care screening, identification, referral to, and linkage for consumers. The partnership between the two divisions is critical to the full integration of services and both divisions are committed to work together toward that goal.

Staff from DMHAS continues to be team members of the 2010 Returning Service Members, Veterans, and Their Family Members Policy Academy conducted by SAMHSA. The New Jersey Veteran Enhancement Team Coalition (VETC) is comprised of DHS representatives from DMHAS, DMAHS, Department of Military and Veterans Affairs (DMAVA), Veterans Service Organizations, Department of Law and Public Safety, Department of Labor, Office of the Attorney General, the GCADA, New Jersey Veterans Administration, New Jersey Army National Guard, and other stakeholders. The VETC developed a strategic plan including five priority areas that was submitted to SAMHSA and to the Governor's Office. DMHAS continues to focus on identifying existing exemplary service in New Jersey; integrate, expand, enhance the service delivery system; and coordinate/expand outreach and engagement strategies that work to assist veterans and their families regarding mental health and substance use disorders. One of the other goals which DMHAS is involved in targets diverting veterans from the criminal justice

system. The Office of the Attorney General and DMHAS created a Veterans Pilot in Atlantic County. The pilot diverts veterans who commit low level offenses from incarceration. The pilot is in its second year. The DMHAS, as a result of a Letter from Kathryn Power, engaged the provider enrollment organization for TRICARE in order to increase the number of mental health providers able to serve TRICARE recipients. Solicitations were made to DMHAS mental health provider agencies to recruit their involvement. DMHAS also continues to participate in and provide training to current and former service members in such topics as suicide prevention, PTSD and substance abuse/additions issues.

The Chief Justice of the New Jersey Supreme Court created an Inter-branch Advisory Committee on Mental Health Initiatives. The Committee was appointed to address important concerns regarding the many individuals with serious mental health needs who intersect with the criminal justice system. The goal of the Committee was to improve the Judiciary's responses to individuals with mental illness who have become entangled in the justice system. The Committee is committed to the belief that greater communication, cooperation and education will result in substantial improvements. The Committee framed its recommendations, which have now been sent out for public comment, to entities outside the Judiciary in the form of suggestions to avoid any appearance of attempting to mandate initiatives to other branches of government. Three DMHAS representatives were officially appointed to this Interagency Committee. DMHAS expects that the staff will be involved with many of the recommendations when they are implemented. Providing educational opportunities for new superior court judges has already happened.

Approximately two years ago the Administrative Office of the Courts (AOC) established a Drug Court Advisory Committee which is chaired by a Drug Court Judge and includes representatives from the Office of the Attorney General, Office of the Public Defender, probation, Drug Court Coordinator, Trial Court Administrator, AOC and DMHAS. The committee focuses on the statewide Drug Court program making policy, program and treatment recommendations. Currently, the committee is focused on the two phase Drug Court expansion.

The Single State Authority on Substance Abuse (SSA)

New Jersey State Parole Board
A Memorandum of Agreement (MOA) will continue to be executed between the New Jersey State Parole Board (NJSPB) and the SSA to purchase, within a FFS network, community-based residential beds for NJSPB parolees under the Mutual Agreement Program (MAP). See attached MOA.

New Jersey Department of Corrections
A similar verbal agreement for MAP will continue between the New Jersey Department of Corrections (DOC) and the SSA to purchase, within a FFS network, community-based residential beds for DOC inmates. The DOC has requested an expansion of services within the provider network starting SFY 2014 that will include Short Term Residential level of care and enhancement services (urinalysis and oral swabs).

The "Engaging the Family Program" is a collaboration between DMHAS and DOC, Division of Programs and Community Services Office of Drug Programs. Pre-release programming addresses the treatment needs of offenders who have substance abuse disorders and who are parents of minors. Referrals will originate from case management sessions between the DOC "Engaging the Family" staff and the program participants prior to release from the custody of the DOC. All program participants who are assessed for substance abuse treatment needs, and are determined to require treatment, and voluntarily agree to participate will be referred to services funded through existing DMHAS funding streams, as annually appropriated, and as available at the time of treatment referral through the NJ 2-1-1 Addictions Hotline. See attached MOA.

Administrative Office of the Courts
The MOA with the AOC will be maintained to fund a full continuum of treatment services for Drug Court applicants who are deemed legally and clinically eligible for Drug Court. State funding appropriated to the AOC for this purpose will be transferred to the SSA, which is responsible for implementing and managing 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. See attached MOA.

Department of Children and Families' Division of Child Protection & Permanency
Additionally, the SSA will coordinate its efforts with those of the DCF Division of Child Protection & Permanency (DCP&P). This collaboration will continue to markedly enhance the capacity of both Divisions' abilities to provide more effective and far-reaching services while minimizing unnecessary service duplication. As part of the Child Welfare Reform, the DCF will continue to provide funding to the SSA to support an initiative for gender specific treatment with specialized services in all modalities of care to women with dependent children and parents who are at risk of losing custody of their young children due to the abuse or neglect of these children resulting from, or aggravated by their substance abuse. See attached MOA.

Robert Wood Johnson Medical School
The SSA will continue to execute an MOA with Robert Wood Johnson Medical School, Department of Pathology and Laboratory Medicine to provide directorship and oversight ensuring HIV rapid testing for clients in an estimated 30-50 licensed substance abuse treatment agencies statewide. These funds will be used as part of the HIV/EIS set-aside. All other HIV diagnostic services, aside from testing, will be contracted with the Department of Health, Public Health Infrastructure, Laboratories, and Emergency Preparedness (PHILEP). See attached MOA's.

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 will be to reduce risky behaviors and promote adoption of health enhancing behaviors. Additionally, the SSA will continue to collaborate with the DOE in identifying and creating 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. See attached MOA.

Department of Health's Office of Tobacco Control
Since 2004, the Division has worked collaboratively via MOU with the Department of Health Office of Tobacco Control (OTC), Tobacco Age of Sale Enforcement (TASE), to implement the Synar portion of the SAPT Block Grant. Staff from the OTC TASE work annually with youth inspectors to conduct random unannounced inspections of licensed tobacco retailers by attempting to purchase tobacco products while the adult inspectors follow up with retailer staff with merchant education materials and with violations if necessary. DMHAS staff generates the random list of retailers to inspect and provide the template for data collection forms as well as the analytical support for the Synar Report by analyzing the data obtained on the forms utilizing SSES. In addition to the annual Synar joint efforts, DMHAS and OTC work collaboratively every three years to conduct a coverage study to ascertain the accuracy of the licensed tobacco retailer list that is used to generate the Synar inspection sites annually. DMHAS staff generates the walking routes for the coverage study using census tracts, provide the data collection template, and analyze the data obtained to ascertain the coverage study rate. OTC adult inspectors canvass the identified areas and visit retailers to ascertain license status and provide merchant education. DMHAS and OTC have recently begun talks to update the MOU from 2004.

Rutgers, The State University of New Jersey
DMHAS will continue a workforce development initiative with the Rutgers Center for Alcohol Studies, Professional Development Division to address the workforce gap in licensed addiction treatment programs throughout the state. This initiative provides renewal/recertification alcohol and drug counseling education courses for credentialed behavioral healthcare professionals, alcohol and drug counselors, and prevention specialists in the state. See attached MOA.

DMHAS in collaboration with Rutgers, The State University of New Jersey School of Social Work, Office of Continuing Education (OCE), is providing education, training, and technical assistance to professional behavioral healthcare planners, including but not limited to county alcoholism and drug abuse directors, in the State of New Jersey. Planners who successfully complete the program will earn a Certificate in Community-Based Planning issued by the Rutgers School of Social Work. See attached MOA.

Committees and Collaborative Projects
New Jersey was one of 17 sites to receive technical assistance through the National Center on Substance Abuse and Child Welfare (NCSACW) In-Depth Technical Assistance (IDTA) grant. IDTA was provided through 2012 to the SSA, DCF's DCP&P and AOC. The goal of IDTA was to improve outcomes for children and families involved with child welfare, substance abuse and the courts. New Jersey received a customized program of IDTA designed to identify and implement key policy and practice changes based on New Jersey's readiness to change and progression through the following five IDTA phases: Site Outreach; Team Development and Orientation; Collaborative Action Planning and Product Development; Implementation, Evaluation, & Sustainability Planning; Follow-up & Aftercare/Site Re-Engagement. New Jersey is in the process of exploring limited continuation of IDTA through the development of a

narrowly focused scope of work that will address emergent issues of concern where New Jersey like many other states, has been experiencing an increase in adult illicit opioid use. Early identification and prevention of substance exposed infants (SEI), including those presenting with Neonatal Abstinence Syndrome (NAS) from maternal opioid use, has the potential to reduce the extensive costs to multiple systems (child welfare, behavioral health and the courts) that occur in the absence of timely prevention and early intervention collaborative approaches.

DCF DCP&P and DHS DMHAS collaborated to develop permanent supportive housing for homeless women with children involved with child welfare and in substance abuse treatment. The Divisions were interested in replicating the Corporation for Supportive Housing (CSH) Keeping Families Together (KFT) initiative that is currently in New York City. This initiative integrates and enhances units of permanent supportive housing for women with children. Services are designed to prevent further child welfare involvement and enhance family functioning. CSH was granted funding through the Robert Wood Johnson Foundation for a planning grant to further develop and refine the KFT initiative and work with DMHAS and DCPP on the planning process. DMHAS and DCF submitted a grant to the Administration for Children, Youth and Families Children's Bureau for a model similar to the KFT program. The initiative was designed to strengthen and keep together families who were unstably housed, involved in the child welfare system and facing substance abuse. Unfortunately, funding was not received.

The Alcohol and Drug Abuse Program for the Deaf, Hard of Hearing and Disabled and a Program Advisory Committee was established pursuant to PL 1995, c.318 (NJSA 26:2B-36 to 39), and continues to meets 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. The Committee is comprised of individuals from statewide disability, substance abuse and social service providers, including five State representative from the Division of Disability Services, Division of Deaf and Hard of Hearing, Division of Vocational Rehabilitation Services, the Council on Developmental Disabilities and the GCADA, in addition to five members who are identified as Deaf, Hard of hearing or disabled and two public members with an interest in substance abuse and co-existing disabilities. Staff from the SSA convene and coordinate this meeting.

Since 2006, the New Jersey State Epidemiological Outcomes Workgroup (SEOW) has met to collect and organize multiple sources of data to guide relevant and effective substance abuse prevention strategies. The purpose is to develop and support a statewide, cross-system, data-driven alcohol, tobacco, and other drug prevention prioritization, implementation and evaluation infrastructure, which will guide and support communities across New Jersey. The SEOW is comprised of government and community agency-based experts in the field of substance abuse. The members come from diverse entities, including universities, research institutions, government agencies, and private organizations. All have extensive experience working with substance-related data. Organizations/institutions that are represented on the SEOW include: Childhood Drinking Coalition, County Alcohol and Drug Directors Association, Department of Education, Department of Health, Division of Highway Traffic Safety, Drug Enforcement Administration, GCADA, JJC, New Jersey State Police, New Jersey Prevention Network, Princeton House Behavioral Health, Rowan University, and Rutgers University.

In August of 2010, DMHAS convened an Addiction Prevention Strategic Planning Committee for the purpose of developing a five-year prevention strategic plan. The purpose of the DMHAS Addiction Prevention Strategic Plan is to focus statewide prevention efforts on specific data-driven priorities for which measurable change can be achieved at the state and community levels. The Strategic Planning committee included community stakeholders and State government partners, including the Alcoholic Beverage Control, DCSOC, DCP&P, and the Division of Developmental Disabilities. In conducting its work, the planning committee formed needs assessment, capacity, and planning sub-committees to analyze existing data on addictions in the state population and current prevention resources. These data provided the foundation for identifying and selecting statewide prevention priorities. The group continues to meet on an as needed basis.

New Jersey, like many states, has developed a comprehensive prevention infrastructure at both state and community levels. Until very recently, however, there was little coordination of planning and service delivery among the various state and community-level entities that are implementing prevention programs and environmental strategies. In early 2012, the GCADA, the DMHAS, the New Jersey Prevention Network (NJPN) and representatives from county government came together to collaborate in the development of a unified, transparent, data-driven process to plan for and deliver services and strategies at the state, county, and municipal levels.

The State Mental Health Authority (SMHA)

State agency representation on the Community Mental Health Planning Council includes the following: DMHAS, DMAHS (Medicaid), DOC, JJC, State Housing Authority (New Jersey Housing and Mortgage Finance Agency-NJHMFA), Division of Vocational Rehabilitation, Division of Family Development (Social Services), and the DOE. Some of the consumer and family members are representatives of consumer advocacy groups, including National Alliance on Mental Illness in New Jersey (NAMI-NJ), County Family Support Organizations, Self Help Centers, Youth Development Council, Statewide Consumer Advisory Committees (SCAC), and various other New Jersey Partners.

The SMHA has a number of formal and informal partnerships with the criminal justice system:

DMHAS representatives were appointed to Governor Christie's Task Force on Reducing Recidivism and participated during the last calendar year. The Task Force had representatives of the Departments of Corrections, Labor and Workforce Development, Community Affairs, the Office of the Attorney General and the State Parole Board and Governor’s Office.

Office of the Attorney General
DMHAS has two MOU's with the Office of the Attorney General (OAG); one moves $50,000 from the OAG to DMHAS to support our joint CIT Center for Excellence. The second MOU creates a pilot Prosecutor Diversion program in Atlantic County for military members and veterans who become entangled in the criminal justice system and who have behavioral health issues.

Administrative Office of the Courts (AOC) /Judiciary
The DMHAS was a an active participant over the past two year in the Chief Justice's Interbranch Advisory Committee on Mental Health Initiatives. The committee recommendations will be implemented and DMHAS will be an integral part of the effort. Several recommendations of the report involve cross training of Judges. DMHAS has presented at the last two Judicial Colleges for Superior Court Judges and also at the Annual Municipal Court Judges Conference.

The DMHAS was instrumental in assisting the AOC to establish a Veteran's Assistance Initiative which is a formal referral system for military service members and veterans who come before the court or are in jail. The referral goes from the court to the New Jersey Department of Military and Veterans Affairs so that the service member can get services if desired. DMHAS can also supplement and/or assist.

The Division of Probation created an advisory committee for its demonstration project of special mental health probation officers (MHPO's). A DMHAS representative was appointed to this group and assisted with the training of the 30 MHPO's and has been troubleshooting the collaboration between the local mental health system and probation office.

State Parole Board (SPB)
While there are no written MOU's or advisory committee memberships, DMHAS has collaborated with the SPB in jointly submitting three Bureau of Justice Assistance Grants, which were unfortunately not funded. There is also regular dialogue and collaboration to gains access for parolees to mental health services.

DMHAS is an official partner in the SPB's new Veterans Assistance Project.

Department of Corrections
While no formal agreement exists, DOC and DMHAS work together to get access to mental health services for ex-offenders.

Department of Labor and Workforce Development (DLWD); Division of Vocational Rehabilitation Services (DVRS)
DVRS and DMHAS jointly fund 22 Supported Employment programs for people with psychiatric disabilities. The joint collaboration has been ongoing for 23 years. DMHAS and DVRS currently have an interagency contract to braid funding for this service. The contracting mechanism was converted to an MOU.

Division of Children's System of Care (DCSOC)

Collaboration with the Department of Human Services (DHS) Division of Medical Assistance and Health Services (DMAHS)

The DHS DMAHS administers the state-and federally- funded Medicaid and NJ Family Care (S-CHIP) programs for certain groups of low- to moderate- income adults and children. DCF DCSOC provides behavioral healthcare to youth and families in a broad continuum of behavioral

health services with total budget authority of state and federal resources consisting of GIA, Medicaid (Title XIX) and S-CHIP (Title XXI). Services are primarily funded through Medicaid (Title XIX and Title XXI) Mental Health Rehabilitation Services Option, Targeted Case Management and Psychiatric Residential Treatment Facility (PRTF) Services for Individuals Under age 21. These benefits are approved by the CMS. Services are provided on a medical necessity basis. DCSOC and DMAHS meet regularly regarding the New Jersey State Plan.

Collaboration with the Department of Children and Families' (DCF) Division of Child Protection and Permanency (DCP&P) Child Welfare Service Recipients

Clinical Consultants report to DCP&P Area Offices four days per week 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 DCP&P. Clinical Consultants translate clinical information into user-friendly language 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.

DCF Office of Adolescent Services (OAS) Transitions for Youth

Transitions for Youth (TFY) is a multifaceted statewide program that utilizes a positive youth development framework to address the complex needs of youth transitioning to adulthood, particularly those who are aging out of foster care or who were involved with New Jersey's juvenile justice or behavioral health systems. TFY's goal is to ensure that youth develop essential skills and competencies in education, employment, daily living, decision-making, and interpersonal communication. TFY is funded primarily through the DCF Office of Adolescent Services (OAS) and is coordinated by the Center for Nonprofit Management and Governance, The School of Social Work at Rutgers, The State University of New Jersey.

All TFY programs are rooted in best practices and integrate Positive Youth Development, a model for improving outcomes for youth by addressing the following domains: housing stability; improved academic functioning; job-readiness skills; financial literacy; emotional regulation and physical wellness; and peer, adult and community partnerships. TFY services for Special Populations include: Gay, Lesbian, Bisexual, Transgender, Questioning and Intersex youth (GLBTQI); parenting youth; youth living with HIV/AIDS and youth with juvenile justice involvement and/or mental health concerns.

A complete description of the programs and supports available through TFY can be accessed at: TFY can be accessed at: http://www.nj.gov/dcf/about/divisions/oas/

DCF Division of Family and Community Partnerships (DFCP)

DFCP serves as DCF's grant-making and best practices team committed to strengthening New Jersey's families. DFCP is committed to provide the resources and technical assistance needed to grow a robust network of public/private partnerships and programs. Schools and community-based organizations are two prime locations for prevention and intervention services. DFCP's goal is to build a continuum of child abuse prevention and intervention programs that are culturally competent, strength based and family-centered, with a strong emphasis on primary child abuse prevention. DFCP's programs include but are not limited to:

Family Success Centers
New Jersey now has one of the country's only statewide systems of publicly supported Family Success Centers. These centers are neighborhood-based gathering places where any community resident can find family support, information and services. The purpose of the Family Success Center is to enrich the lives of children by making families and neighborhoods stronger. There is no cost to access services provided by Family Success Centers. Some of the services include: employment, information and referral, parent education, health care, parent-child activities, home visiting, life skills training, advocacy and housing.

PALS Programs (PEACE: A Learned Solution)
DFCP oversees PALS programs in counties for children who have witnessed domestic violence. PALS is an intensive program that provides counseling and creative arts therapy for children who have witnessed domestic violence. The program serves children primarily aged four to twelve.

Outreach to At-Risk Youth
Outreach to At-Risk Youth is an initiative designed to prevent crime and deter gang involvement by providing enhanced recreational, vocational, educational, outreach or supportive services to youth, ages 13 to 18, with the option to serve youth until age 21. Programs are located in communities with demonstrated high crime and gang violence.

Home Visitation Program
The Home Visitation Program provides services to families challenged by complex health related and/or social problems. This program focuses on young families who are at risk for abuse and neglect with primary prevention and early intervention services for pregnant women and children up to age five.

Strengthening Families through Early Care and Education
The Strengthening Families Initiative (SFI) is an approach to preventing child abuse and neglect by strengthening families through early care and education. The Center for the Study of Social Policy developed the Strengthening Families through Early Care and Education Framework. The fundamental principle is that certain protective factors contribute towards family resiliency and strength. Early Care and Education Centers play a prominent role in building these protective factors among the families they serve. Through seven key strategies, centers become well positioned to help families build these protective factors that have proven to be effective in preventing child abuse and neglect.

Children's Trust Fund
Children's trust and prevention funds are state level organizations dedicated to the prevention of child abuse and neglect. There are now 52 trust and prevention funds, established by legislative action, in every state of the union, Puerto Rico and the District of Columbia. Trust and prevention funds create a vital public-private partnership, since, in most states, boards of directors have representatives of government, the corporate sector, and private citizens are appointed by the Governor. The funds are situated within state government and may be located administratively within various state agencies, governors' offices, or independently.

Funding for trust and prevention funds comes from a variety of sources, such as voluntary state income tax check-off contributions; surcharges on birth, divorce, or death certificates; line item state appropriations; interest from the trust fund; corporations and private foundations; and individual contributions. Every state that has an established children's trust or prevention fund is eligible for a federal community-based grant.

The common purpose of trust or prevention funds is the prevention of child abuse and neglect. Each state undertakes a variety of creative and innovative activities to accomplish this purpose, just as each state has established funding guidelines and policies that identify the types of prevention programs eligible for financial support, funding priorities, and funding limitations. The funding process encourages the development of creative strategies for preventing child abuse and neglect. Examples of such strategies are parenting education and role modeling for incarcerated women, curriculum development for religious communities, culturally specific sexual abuse prevention education for children, and programs for families recovering from substance abuse.

Additional information regarding the NJ Children's Trust fund can be accessed at: http://www.nj.gov/dcf/about/child_trust_fund.html

School Based Youth Services Program (SBYSP)
The School Based Youth Services Program (SBYSP) sites are located in each of the 21 counties in or near schools in urban, rural and suburban communities. The programs are open to all youth ages 10 -19 enrolled in the school that is home to the SBYSP, and provide services before, during and after school and throughout the summer. Major services include: mental health and family services; health services; substance abuse counseling; employment services; pregnancy prevention programs; learning support services; referrals to community based services; and recreation.

Prevention of Juvenile Delinquency Programs (PJD)
Prevention of Juvenile Delinquency Programs (PJD) provide healthy alternatives for youth who have had trouble with the law, in conjunction with the Stationhouse Adjustment regulations of the NJ Department of Law and Public Safety and has increased the state's capacity to address the complex needs of school-aged children.

Adolescent Pregnancy Prevention Initiative
The Adolescent Pregnancy Prevention Initiative uses education, counseling and health services to reduce the birth rate among teens in high school. Any youth, at-risk or not, enrolled in the

school that is home to the APPI program is eligible for services. Risk factors include sexual abuse or neglect at home, low school achievement, poverty, substance abuse or living in a home where siblings or relatives gave birth during their teen years. Referrals can come from peers, family members, guidance counselors, or foster families. Students also may enroll themselves.

Family Empowerment Program
The Family Empowerment Program (FEP) is a unique intervention program that targets students and families with intergenerational distress related to substance abuse. It provides a comprehensive intervention that integrates direct family system and adolescent development services with school and community resources. Related issues include substance abuse, mental health, academic performance and attendance, violence, gangs and juvenile justice involvement. The goal of the program is to maintain the student in school, while facilitating positive change that reduces risk factors in both student and family.

Collaboration with the New Jersey Juvenile Justice Commission and Juvenile Detention Centers

Please see Section I. DCSOC Justice

Collaboration with the Department of Human Services (DHS) Division of Developmental Disabilities (DDD) and Division of Mental Health and Addiction Services (DMHAS)

On June 29, 2012 Governor Chris Christie signed a bill that 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 removes barriers to accessibility, provides more complete 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 DHS began January 1, 2013. Planning meetings between DCSOC, DDD and DMHAS, as well as stakeholders and provider agencies, began in 2011 and are ongoing.

Transition of Aging Out Youth to the Adult Mental Health System
DCF DCSOC and the DHS DMHAS continue their effort in long-term joint planning for easing the transition of aging-out youth who need to move from the child system to the adult mental health system. Guidelines for successful transition were developed as well as "The Tool" to document information and inform participants. Additional information regarding these services is available at: http://www.state.nj.us/dcf/providers/csc/

Collaboration with the New Jersey Department of Education (DOE)

Recognizing the importance of the educational community in a youth's life, the Department has undertaken several strategies to coordinate services for troubled youth with the state Department of Education (DOE). As part of the restructuring of the New Jersey child welfare system, DCF has targeted several areas of cooperation with DOE to improve the lives and access to education for youth in the child welfare system. These activities have been expanded to include all youth who are accessing mental health services through DCSOC. Goals have been set which ensure all youth in out-of-home settings are registered for school within 3 days of movement to a new setting/residence. A roundtable co-hosted by DCF and DOE in May 2007 established a work

group to develop and implement memoranda of understandings of the supports and services the two departments will provide to youth who are admitted into an out-of-home setting. While primarily focused on youth in the child welfare system, the MOUs are applicable to all DCF youth. One of the two committees established as a result of the roundtable will focus on youth, special education and the impact on the education system of youth who are placed into an out of district school community as a result of the DCF service plan for that youth.

Additionally, DCF/DCSOC is represented on the DOE, Office of Educational Support Service's interagency work group to study and take actions on the issues of student absences and truancy. The purpose of the workgroup is to continue the work of previous statewide groups organized to study and manage issues, concerns, practices and recommendations regarding student unexcused absences and truancy. Emphasis is placed on assessing and addressing the effects of existing statutes and regulations on absences and truancy and on examining and advancing the effectiveness of courts, school, human services agencies and other resources in addressing truancy cases.

The DCF agreed to participate and forwarded a letter of support as one of the State partner agencies in the New Jersey DOE's application to the United States Department of Education for the Building State Capacity for Preventing Youth Substance Abuse and Violence Program Grant Competition. DCSOC will continue its collaboration with DOE and serve as the DCF point of contact for this project.

DCF Activities Related to the Individuals with Disabilities Act (IDEA) for Children

The New Jersey DOE, Office of Special Education Programs, ensures compliance with the statutory requirements of the Individuals with Disabilities Education Act (IDEA) for all New Jersey students with disabilities, from age three to twenty-one, who receive educational services in the state. The DOE guarantees that a free and appropriate education is provided to youth with disabilities, including youth with serious emotional and behavioral disturbances.

The New Jersey DCF Office of Education serves children who are clients of one of the Divisions of DCF, either in the institutions in which they reside or at one of 18 Regional Schools staffed by specially trained administrators, teachers and aides.

The main programs offered by the DCF Office of Education include:

- Regional School and Institutional programs for children, youth and young adults receiving DCF services. Each of the Office of Education's 18 Regional Schools offers individualized, comprehensive year-round programs designed to meet the educational and psychological needs of students with moderate and severe cognitive impairments. Multiple disabilities, autism, behavioral or emotional disturbances and other disabilities that cannot be served in the public school system. In addition to their educational program, children receive child study, clinical and rehabilitative services.

- Project TEACH (Teen Education and Child Health) is an alternative, year-round education program for pregnant or parenting teens. Project TEACH services students at risk of school failure.

- Transition Education Center is an alternative year-round program designed to meet the needs of an array of "at-risk" students who are referred because of their involvement with the juvenile justice system. The TEC program provides a comprehensive educational program which provides the at risk adolescent with the skills needed to create a positive live for themselves in order to promote their successful reintegration to future school, work and/or community endeavors.

- Technology for Life and Learning Center (TLLC) assists students with disorders that affect their ability to communicate. The TLLC provides two distinct programs: Augmentative and Alternative Communication (AAC) and Assistive Technology Educational Achievement Models (ATEAM). Both provide diagnostic and intervention services to enable student so become proficient users of assistive technology tools/strategies, thereby increasing their function in identified areas.

MEMORANDUM OF AGREEMENT

BETWEEN

THE DEPARTMENT OF HUMAN SERVICES (DHS)
DIVISION OF MENTAL HEALTH AND ADDICTION SERVICES (DHS-DMHAS)
OFFICE OF TREATMENT

AND

THE NEW JERSEY STATE PAROLE BOARD (NJSPB)
DIVISION OF COMMUNITY PROGRAMS

FOR

MUTUAL AGREEMENT PROGRAM

WHEREAS the New Jersey Department of Human Services (DHS), Division of Mental Health and Addiction Services (DHS-DMHAS), and the New Jersey State Parole Board (NJSPB) wish to purchase, on a fee-for-service (FFS) basis, a full continuum of care of DHS-DMHAS licensed substance abuse treatment services, including long-term and short-term residential treatment, partial care, halfway house, intensive outpatient and outpatient counseling services, detoxification, TB tests, ASI assessments, urinalysis, and co-occurring services including psychotropic medications for the placement of parolees during State Fiscal Year 2013 to benefit the parolees demonstrably in need of such treatment; and

WHEREAS DHS-DMHAS has the statutory authority under N.J.S.A. 26:2B-7 et seq. and N.J.S.A. 26:2G-1 et seq. to ensure that treatment services for criminal offenders are provided and the Governor has allocated funding for such services in the State Fiscal Year 2013 budget; and

WHEREAS DHS-DMHAS and NJSPB find it in the public interest to reduce prison overcrowding, reduce recidivism and provide substance abuse treatment to alcohol and other drug addicted parolees within community-based residential and outpatient substance abuse treatment programs through the Mutual Agreement Program (MAP); and

WHEREAS NJSPB has the statutory authority to assign parolees to DHS-DMHAS licensed facilities for alcohol and drug treatment services as a specific condition of parole; and

WHEREAS NJSPB and DHS-DMHAS believe providing a full continuum of care of DHS-DMHAS licensed providers to parolees not only provides the offenders the opportunity to address his/her substance abuse as part of his/her rehabilitation, but also is a more cost effective measure than the daily costs of incarcerating offenders;

NOW, THEREFORE, THE PARTIES HERETO AGREE AS FOLLOWS:

I. Attachment A, Section VI, Budget/Cost Proposal in this MOA shall make available a total of $3,272,889 for the period of July 1, 2012 until June 30, 2013. The total funding of $2,618,000 is to be provided by NJSPB; $654,889 is to be provided by DHS-DMHAS.

II. Obligations and Rights of the Funding Agencies

(A.) The New Jersey State Parole Board Obligations

All of the requirements of this section apply to NJSPB:

1. NJSPB shall provide funding to DHS-DMHAS in the amount up to $2,390,296 for the purchase of a full continuum of care for MAP community-based DHS-DMHAS licensed substance abuse treatment including long term and short term residential treatment, partial care, halfway house, intensive outpatient, outpatient, detoxification, TB tests, ASI assessments, co-occurring services including psychotropic medications and quality assurance, program coordination and management functions on a fee-for-service basis, and to offset administrative costs. Payment is contingent upon the satisfactory delivery of services as described herein in this MOA, Section II (C.) Department of Human Services Obligations. Payment obligations, as well as reporting and monitoring requirements, and other special conditions to this agreement, are contained in Attachment A, which is incorporated herein by reference. Payments shall be made in accordance with the provisions in Attachment A, Section I. Payments shall be made for approved costs, contained in Attachment A, which is incorporated herein by reference.

2. NJSPB will provide $175,000 to DHS-DMHAS for administrative support. See Section II. 5. k.

3. As of SFY 2011 DHS-DMHAS started utilizing CSC, as a fiscal agent. This service requires $52,704 which is included in the administrative support funded by NJSPB in SFY 2013.

4. NJSPB shall monitor the progress of this project to ensure that services are being provided in accordance with Section II (C.), which establishes the work products that must be completed in order for funds to be provided, and the timelines for completion. All financial and performance reporting and MOA monitoring requirements are contained in Attachment A Sections II and III and IV.

5. This section establishes all other obligations of NJSPB:

a. NJSPB shall screen offenders prior to their release on parole from a county or state correctional facility in order to determine the need for substance abuse assessments.

b. ASI assessments and urinalysis. Co-occurring services will be provided by DHS-DMHAS/SPB co-occurring providers and will include psychotropic medications.

c. NJSPB shall identify the supervising parole officer as the contact person to work with each of the treatment providers on the following issues and concerns: parole release dates; any other problems which might arise in connection with the transfer of an NJSPB MAP referral from the institution to the substance treatment program; and problems relating to the MAP parolee's progress in or continued participation in the recipient substance abuse treatment program and advise DHS-DMHAS of any concerns accordingly.

d. NJSPB will work with DHS-DMHAS to continue to improve their referral process to make it American Society of Addiction Medicine (ASAM) driven and assure that referrals are to the appropriate level of care whenever possible.

e. NJSPB contact person shall also work to connect the parolee and treatment program staff with the parolee's Parole Officer to ensure a smooth transition to aftercare (if applicable) and to community supervision at the conclusion of residential care.

f. NJSPB shall notify each substance abuse treatment provider of the Parole Officer's name, address, telephone number, and/or other contact person at the District Parole Office responsible for the parolees in that treatment program utilizing the SPB/DMHAS referral form which includes the parolees SBI number.

g. NJSPB shall work with the institutional medical provider to help ensure that a two-week supply of medication, if indicated, is available for each parolee at the time of the parolee's arrival at the treatment program. Following the two-week period, the MAP treatment provider shall be responsible for obtaining medications for parolees through other available means.

h. NJSPB shall ensure that infectious medical clearance required by health facility licensure regulations is obtained prior to parolee's admission to receiving substance abuse treatment programs. DHS-DMHAS SPB MAP providers will be eligible for reimbursement for TB tests for SPB referrals as one means to expedite the admission of clients to residential treatment.

i. NJSPB District Parole Offices may refer and assign appropriate parolees to appropriate DHS-DMHAS licensed community-based substance abuse treatment including long-term and, short-term residential treatment, partial care, halfway house, intensive outpatient, outpatient counseling, detoxification, TB tests and co-occurring services. It is understood that placements into treatment are best determined by the ASAM Level of Care Placement Criteria; and, if a Parole Officer makes a placement that does not meet this criteria, a network treatment provider may reassess and request a transfer for a more appropriate level of care for that client. No individual may be referred for psychiatric services without a substance abuse treatment referral.

j. NJSPB shall notify DHS-DMHAS of any changes in NJSPB's policies or procedures that may affect parolee referrals or obligations of DHS-DMHAS contracted agencies that provide treatment services to MAP parolees in order that DHS-DMHAS may notify its contractees to take other appropriate measures to ensure the continued effectiveness of the MAP. NJSPB shall not communicate directly with DHS-DMHAS contractees regarding changes in policies or procedures without previous notification and agreement with DHS-DMHAS.

k. NJSPB shall transfer a portion of its funding into such administrative accounts as DHS-DMHAS shall specify to support administrative and professional positions and costs associated with management of the MAP program.

l. NJSPB shall review actual utilization of FFS MAP substance abuse treatment services purchased through DHS-DMHAS on a monthly basis, using the monthly and cumulative utilization reports submitted to DHS-DMHAS by CSC for NJSPB utilization.

m. NJSPB, in making placements to MAP, shall only utilize DHS-DMHAS licensed, MAP network providers. All referrals shall be clinically driven unless it is for a Parole Board mandated client and shall address client needs without disruption to treatment services.

n. NJSPB will work with their Board to ensure that all referrals are made for lengths of stay that are clinically driven and allow for step down from residential to outpatient services as appropriate. SPB will update DHS-DMHAS on progress toward this goal.

o. NJSPB shall share information on any utilization and/or programmatic deficiencies in MAP agencies with DHS-DMHAS in order to jointly develop and implement appropriate corrective actions.

p. NJSPB shall participate in a two-way information exchange with DHS-DMHAS for tracking of census and status of MAP parolees, as well as incident reporting.

q. NJSPB shall advise DHS-DMHAS in detail, by February 28, 2013 of any and all planned changes in funding or service configurations for State Fiscal Year 2013 with respect to the MAP services purchased through DHS-DMHAS pursuant to Section II (A.) 1. of this MOA.

6. In addition to the above, NJSPB is required to abide by all the general requirements that are contained in Sections III (General Provisions) and IV (Terms and Termination) of this MOA.

(B.) The New Jersey State Parole Board Rights

All of the rights outlined in this section are applicable to NJSPB.

1. Audit

For audit purposes, the recipients of these funds must be in compliance with State Circular Letter 04-04 OMB. In addition, NJSPB shall have the right to, at any time, audit any and all accounts and/or records maintained by DHS-DMHAS pertaining to these funds. To effectuate this provision, NJSPB shall be afforded, upon reasonable notice and during normal business hours, access to all records and/or data of DHS-DMHAS that pertain to this MOA. The provisions of this subparagraph shall continue for a period of seven years after the submission and acceptance of the financial and programmatic reports required under this MOA.

2. Work Product

All data, technical information, materials gathered, originated, developed, prepared, used or obtained in the performance of the requested services, including but not limited to, all papers, reports, surveys, plans, charts, records, analyses or publications produced for or as a result of this MOA by DHS-DMHAS shall bear an acknowledgment of the support of NJSPB. No work product produced utilizing funds or data obtained under this MOA shall be published or distributed to the public without the prior written consent of NJSPB and DHS-DMHAS. NJSPB and DHS-DMHAS shall have the right to edit said work product and shall further have the right to add disclaimers as they deem appropriate.

3. NJSPB shall also not be held liable for any termination of this MOA due to the absence of available funding appropriations from the New Jersey

legislature to NJSPB but shall pursue best efforts to seek replacement funding through transfers or supplemental appropriations.

(C.) <u>The Department of Human Services, Division of Mental Health and Addiction Services Obligations</u>

All of the requirements of this section apply to DHS-DMHAS:

1. DHS-DMHAS shall, on a FFS basis, contract with appropriate DHS-DMHAS licensed and SPB approved provider network approved community-based substance abuse treatment providers including long-term and short-term residential treatment, partial care, halfway house, intensive outpatient, outpatient counseling, detoxification, TB tests, ASI assessments, urinalysis and co-occurring services including psychotropic medications.

2. DHS-DMHAS shall provide services in accordance with Section II (C.) 5. which establishes the service deliverables which this agency must perform, in accordance with the established time frames established for each item in Section II (C.) 6.

3. DHS-DMHAS shall be required to submit expenditure and final reports. DMHAS shall request funds from NJSPB in accordance with the requirements of Attachment A.

4. DHS-DMHAS shall be required to maintain all records related to this MOA for a period of seven years following submission and acceptance of the financial and programmatic reports required under this MOA.

5. <u>Service Deliverables to be provided</u>. In exchange for funding provided by NJSPB as indicated in Section II (A.) 1., DHS-DMHAS agrees to perform the following:

   a. DHS-DMHAS program monitors shall visit each MAP treatment program and assess the quality and frequency of treatment received by each referred client relative to that client's documented needs. DHS-DMHAS program monitors shall review that treatment lengths of stay in all levels of care will be clinically driven (currently Parole Board mandated clients may have a legally driven length of stay instead of a clinically driven length of stay) with ongoing assessments of clinical needs, and include discharge and transfers as clinically indicated. Additionally, DHS-DMHAS monitors shall review programs' administration, staffing and other aspects of the treatment programs' operations consistent with DHS-DMHAS review of all substance abuse treatment contractees.

   b. DHS-DMHAS shall share information on any MAP utilization and/or

programmatic deficiencies in MAP agencies with NJSPB in order to jointly develop and implement appropriate corrective actions.

c. DHS-DMHAS shall participate in a two-way information exchange with NJSPB for census tracking and status of MAP parolees as well as incident reporting.

d. DHS-DMHAS shall make available for MAP referrals an updated MAP Provider Network Directory.

e. DHS-DMHAS, in collaboration with NJSPB, agree to monitor the assessment and referral program to ensure optimum utilization of services.

6. Time Frame for Performance of Service Deliverables. This section contains the timetable for each of the services indicated in Section II (C.) 5. DHS-DMHAS agrees that the service deliverables indicated in Section II (C.) 5. shall be performed by the corresponding date or time period as follows:

a. DHS-DMHAS shall perform annual site monitoring visits, as appropriate to program scope and size. Monitoring activities to maintain service accountability shall occur on a more frequent schedule, as determined in collaboration with NJSPB. (Section II (C.) 5. a.

b. DHS-DMHAS shall share programmatic deficiencies with NJSPB, as needed. (Section II (C.) 5. b.

c. DHS-DMHAS shall conduct MAP/SPB Provider Meetings as needed.

d. DHS-DMHAS shall participate in information exchange with NJSPB. (Section II (C.) 5. c.

e. DHS-DMHAS shall provide monthly and cumulative utilization reports which shall be provided by CSC and DHS-DMHAS staff to NJSPB within 15 days of the end of each month.

7. In addition to the above, DHS-DMHAS is required to abide by all general requirements contained in Sections III and IV of this MOA

(D.) The Department of Human Services, Division of Mental Health and Addiction Services Rights

All of the rights of this section apply to DHS-DMHAS:

1. DHS-DMHAS shall not be required to fulfill its obligations under this MOA should funding from NJSPB required pursuant to Section I not be made available in a timely manner.

2. DHS-DMHAS shall also not be held liable for any termination of this MOA due to the absence of available funding appropriations from the New Jersey Legislature to DHS-DMHAS.

3. DHS-DMHAS shall be permitted a minimum of 60 days lead time to implement any changes in accordance with the notice requirements applicable to its contracting process and Section I of this MOA.

III. General Provisions

(A.) Mandatory General Provisions

1. During the term of this MOA, DHS-DMHAS and NJSPB shall comply with all federal, state and municipal laws, rules and regulations generally applicable to the activities performed pursuant to this MOA.

2. DHS-DMHAS and NJSPB shall maintain accurate books and records of all disbursements, funds received, funds spent and funds available as a result of this MOA.

3. DHS-DMHAS and NJSPB are independent entities and no party shall hold itself out as an agent, partner or representative of the other.

4. Failure by any party to exercise any right or demand performance of any obligation under this MOA shall not be deemed a waiver of such right or obligation.

5. If any of the provisions of this MOA are, or become invalid, to any extent, the other provisions of this MOA shall not be effected thereby. In the event of the invalidity of a provision, the parties agree to accept a provision that reflects as closely as possible the intention of the invalid provision.

6. This MOA may not be assigned without the prior written consent of all parties.

7. The laws of the State of New Jersey govern this MOA.

8. This document represents the entire MOA among the parties and shall not be amended except by the express written consent of all parties, in accordance with the provisions of Attachment A, Section III.

(B.) Other Applicable Provisions

1. DHS-DMHAS and NJSPB reserve a royalty-free, nonexclusive, and

irrevocable license to reproduce, publish or otherwise use, and to authorize others to use, the copyright in any work developed under the agreement.

2. The parties agree that all parolee data, records and information resulting from this agreement are to be considered confidential and shall be solely used for the purposes as outlined above. All parties are required to use reasonable care to protect the confidentiality of this information and to comply with 42 CFR, part 2.

3. Any research resulting from this MOA shall comply with all applicable State and Federal requirements for protection of human subjects.

4. In the event services end by either MOA expiration or termination, DHS-DMHAS and NJSPB agree to collaboratively arrange for alternative placements of parolees until new services can become completely operational or to continue existing MAP services for a transitional period. If a transition period is requested by NJSPB, such period shall not exceed more than 180 days beyond the expiration date of the MOA, or any extension thereof. Subject to availability of appropriations to NJSPB, DHS-DMHAS shall be reimbursed for services and administration during the transitional period at the rate in effect when the transitional period clause is invoked by NJSPB.

IV. Terms and Termination

(A.) Subject to any rights of termination hereinafter set forth, this MOA shall become effective as of July 1, 2012 and shall remain valid through June 30, 2013, unless extended pursuant to Section III or Section V. A portion of the project period is retroactive, and neither party shall incur penalties as a result of any non-compliance prior to the execution of this MOA.

(B.) This MOA may be terminated by either party to this MOA with or without cause upon sixty (60) days advance written notice. Notice of termination shall be delivered via U.S. mail, return receipt requested, and shall be effective upon receipt. Notice shall be sent to the appropriate contact person identified in Section V.

(C.) Upon the issuance of notice of termination by DHS-DMHAS, automatic termination under Section IV (A), or upon receipt by DHS-DMHAS of notice of termination issued by NJSPB, all funds contributed by NJSPB that are not due and owing to either DHS-DMHAS or a Service Provider Agency, in any DHS-DMHAS account whatsoever, shall be returned to NJSPB through the contact person identified in Section V without any further assessment or expenditure except as specifically approved by NJSPB in writing.

V. Principal Contacts

The principal contacts for all notifications required or otherwise necessary under this MOA shall be as follows:

For the Department of Human Services:

Program Management Officer
Lynn A. Kovich, Assistant Commissioner
Division of Mental Health and Addiction Services
609- 777-0702(office)
609- 777-0835 (fax)
50 East State Street
PO Box 727
Trenton, NJ 08625-727

Fiscal Officer
Steve Adams
Chief Financial Officer
Division of Mental Health and Addiction Services
609- 777-0787(office)
609- 777-0835 (fax)
50 East State Street
PO Box 727
Trenton, NJ 08625-727

For the New Jersey State Parole Board:

Program Management Officer
Leonard Ward, Director
Division of Community Programs
609- 633-7703 (Office)
609-633-7930 (fax)
PO Box 862
Trenton, NJ 08625

Fiscal Officer
William Cranford
Chief, Fiscal and Administrative Services
609-292-3974 (phone)
609-777-0183 (fax)
PO Box 862
Trenton, NJ 08625

VI. We, the undersigned, consent to the contents of this MOA.

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

Signature: _____ Date: 3/6/13

Lynn A. Kovich
Assistant Commissioner

New Jersey State Parole Board:

Signature: _____ Date: 12/13/12

James T. Plousis
Chairman

Attachment A

The provisions and conditions of this attachment are deemed to be incorporated in the Memorandum of Agreement between the New Jersey State Parole Board (NJSPB) and the New Jersey Department of Human Services, Division of Mental Health and Addiction Services (DHS-DMHAS), entitled "Mutual Agreement Program".

I. Method of Payment

Cost reimbursement payments shall be made by NJSPB on the following basis:
[ ] Monthly
[ ] Quarterly
[ ] Lump Sum
[ ] Based on submission of the following reports:
[X] Other

A. DHS-DMHAS shall submit monthly utilization of service reports indicating the providing agency, client name(s), and type of service, cost of service, SBI number, total of all services by providing agency and total of all services for all agencies. The reports shall be due within 14 calendar days of the end of each month for the previous two month's utilization.

B. On a monthly basis, on or about the 20th of each month, a fiscal/program utilization meeting or telephone conference call shall occur between NJSPB and DHS-DMHAS to review prior and future utilization, funding levels, and future funding allocations. Advance receipt of statistical, program utilization and funding reports provided by DHS-DMHAS shall be provided prior to the monthly meeting/conference call. If an analysis by DHS-DMHAS and NJSPB concludes that the advance funding provided by NJSPB is insufficient, additional funding shall be provided by NJSPB within 14 calendar days.

C. Upon execution of this Agreement, NJSPB shall provide DHS-DMHAS with six months of advance payment for the estimated cost of fee for service substance abuse treatment services projected for $3,272,889 at the SFY13 annualized level.

D. In January 2013 NJSPB will advance the remaining balance for the remaining six months of SFY13.

E. A quarterly reconciliation shall be performed by DHS-DMHAS and submitted to NJSPB for review to ensure that billings and actual utilization are in agreement. Any adjustments will be reflected in subsequent requests for additional funding.

II. Financial and Performance Reporting and MOA Monitoring

A. Monthly expenditure reports are required.

B. NJSPB requires technical assistance meetings with DHS-DMHAS on the following basis:
[ ] Initial [X] Monthly [ ] Quarterly [X] Final [ ] Other (Describe)

III. Modifications to the Agreement

A. MOA extensions may be made to this MOA with the approval of the signatories identified in Section VI.

B. Budget revisions may be made to this agreement with the approval of the Program Management Officers and Fiscal Officers identified in Section V.

C. Modifications to Section II of the MOA, regarding service deliverables to be performed under Sections II (A.) and II (C.) may be made with the approval of the Program Management Officers identified in Section V.

IV. Special Conditions

This MOA does not include any other special conditions.

V. Multi-Year Agreements

This MOA is for a period of one year from July 1, 2012 until June 30, 2013 and authorization is approved for that period of time, except if Section III (a.) of Attachment A is invoked. This MOA may be renewed for an additional year in writing by agreement of both parties. Approval may be granted by the signatories identified in Section VI or their successors. Funding for the renewal period is subject to the Annual Appropriations Act.

VI. Budget/Cost Proposal

Under this Memorandum of Agreement (MOA), a total of $2,618,000 shall be made available for the period of July 1, 2012 until June 30, 2013. An additional amount of up to $2,000,000 may be made available through June 30, 2013 if appropriate and approved by the Department of Treasury.

The total amount of appropriated funding is $2,390,296 to be provided by NJSPB shall be transferred to DHS-DMHAS during SFY 13.

NJSPB will also be required to provide $175,000 to offset administrative costs. This amount shall be due on an annual basis and is inclusive of $52,704 in fiscal agent costs.

DHS-DMHAS will contribute up to $654,889 for eligible network services as it deems appropriate.

NJSPB shall have the opportunity, at NJSPB discretion, to transfer at any time additional amounts to DHS-DMHAS for use in NJSPB fee-for-service network. Such a transfer shall not impact the allocation of DHS-DMHAS program or Cost of Living Adjustments funds available to the program, after the date of signature of this MOA. The addition of monies may be made as specified under Section II (A.) 3.

MEMORANDUM OF UNDERSTANDING

BETWEEN

THE NEW JERSEY DEPARTMENT OF CORRECTIONS (DOC)
DIVISION OF PROGRAMS AND COMMUNITY SERVICES
OFFICE OF DRUG PROGRAMS

AND

THE NEW JERSEY DEPARTMENT OF HUMAN SERVICES (DHS)
DIVISION OF MENTAL HEALTH AND ADDICTION SERVICES (DMHAS)

FOR

"ENGAGING THE FAMILY IN THE RECOVERY PROCESS – AN INNOVATIVE APPROACH FOR THE MAX OFFENDER" PROGRAM

COLLABORATION

March 1, 2012 - SEPTEMBER 30, 2014

The New Jersey Department of Corrections (DOC) is the recipient of federal funds from the U.S. Department of Justice, Bureau of Justice Assistance, awarded under the FY10 Second Chance Act (SCA) Family-Based Prisoner Substance Abuse Treatment Grant. The Second Chance Act of 2007 (Pub. L. 110-199) provides a comprehensive response to the increasing number of people who are released from prison and jail and returning to communities, including resources to address the myriad of needs of these offenders to achieve a successful return to their communities. Section 113 specifically addresses the treatment needs of offenders who have substance abuse disorders and who are parents of minors.

Awarded on October 1, 2010, the FY10 SCA Family-Based Prisoner Substance Abuse Treatment Grant supports the "Engaging the Family in the Recovery Process – An Innovative Approach for the Max Offender" Program, hereafter referred to as the "Engaging the Family" Program. The project design includes a partnership with the New Jersey Department of Human Services (DHS), Division of Mental Health and Addiction Services (DMHAS), as supported by DMHAS at the time of grant application.

On October 1, 2011, the DOC received two additional federal funding awards for the "Engaging the Family" Program. Both of these grants also propose collaboration with DMHAS, as developed through the FY10 SCA Family-Based Prisoner Substance Abuse Treatment Grant. These grants include the FY11 SCA Family-Based Offender Substance

Abuse Treatment Grant awarded by the U.S. Department of Justice, Bureau of Justice Assistance, and the Community-Centered Responsible Fatherhood Ex-Offender Reentry Pilot Project awarded by the U.S. Department of Health and Human Services, Administration for Children and Families.

This Memorandum of Understanding (MOU) outlines the role of the DOC and DMHAS in the "Engaging the Family" Program. An MOU to formalize the collaboration is required by the Bureau of Justice Assistance under the FY10 and FY11 Family-Based Substance Abuse Treatment Grants. There is no transfer of federal grant funds from the DOC to DMHAS for collaboration in the "Engaging the Family" Program. All program participants who are assessed for substance abuse treatment needs, and are determined to require treatment, and voluntarily agree to participate, will be referred to services funded through existing DMHAS funding streams, as annually appropriated, and as available at the time of treatment referral through the NJ 2-1-1 Addictions Hotline.

A. The New Jersey Department of Corrections' obligations under the "Engaging the Family" Program shall include the following:

1. The DOC will provide inmates who are enrolled in the "Engaging the Family" Program with pre-release programming including substance abuse education, parenting skills, relationship strengthening, and financial literacy/management. The substance abuse education curriculum will be the "Living in Balance (LIB): Moving from a Life of Addiction to a Life of Recovery." LIB is an evidence-based practice, and is recognized as such in the Substance Abuse and Mental Health Services National Registry of Evidence-Based Programs and Practices.

2. The DOC will utilize federal grant funding, awarded to the DOC, to support the costs of personnel who will administer substance abuse assessments to the program participants, and provide pre and post-release case management services. Case management will include treatment referrals that will be initiated through the NJ 2-1-1 Addictions Hotline.

3. The DOC will hire staff for the assessment and treatment referral component of the program who meet the licensing requirements, as established by DMHAS, to administer the Level of Care Inventory (LOCI), and input assessment data into the NJ Substance Abuse Management System (NJ SAMS). The DOC will forward resumes of the program staff to DMHAS for review and approval.

4. The DOC staff will attend training in the LOCI, NJ SAMS, and the NJ 2-1-1 Addictions Hotline, as sponsored and scheduled by DMHAS.

5. The DOC will ensure that unauthorized personnel will not gain access to NJ SAMS and will not allow any personal computer or laptop computer with NJ SAMS access to operate within the prison environment. Any

computer that is equipped to allow NJ SAMS access will be maintained within the Office of Drug Programs, DOC Central Office Headquarters.

6. The DOC will refer "Engaging the Family" participants to substance abuse treatment services through the NJ 2-1-1 Addictions Hotline. DOC will only refer program participants for treatment who have been assessed through the LOCI as needing treatment, and who volunteer to participate.

7. The DOC will monitor the referrals that are initiated through the NJ 2-1-1 Addictions Hotline through NJ SAMS to determine if the program participants were accepted for treatment by the referral agency.

8. The DOC will also follow–up with the licensed treatment providers that accept the program participants for substance abuse treatment to discuss level of service, discharge, etc. The DOC will request that each program participant sign a record of release form, and DOC will forward the signed forms to the licensed treatment providers prior to requesting information.

9. The DOC will share "Engaging the Family" Program performance measurement data, as reported to the various federal grantor agencies, with DMHAS. This will allow DMHAS to review outcome data, and the impact of the collaboration on grant program outcomes.

B. The New Jersey Department of Human Services' obligations under the "Engaging the Family" Program shall include the following:

1. The DMHAS requires each licensed treatment agency to enter client data into the New Jersey Substance Abuse Monitoring System (NJ SAMS), in accordance with the New Jersey Administrative Code. NJ SAMS complies with all applicable Health Insurance Portability and Accountability Act (HIPAA) and federal confidentiality standards. The DMHAS will allow remote access to NJ SAMS for DOC "Engaging the Family" staff who meet DMHAS licensing requirements, and have participated in DMHAS-sponsored training.

2. The DMHAS will provide training to DOC staff hired for the "Engaging the Family" Program. This includes training in LOCI, NJ SAMS and the NJ 2-1-1 Addictions Hotline. The training will be facilitated at no cost to the DOC.

3. The DMHAS acknowledges that "Engaging the Family" Program participants will be referred for treatment services through the NJ 2-1-1 Addictions Hotline. Referrals will originate from case management sessions between the "Engaging the Family" staff and the program participants prior to release from the custody of the DOC.

4. The DMHAS acknowledges that the DOC will request information from the licensed treatment providers regarding treatment provided to the "Engaging the Family" Program participants. Information will be requested only after a record of release form, authorizing the release of information to the DOC and signed by the program participant, is received by the licensed treatment provider. The information requested, such as level of services and date of discharge, will be utilized for performance measurement reporting to the federal grantor agencies. Participant names are not reported to the federal grantor agencies.

5. The DMHAS will provide applicable licensing, accreditation, and certification documents for all collaborating service provider organizations to maintain in the official grant file. All collaborating service providers shall have a minimum of two (2) years of experience providing relevant services.

6. The DMHAS acknowledges that post-release treatment options for the target population of this initiative will be clinically appropriate for the substance abuse treatment needs of the offenders.

C. The principal contacts for all notifications required or otherwise necessary under this Memorandum of Understanding shall be:

1. New Jersey Department of Corrections, Office of Drug Programs

a. Dr. Herbert Kaldany
Acting Director
Office of Drug Programs
Stokes Building
P.O. Box 863
Trenton, NJ 08625-0863
(609) 633-0648 (office)
(609) 777-4114 (fax)

b. Thurman Miller
Program Coordinator
Office of Drug Programs
Stokes Building
P.O. Box 863
Trenton, NJ 08625-0863
(609) 984-2295 (office)
(609) 777-4114 (fax)

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

    a. Carmine J. Centanni
    Criminal Justice Coordinator
    Department of Human Services
    Division of Mental Health and Addiction Services
    120 South Stockton Street
    P.O. Box 362
    Trenton NJ 08625-0362
    (609) 984-1142 (office)
    (609) 292-3816 (fax)

    b. Christine K. Scalise
    Program Manager Special Populations
    Department of Human Services
    Division of Mental Health and Addiction Services
    120 South Stockton Street
    P.O. Box 362
    Trenton, NJ 08625-0362
    (609) 292-8186 (office)
    (609) 292-3816 (fax)

D. This Memorandum of Understanding shall be effective for the period of March 1, 2012 through September 30, 2014.

E. This Memorandum of Understanding may be terminated by either party upon 30 days written notice. Any modification to the terms of this Memorandum of Understanding shall be by addendum, mutually agreed to, and in writing.

This document represents the entire agreement among the parties. We, the undersigned, consent to the contents of this Memorandum of Understanding.

The New Jersey Department of Corrections:

Signature: _____ Date: 9/6/12

Mark Farsi
Deputy Commissioner

The New Jersey Department of Human Services:

Signature: _____ Date: 9/5/12

Lynn A. Kovich
Assistant Commissioner

MEMORANDUM OF AGREEMENT

BETWEEN

THE NEW JERSEY DEPARTMENT OF HUMAN SERVICES (DHS)
DIVISION OF MENTAL HEALTH AND ADDICTION SERVICES (DMHAS)
OFFICE OF TREATMENT AND RECOVERY SUPPORTS
AND

THE ADMINISTRATIVE OFFICE OF THE COURTS (AOC)

FOR

DRUG COURT TREATMENT SERVICES

WHEREAS a Memorandum of Agreement ("the Agreement") between the Administrative Office of the Courts (AOC) and the Department of Human Services, Division of Mental health and Addiction Services (DMHAS) for the management of Drug Court Treatment Services is effective July 1 2012, and

WHEREAS DMHAS' Drug Court Unit and the AOC wish to purchase substance abuse treatment services as described herein the Agreement, Section III(A)(1a) for Drug Court participants, and

WHEREAS pursuant to N.J.S.A. 26:2B-7 et. seq. and N.J.S.A. 26:2G-31 et. seq. for the provision of substance abuse treatment services for criminal offenders, the goal of this Agreement is:

- To reduce prison overcrowding and recidivism, and provide substance abuse treatment to alcohol and other drug dependent individuals who are eligible for sentencing under N.J.S.A. 2C:35-14 or other provisions of the New Jersey Code of Criminal Justice.

WHEREAS the AOC and DMHAS shall effectuate an efficient data driven program and fiscal management process to coordinate the treatment delivery system described in Section III (A) (1a) of this Agreement,

NOW, THEREFORE, THE PARTIES HERETO AGREE AS FOLLOWS:

I. Under this Agreement, the AOC is hereafter referred to as "the Judicial Oversight Agency" and DMHAS is hereafter referred to as "the Treatment Oversight Agency."

II. Obligations and Rights of the Judicial Oversight Agency

(A.) Obligations of the Judicial Oversight Agency

1. The AOC shall provide funding to DMHAS in the amount of approximately $28,537,293 for the purchase of licensed treatment services which spans the full continuum of care for Drug Court participants including, but not limited to, long-term residential, short-term residential, detoxification, halfway house, partial care, outpatient and intensive outpatient, clinical reviews, recovery enhancements, co-occurring and medication-assisted treatment services.

2. DMHAS will not be responsible for treatment expenditures in excess of AOC funding allocation of section II (A) (1). The AOC shall project annual volume and maximum service levels for SFY 2013 for Drug Court participants by vicinage. The AOC will keep DMHAS advised of any changes in levels of performance or need in the individual vicinages, which might affect these projected service levels.

3. If the AOC and DMHAS identify the need for increased funding for Drug Court it is the AOC who is responsible for formal budget requests from OMB and the legislature.

4. AOC shall support and staff a Drug Court Treatment Sub-Committee, chaired by a Vicinage Drug Court Coordinator, to enhance the coordination of case management activities between the drug court teams and the treatment providers who service Drug Court participants. The AOC agrees to collaborate with DMHAS on the selection of treatment provider representatives for this committee, through an open and fair application process.

5. AOC will maintain data on new admissions to drug court and initial treatment referrals and provide that information to DMHAS on a monthly basis, especially on pre-sentence treatment referrals. AOC and DMHAS will coordinate data collection efforts in order to manage and, when necessary, contain the costs incurred by participants re-admitted to treatment. AOC will refer no more clients for treatment than can be serviced by existing resources. DMHAS will not be held responsible for treatment expenditures beyond the current fiscal year allocation.

6. AOC agrees that every new Drug Court participant being referred for treatment will have as their unique identifiers, the SBI number and social security number, alerting the Drug Court network providers of the approved payor source.

7. The AOC will ensure that all Drug Court participants initially referred to treatment have a current (within 3 months) Addiction Severity Index (ASI) completed, DMHAS licensure required medical documentation, and a completed American Society of Addiction Medicine (ASAM PPC-2R)-

informed narrative assessment with initial placement recommendations, which is forwarded to the admitting DMHAS Drug Court Network Provider prior to admission.

8. AOC will work with each vicinage to identify a contact person responsible to work with each DMHAS Drug Court Network treatment provider to address any treatment issues or concerns that may arise throughout the Drug Court participant's course of treatment and who will also notify DMHAS, as appropriate. The contact person will be the Vicinage Drug Court Coordinator unless otherwise indicated by the AOC.

9. The AOC will authorize DMHAS to utilization of up to $266,222 of the funds allocated for drug treatment for operating expenses for the fiscal agent in 2013. This represents the maximum funding available for the projected Drug Court percentage of total volume of claims submitted to the fiscal agent. The AOC's understanding is that DMHAS' administrative costs will be set at $615,000 for FY2013. The $28,537,293 in funding provided to DMHAS includes contracts, fee-for-service provider network, DMHAS administrative, fiscal agent, recovery supports and co-occurring treatment costs.

10. The AOC agrees to work collaboratively with DMHAS on any changes in program eligibility criteria and increases in types of services or rates paid for services to or on behalf of clients for all programs under the purview of the Department of Human Services, not mandated by federal law. Approval by the Director of the Division of Budget and Accounting must be obtained prior to implementation of any desired changes in program eligibility, types of services or rates paid.

11. In addition to the above, the AOC is required to abide by all general provisions, terms, and terminations contained in Sections IV and V of this Agreement.

(B.) Rights of the Judicial Oversight Agency

1. The AOC shall not be held liable for any termination of this Agreement due to the absence of available funding appropriations from the New Jersey Legislature to the AOC. Notice shall be provided to DMHAS in the manner outlined in Section V of this Agreement

2. Work Product: Information used or obtained in the performance of Drug Court treatment services, produced for or because of this Agreement shall bear an acknowledgment of the participation of both the AOC and DMHAS. AOC shall be given the opportunity for advance review of work

products and publications of DMHAS, which relate to utilization of drug treatment services by the AOC or vicinage Drug Courts.

III. Obligations and Rights of the Treatment Oversight Agency

(A.) Obligations of the Treatment Oversight Agency

1. DMHAS agrees to perform the following services:

   a. DMHAS shall execute all contracts and network agreements and provide oversight and management of the statewide Drug Court licensed treatment provider network's full continuum of care including, but not limited to, long-term residential treatment, short-term residential treatment, detoxification, halfway house, partial care, intensive outpatient and outpatient, clinical reviews, recovery enhancements, co-occurring and medication assisted treatment services.

   b. DMHAS will utilize a combination of slotted and fee-for-service mechanisms to maintain flexibility, funding accountability and access to care. Fee-for-service beds shall be purchased based on existing rate schedules with slotted beds to be purchased on existing DMHAS rates with Cost of Living Adjustment percentage (COLA %) increases as available.

   c. DMHAS will require Drug Court network providers to gather financial data through the administration of the DMHAS' DASIE. Data gathered will be reviewed by AOC and DMHAS to inform future income eligibility decisions.

   d. DMHAS monitors shall review program administration, staffing and all other aspects of the treatment program operation consistent with DMHAS' review of all substance abuse treatment programs.

   e. The Department of Human Services, Office of Licensure (OOL) complaints unit agrees to conduct an investigation to address any formal Vicinage Drug Court complaints that are received through OOL's formal complaint process. In addition, upon reasonable suspicion, DMHAS monitors and/or DMHAS drug court designated staff will review and investigate incidents of treatment and/or billing concerns as reported by the AOC.

2. DMHAS, through a responsive bidding process, has contracted with a Fiscal Agent who will maintain a database of services provided and reimbursed for Drug Court participants, train providers to use their billing system, and provide the AOC and

DMHAS with previously agreed upon monthly reports that will inform the ongoing utilization management.

3. DMHAS staff will provide technical assistance (TA) and training to providers relevant to clinical and administrative issues, as needed.

4. In addition to the above, the DMHAS is required to abide by all general provisions, terms, and terminations contained in Sections IV and V of this Agreement.

(B.) Rights of the Treatment Oversight Agency

1. DMHAS shall not be required to fulfill its obligations should funding for Drug Court activities not be made available by the New Jersey Legislature. Notice shall be provided to the AOC in the manner outlined in Section V of this Agreement.

2. Work Product: Information used or obtained in the performance of Drug Court treatment services, produced for or because of this Agreement shall bear an acknowledgment of the participation of both DMHAS and AOC. DMHAS shall be given the opportunity for advance review of work products and publications of AOC, which relate to utilization of drug treatment services by the AOC or vicinage Drug Courts.

IV. DMHAS and AOC Collaborative Section

(A.) AOC, in partnership with DMHAS, shall work to establish and support the activities of Committees and Workgroups convened to address a variety of program elements including but not limited to: best practices, utilization of services, performance improvement practices, collaboration and coordination among program partners, and recovery support services.

(B.) DMHAS shall work in collaboration with the AOC to add or delete services.

(C.) DMHAS and AOC shall exchange data on a regular basis to ensure client matching. DMHAS and AOC shall remain flexible in the data exchange process to avoid needless duplication of effort in the development of management reports based on collective data. DMHAS and AOC shall work in collaboration to analyze collective data to more effectively monitor and manage treatment funds.

(D.) DMHAS and AOC shall work in collaboration to develop budgetary parameters and best practices for the courts and treatment providers to deal with participant relapses and treatment re-admissions. The goal is to both contain costs and assist the teams in responding in an effective and clinically appropriate manner to participant relapse and treatment needs.

(E.) AOC and DMHAS shall collaborate on the development of parameters for pre-sentence treatment services to more effectively service the Drug Court population.

(F.) AOC and DMHAS shall collaborate on resource development for Drug Court including recovery support services, client cost sharing and federal funding opportunities.

V. General Provisions

(A.) Mandatory General Provisions

1. During the term of this Agreement, DMHAS and AOC shall comply with all federal, state and municipal laws, rules and regulations generally applicable to the activities performed pursuant to this Agreement.

2. DMHAS and AOC are independent entities and neither party shall hold itself out as an agent, partner or representative to the other.

3. Failure by either party to exercise any right or demand performance of any obligation under this Agreement shall not be deemed a waiver of such right or obligation.

4. If any of the provisions of this Agreement are, or become invalid, to any extent, the other provisions of this Agreement shall not be effected thereby. In the event of the invalidity of a provision, the parties agree to accept a provision, which reflects as closely as possible the intention of the invalid provision.

5. This Agreement may not be assigned without the prior written consent of both parties.

6. The laws of the State of New Jersey govern this agreement.

7. Extensions may be made to this agreement with the approval of the Program Management Officers and Fiscal Officers identified in Section VII.

VI. Terms and Termination

(A.) If funds are not received in a timely manner and in advance of the need to pay for services authorized by the AOC, or their agents including DMHAS, then DMHAS is not liable for non-payment to provider agencies. Upon notice to the AOC, DMHAS is empowered to initiate immediate contract decreases to avoid any overspending of funds.

(B.) The presence of funding alone in subsequent years without a signed Agreement is insufficient to renew the agreement; however, due to the responsibilities placed on the AOC and DMHAS to appropriately manage this program, each agency will make a good faith effort to renew this agreement on a timely basis.

(C.) Funds received by DMHAS but not projected to be spent for the service period will be returned by July 31, 2013.

(D.) All other provisions of the Agreement shall remain valid through the remaining term of the Agreement unless modified.

(E.) Subject to any rights of termination set forth, this Agreement shall become effective on July 1, 2012 and shall remain valid through June 30, 2013.

(F.) This Agreement may be terminated by either party with or without cause upon thirty (30) days advance written notice.

(G.) Notice of termination shall be delivered via United States mail, return receipt requested, and shall be effective upon receipt. Notice shall be sent to the appropriate contact person identified in Section VI.

VII. Principal Contacts

The principal contacts for all notifications required or otherwise necessary under this Agreement shall be as follows:

For the Department of Human Services, Division of Addiction Services:

Program Management Officer
Lynn A. Kovich
Assistant Commissioner
Division of Mental Health and Addiction Services
50 E. State Street
PO Box 727
Trenton, NJ 08625-727
609-777-0702 (office)
609-777-0835 (fax)

Fiscal Officer
Steve Adams
Chief Financial Officer
Division of Mental Health and Addiction Services
50 E. State Street
PO Box 727
Trenton, NJ 08625-727
609-777-0787(office)
609-777-0835 (fax)

For the New Jersey Administrative Office of the Courts:

Program Management Officer
Joseph J. Barraco, Esq.
Assistant Director, Criminal Practice
Administrative Office of the Courts
609-292-4638 [office]
609-292-9659[fax]
Hughes Justice Complex Building
P.O. Box 982
Trenton, NJ 08625

Fiscal Officer
James Agro
Assistant Director, Management Services
Administrative Office of the Courts
609- 292-0499 [office]
P.O. Box 985
Trenton, NJ 08625

VIII. We, the undersigned, consent to the contents of this Agreement.

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

Signature: _____ _____

Lynn A. Kovich
Assistant Commissioner

Date

New Jersey Administrative Office of the Courts:

Signature: _____ _____

Hon. Glenn A. Grant, JAD
Acting Administrative Director of the Courts

Date

Attachment A

The provisions and conditions of this attachment are deemed to be incorporated in the Memorandum of Agreement between the Administrative Office of the Courts (AOC) and the New Jersey Department of Human Services, Division of Mental Health and Addiction Services (DMHAS), entitled Drug Court.

I. Method of Payment

Cost reimbursement payments shall be made by AOC on the following basis:
[ ] Monthly
[ ] Quarterly
[ ] Lump Sum
[ ] Based on submission of the following reports:
[x] Other: Per DMHAS' letter requesting additional funds from AOC.

II. Budget Proposal

Under this Memorandum of Agreement, a total of approximately $28,537,293 shall be made available for the period of July 1, 2012 until June 30, 2013.

The total funding amount supports DMHAS' slot based and fee-for-service contracts, incentive, medication-assisted, co-occurring and recovery enhancement services, fiscal agent, DMHAS administration costs, and expansion development costs.

DMHAS' Drug Court treatment budget projections include, but are not limited to, the following licensed treatment services: long-term and short-term residential, long-term women with children, detoxification, halfway house, partial care, intensive outpatient, outpatient, medication-assisted, co-occurring services, clinical reviews and recovery enhancements for post conviction clients.

SFY 2013 MEMORANDUM OF UNDERSTANDING (MOU)
BETWEEN
THE DIVISION OF YOUTH AND FAMILY SERVICES (DYFS)
AND
THE DIVISION OF MENTAL HEALTH AND ADDICTION SERVICES (DMHAS)
FOR
DYFS CHILD WELFARE SUBSTANCE ABUSE SERVICES (CW)

WHEREAS, the Division of Youth and Family Services (hereafter referred to as DYFS) in partnership with the Division of Mental Health and Addiction Services (hereafter referred to as DMHAS) recognize the need to promote and provide coordinated enhanced child welfare substance abuse treatment services for residential, intensive outpatient, outpatient and methadone maintenance for children and families who have an open child welfare case with DYFS, and

WHEREAS, the DYFS and DMHAS agree that enhanced treatment services shall include, but shall not be limited to substance abuse screening, assessment, treatment planning with DYFS and coordination with the Child Protection Substance Abuse Initiative (CPSAI) that promote children's outcomes of safety, stability, permanency, wellbeing, and parents' outcomes of personal responsibility and transition to self-sufficiency, and

WHEREAS, the DYFS and DMHAS agree that the DYFS Child Welfare Substance Abuse Treatment Providers (CWSATP) shall use the same substance abuse assessment tools, which are based on American Society of Addiction Medicine (ASAM) criteria, to determine that DYFS involved families are placed in the appropriate level of treatment. The CPSAI and Work Force New Jersey-Substance Abuse Initiative (WFNJ-SAI) vendors shall coordinate services with the DYFS CWSATP to maximize the utilization of enhanced residential and outpatient treatment slots and the fee-for-service Work First New Jersey Provider Network for residential and outpatient treatment, and

NOW, THEREFORE, THE PARTIES HERETO AGREE AS FOLLOWS:

I) Under this agreement, the Division of Youth and Family Services (DYFS) is the "Funding Agency" and the Division of Mental Health and Addiction Services (DMHAS) is the "Service Provider Agency."

A) Obligations of the Funding Agency:

1) Under this agreement, the Funding Agency shall provide $12,153,151 for continuation funding of current Child Welfare (CW) substance abuse services.

(a) The DYFS portion shall not exceed $12,153,151 for the period of July 1, 2012 to June 30, 2013 and payment is contingent upon the satisfactory delivery of services by the Provider Agency.

(b) This annualized funding amount includes $9,493,271 for the parenting and child programs, $529,848 for the 44 IOP one time funding slots and $2,130,032 for the adolescent programs.

(c) If substance abuse services for adolescents have not transitioned to DCF/DCBHS by January 1, 2013, the remaining balance needed to continue adolescent services under DMHAS will be transferred by DCF to DMHAS.

B) DYFS shall monitor the progress of the DMHAS obligations to ensure completion within the stated timelines in order for funds to be provided. All financial, programmatic, performance and other monitoring requirements are in accordance with previous agreements and the Expenditure Reporting Instructions and Program and Outcomes Reporting and MOU Monitoring (Available upon request)

1) Payments shall be made to DMHAS in accordance with the provisions in Attachments A for the approved $12,153,151 allocation for the continuation of existing DYFS Child Welfare Substance Abuse Services.

2) Funds shall be transferred from DYFS to DMHAS upon execution of this agreement.

C) DYFS Rights

1. Audit.

(a) The Funding Agency shall have the right at any time to audit all accounts and records maintained by the recipient of these funds. To effectuate this provision, the Funding Agency shall be afforded, during normal business hours access to all records and/or data of the Provider Agency indicated in section III that pertain to this agreement. The provisions of this subparagraph shall continue for a period of seven years after the submission and acceptance of the financial and programmatic reports required under this agreement.

(b) The Grantee (Subgrantee) shall meet the standards prescribed by the Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR, Part 11, dated June 9, 1987 and HIPPA. Staff shall receive training on confidentiality guidelines and its limits. As the "Funding Agency," DYFS

has authority to evaluate and audit all recipients' records, as granted under the exclusions to the Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR, Part 11, dated June 9, 1987 and HIPPA.

2) Reporting Requirements:

(c) Quarterly Program Utilization Reports shall be submitted by Christine Scalise, DMHAS Manager of Child Welfare and Targeted Populations Unit, to Tyrone Richardson, DCF, Statewide Manager for Child Welfare and Substance Abuse Services, Office of Child and Family Health.

(d) Quarterly Financial Reports must be submitted by Mian Shi, Fiscal Services Unit, Division of Mental Health and Addiction Services, to DYFS within 20 days of the end of each calendar quarter. These reports should be sent to the attention of Jim Dolan, Office of Budget and Revenue at the Department of Children and Families (DCF) Business Operations. A cover memo must be submitted by an authorized agency official along with the name and telephone number of the individual that completed the report.

(e) Final Reports must be submitted by DMHAS to DYFS within 90 days of the end of this MOU.

II) Obligations and Rights of the Service Provider Agency

A) DMHAS shall ensure that,

1) The contracted Child Welfare agencies will provide

a. Consultation with DYFS workers as needed to incorporate the treatment plan with the goals of the DYFS case plan.
b. Standardized substance abuse assessments, including urine drug screens, referral if needed to other appropriate levels of treatment.
c. Collaboration with referring provider for treatment coordination, and monitoring of treatment compliance in keeping with current case closing protocols.
d. Notification to DYFS 24 hours prior to discharge in services.
e. Transportation and support services.
f. Ongoing written and verbal case conferencing with DYFS staff.

III) Terms and Terminations

A) This agreement may be terminated by either party with or without cause upon sixty (60) days in advance written notice.

B) Subject to any rights of termination hereinafter set forth, this agreement shall become effective on July 1, 2012 and shall remain valid through June 30, 2013. Extensions of this agreement or changes in funding which impact the services provided require the approval of both DYFS and DMHAS.

IV) Principal Contacts

A) The principle contacts under this agreement for the Division of Youth and Family Services shall be:

1) Program Officer:
(a) Tyrone Richardson, Department of Children and Families, Office of Child and Family Health, 50 East State Street, CC# 903, P.O. Box 717, Trenton, NJ 08625-0717, Telephone 609-888-7373.

2) Fiscal Contact:
(a) Jim Dolan, Department of Children and Families, Business Operations, 50 East State Street, CC# 974, P.O. Box 717, Trenton, New Jersey 08625-0717, Telephone: 609-888-7555.

B) The principal contact for all notifications under this Agreement for Division of Addiction Services shall be:

1) Program Officer:
(a) Christine Scalise, Division of Mental Health and Addiction Services, 120 Stockton Street, 3rd Floor, P.O. Box 362, Trenton, N.J. 08625-0362, Telephone (609) 292-7293.

2) Fiscal Officer:
(a) Mian Shi, Division of Mental Health and Addiction Services, Fiscal Services Unit, 120 Stockton Street, 3rd Floor, P.O. Box 362, Trenton, N.J. 08625-0362, Telephone (609) 292-0747.

V) We the undersigned, consent to the contents of this agreement:

The New Jersey Department of Children and Families, Division of Youth and Family Services

Signature: _____ Date: 6/22/12

Allison Blake, Ph.D., L.S.W.
Commissioner for Department of Children and Families

Signature: _____ Date: 6/15/12

Kara Wood
Director for the Division of Youth and Family Services

The New Jersey Department of Human Services, Division of Addiction Services

Signature: _____ Date: _____

Jennifer Velez
Commissioner for the Department of Human Services

Signature: _____ Date: _____

LYNN Kovach
Assistant Commissioner, Division of Mental Health and Addiction Services

SFY 2013 MEMORANDUM OF UNDERSTANDING BETWEEN THE DIVISION OF MENTAL HEALTH & ADDICTION SERVICES AND THE DEPARTMENT OF CHILDREN & FAMILIES

THE PARTIES MUTUALLY AGREE AS FOLLOWS:

I) Under the following Mutual Agreement and Expectations, the Division of Children and Families (DCF) is hereafter referred to as the "Funding Agency" and the Division of Mental Health & Addiction Services (DMHAS) is hereafter referred to as the "Service Provider Agency".

(A) Obligations and Rights of the Funding Agency (DCF):

1) To fund Young Adult Transitional Housing Program $331,321; which is part of Community Hope. The DCF funds shall transfer from DCF to DMHAS for approved expenditures for the period of July 1, 2012 to June 30, 2013 upon execution of this mutual agreement. DCF will ensure accurate transfer of funds to DMHAS for the agreed upon number of slots to be used by DCF sponsored youths. The number of DCF sponsored youth agreed upon by DCF and DMHAS is six (6). These youth are between the ages of 17 ½ and 18 years old. Individuals between the ages of 17 to 171/2 years will only be admitted under written approval by the DCF.

2) $331,321 in DCF funds shall be made available to DMHAS for the provision of Young Adult Transitional Housing Program (YATHP) services for six DCF slots to be made available at Community Hope.

a) Payment to DMHAS for the YATHP by DCF is contingent upon the DCF sponsored youth being under the auspices of DMHAS and as approved by DCF.

3) Audit:

a) The funding agency shall have the right to audit all records maintained by the Service Provider. In order to effectuate this provision, the funding agency shall be afforded access to all records that receive funds under this MOU, during normal business hours.

4) Work Product:

a) All data, technical information, materials gathered, originated, developed, prepared, used, or obtained in the performance of the requested services, including but not limited to all papers, reports, surveys, plans, charts, records, analyses or publications produced or as

a result of this agreement shall bear an acknowledgment of the support of the Funding Agency. No work product produced utilizing funds or data obtained under this agreement shall be released to the public. The funding agency shall have the right to edit said work product and shall further have the right to add co-authorship or disclaimers as it, in its sole discretion, deems appropriate. The funding agency shall assume Open Public Records Act (N.J.S.A. 47:1A-1) as it pertains to work product provided by Agency.

b) All parties covered under this agreement and any person or entity under contract to provide services shall follow the confidentiality law and regulations of N.J.S.A. 44:10-47 and N.J.S.A. 10:90-7.7, and Health Insurance Portability and Accountability Ace (HIPAA) guidelines when requesting and/or releasing client information.

II) Obligations and Rights of the Service Agency (DMHAS):

A) Reporting Requirements:

1) Quarterly Financial Reports must be submitted within thirty (30) days of the end of each calendar quarter. These reports should be sent to: Michele O'Brien. A cover memo must be submitted by an authorized agency official along with the name and telephone number of the individual that completed the reports.

2) Final Reports of Expenditures must be submitted by DMHAS to DCF within 125 days of the end of this MOU. DMHAS is the pass through agency that is entitled to hold copies of all records and provide copies of such to the funding agency.

3) Quarterly Levels of Service (LOS) must be submitted within thirty (30) days of the end of each quarter. The LOS must be calculated based on 100% LOS which includes six (6) slots. Community Hope will have three (3) slots in the A+ type facility and three (3) slots in the B type facility. All copies of reports pertaining to the six (6) DCF slots, sent to DMHAS must be forwarded to DCF for their records. Community Hope shall complete their LOS for the six (6) DCF slots on the DCF format (Attachment C) which will be submitted to DMHAS and then forwarded to DCF.

III) Terms of Agreement:

A) CH will provide a total of six (6) slots, three (3) of which will be in an A+ type facility and three (3) will be in a B type facility. Services for DCF sponsored youth in both facilities will be in accordance with the

DCF Annex A (Attachment A). DCF will be the sole referent for these six (6) slots. Referrals will be routed through the DCF assigned gatekeeper. CH will provide the DCF assigned gatekeeper with copies of Individual Recovery Plans (IRP) for all DCF sponsored youth on a quarterly basis for the first year of enrollment and every six months thereafter in accordance with N.J.A.C. 10:37A. As part of the IRP, CH will include transitional goals for all DCF sponsored youth in order to assist them in aging out of DCF services and into DMHAS within 18 months of either their 18th birthday (if admitted prior to age 18) or their admission date for all other DCF sponsored youth. DCF will communicate its transitional goals developed with the youth to Community Hope so they are consistent. Extensions beyond eighteen (18) months will be considered on a case by case basis by the DCF Morris/Passaic/Sussex Area Director. Community Hope can not substitute a DCF slot with a non-DCF sponsored youth without prior written approval of the DCF Morris/Passaic/ Sussex Area Director.

B) CH will provide a monthly roster of all DCF sponsored youth, to the DCF Contract Administrator (Attachment D). This report will be submitted no later than 10 business day after the completion of each month. CH will provide the DCF gatekeeper with copies of all individual consumer agreements including the Transitional Housing Services Agreement. This agreement must detail all service fees and other financial obligations for which CH expects compensation from the DCF sponsored youth, and must also include an explanation of how the DCF sponsored youth will be assisted in meeting these obligations. CH will provide an explanation on their procedure for collecting from DCF sponsored youth any unpaid debts incurred by them in the DCF Annex A (Attachment A). For DCF sponsored youth under the age of 18, DCF will be assessed directly by CH an additional placement support fee in the amount of $729.25 per month, until the DCF sponsored youth's 18th birthday (Attachment B). The placement support fee is equivalent to the full amount that would be paid by SSI for those found eligible. This fee will be billed directly to the DCF LO that oversees supervision of the DCF sponsored youth. CH will not assess DCF any additional fees.

C) DCF can conduct an independent annual site review to ensure DCF sponsored youths' records are accurately maintained; and to review financial information regarding same DCF sponsored youths.

D) The details within this agreement shall be incorporated into the Annex A. Additionally, all services, fees, and programmatic details must also be detailed in the Annex A.

E) Any and all complaints reported to DMHAS will be forwarded to DCF with any details that have been provided.

IV) Terminations:

A) This agreement may be terminated by either party with or without cause upon (60) sixty days in advance with written notice.

B) DCF shall not be held liable for any termination of this MOU due to changes in available funding. In the event funding for the project is cut, it shall be within DCF discretion to terminate the MOU.

C) Subject to any rights of termination hereinafter set forth, this agreement shall become effective on July 1, 2012 and remain valid through June 30, 2013. Extensions of this agreement require the written approval of DCF and DMHAS.

V) Principal Contacts:

A) The principal contacts for the YATHP program under this agreement for DMHAS shall be:

Program Contact	Fiscal Contact
Eileen Alexander Program Analyst 100 Hamilton Plaza Suite 615, Box 4 Paterson, NJ 07505	Susanne Rainier Chief Bureau of Contract Administration PO 727 Trenton, NJ 08625-0727

B) The principal contact for all notifications under this agreement for DCF shall be:

Program Contact	Fiscal Contact
Michele O'Brien Northern Business Office Mack Cali Corporate Center 102 Littleton Road Morris Plains, NJ 07950	Michele O'Brien

We, the undersigned, consent to the contents of this agreement:

The New Jersey Department of Mental Health and Addiction Services

Signature: _____ Date: _____
Lynn A. Kovich, Assistant Commissioner

New Jersey Division of Children and Families

Signature: _____ Date: _____

MEMORANDUM OF AGREEMENT

BETWEEN

THE DEPARTMENT OF HUMAN SERVICES
DIVISION OF MENTAL HEALTH AND ADDICTION SERVICES
(Hereafter DMHAS)

AND

UNIVERSITY OF MEDICINE AND DENTISTRY OF NEW JERSEY-
ROBERT WOOD JOHNSON MEDICAL SCHOOL
(Hereafter UMDNJ-RWJ)

FOR

RAPID HIV TESTING SERVICES

WHEREAS, the New Jersey Department of Human Services (DHS), Division of Mental Health and Addiction Services (DMHAS) and the University of Medicine and Dentistry of New Jersey Robert Wood Johnson-Medical School (UMDNJ-RWJ) wish to provide HIV screening by ensuring rapid HIV testing for clients in DMHAS licensed substance use disorder treatment programs; and

WHEREAS, the DHS/DMHAS wishes to purchase administrative and program services to include lab directorship, consultation, lab oversight, authorization, technical support and mobile testing services through UMDNJ-RWJ to ensure rapid HIV testing for clients in DMHAS licensed substance use disorder treatment programs; and

WHEREAS, the DHS/DMHAS and UMDNJ-RWJ recognize that individuals with substance use disorders, specifically intravenous drug users, are at higher risk for contracting HIV/AIDS than the general population DMHAS and UMDNJ-RWJ find it in the public interest to provide rapid HIV testing at DMHAS licensed substance use disorder treatment programs;

NOW, THEREFORE, THE PARTIES HERETO AGREE AS FOLLOWS:

Under this Memorandum of Agreement (MOA), a total of $2,633,143.01 will be made available for the period of October 1, 2012 through September 30, 2015 to provide rapid HIV testing support to permit testing for a maximum of 10,000 unduplicated clients annually, who will be offered HIV testing via on-site testing by a DMHAS licensed agency and/or UMDNJ-RWJ at a maximum of 74 DMHAS-licensed substance abuse treatment programs statewide.

I. Obligations and Rights of the Funding Agency

(A.) New Jersey Department of Human Services, Division of Mental Health and Addiction Services Obligations

1. The DMHAS shall provide funding annually in an amount not to exceed

$880,858.36. Payment is contingent upon the satisfactory delivery of services as described herein, Section II, (A.) "UMDNJ-RWJ Obligations." Payment obligations are contained in Attachment A, and incorporated herein by reference. Payments shall be made in accordance with the provisions in Attachment A, Section I.

2. DMHAS shall maintain the right to monitor the progress of this project to ensure that services are being provided in accordance with Section II (A.), which establishes the work products and deliverables which must be completed. All financial, performance and MOA monitoring requirements are contained in Attachment A, Sections II, III and IV.

3. DMHAS shall notify UMDNJ-RWJ of any changes in policies or procedures that may affect the service agency's obligations. Changes in policies, procedures or agency contact information will include notification and discussion with UMDNJ-RWJ.

4. In addition to the above, DMHAS is required to abide by all general provisions and requirements contained in Sections III and IV of this Agreement.

5. The DMHAS will require sites licensed by UMDNJ-RWJ to perform rapid HIV testing and to offer HIV testing to all clients at intake to their facility as well as every six (6) months thereafter for any client who tests negative and/or refuses testing at admission.

6. The DMHAS will determine a list of site locations eligible to receive mobile testing services through UMDNJ-RWJ. DMHAS will determine eligibility for mobile testing services based on results from an HIV testing needs survey conducted in March 2011, as well as from data provided by the Division of HIV/AIDS, STDs and Tuberculosis Services (DHSTS) on incidence of HIV/AIDS infection by county and city in New Jersey. Specific emphasis for mobile services will be at residential and outpatient treatment programs located in areas of the State with the highest incidence of intravenous drug use and HIV/AIDS infection..

(B.) The New Jersey Department of Human Services, Division of Mental Health and Addiction Services Rights

1. DMHAS reserves the right to terminate this MOA should the funding be depleted prior to the end of the Agreement.

2. DMHAS shall not be held liable for any termination of this MOA due to the absence of or a change in available funding from the Federal Block Grant to DMHAS.

3. Audit. For audit purposes, the recipients of these funds must be in compliance with State Circular Letter 04-04 OMB. In addition, DMHAS shall have the right to at any time audit any and all accounts and/or records maintained by UMDNJ-RWJ pertaining to these funds. To effectuate this provision, the DMHAS shall be afforded, during normal business hours, access to all records and/or data of UMDNJ-RWJ or its agent/consultants which pertain to this Agreement. The provisions of this subparagraph shall continue for a period of seven years after the

submission and acceptance of the financial and programmatic reports required under this MOA.

4. Work Product. All data, technical information, materials gathered, originated, developed, prepared, used or obtained in the performance of the requested services, including but not limited to, all papers, reports, surveys, plans, charts, records, analyses or publications produced for or as a result of the Agreement shall bear an acknowledgment of the support of DMHAS. No work product produced utilizing funds or data obtained under this Agreement shall be released to the public without the prior written consent of both DMHAS and UMDNJ-RWJ. DMHAS shall have the right to edit and shall further have the right to add disclaimers as they deem appropriate.

5. Publishing. Any research, which must be conducted on populations served under this Agreement, will be subject to review by an Institutional Review Board prior to initiation. All reports, data sheets, documents, etc. generated under this Agreement shall be accessible to DMHAS. UMDNJ-RWJ shall deliver to DMHAS, upon demand, all copies of materials relating or pertaining to this Agreement when it is completed or terminated. UMDNJ-RWJ shall inform DMHAS in advance of any publication or other public disclosure of any material and/or information related to this Agreement.

6. Subgrants. DMHAS must approve any contract entered into by UMDNJ-RWJ with third-party providers of services authorized under this MOA. Reimbursement for services provided by a sub-contractor will not be authorized by DHS unless DMHAS Program Management Officers (PMOs) and Grants Management Officers (GMOs) have approved the legal agreement and budget for such services. UMDNJ-RWJ must provide no less than 75% of the services directly.

II. Obligations and Rights of the Recipient Agency

(A.) University of Medicine and Dentistry of New Jersey- Robert Wood Johnson Medical School Obligations

1. UMDNJ-RWJ shall provide services in accordance with Section II (A.) 4. which establishes the service deliverables which this agency must perform.

2. UMDNJ-RWJ shall be required to submit expenditure, progress and final reports and state invoices in accordance with the requirements of Attachment A.

3. UMDNJ-RWJ shall be required to maintain all records for a period of seven years.

4. Services to be provided in exchange for funding provided by DMHAS as indicated in Section I (A.) (1.):

UMDNJ-RWJ staff shall provide administrative services to include consultation, lab oversight and authorization to ensure rapid HIV testing for clients in State licensed substance use disorder treatment programs. Services will include, but not be limited to:

a. Providing the clinical laboratory directorship, as required, to maintain a New Jersey clinical laboratory licensure on behalf of the DHS/DMHAS at a maximum of 74 sites designated by DMHAS.

b. Providing technical assistance to DHS/DMHAS agencies to ensure clients are offered testing at admission and again thereafter every six months for those individuals testing negative, while in treatment.
c. Providing mobile testing services, including pre- and post-test counseling services at substance use disorder treatment program sites designated by DMHAS via a certified HIV counselor/tester who shall be hired by UMDNJ-RWJ. DMHAS will determine eligibility for mobile testing services based on results from an HIV testing needs survey conducted in March 2011 as well as from data provided by the Division of HIV/AIDS, STDs and Tuberculosis Services (DHSTS) on incidence of HIV/AIDS infection by county and city in New Jersey. Specific emphasis for mobile services will be at residential and outpatient treatment programs located in areas of the State with the highest incidence of intravenous drug use and HIV/AIDS infection.
    i. The number of designated DMHAS sites will be determined by the number of HIV Mobile counselor/testers available through funding of this MOA.
    ii. UMDNJ-RWJ and DMHAS will establish protocols for the mobile testing services provided prior to implementation of this pilot.
    iii. The mobile counselor/tester will coordinate with the appropriate personnel at the designated sites to ensure that all documentation and statistical reporting required by DMHAS is completed in accordance with DHS/DMHAS policies.
d. Providing technical assistance to DHS/DMHAS agencies to ensure testing targets are being met at each agency.
e. Submitting necessary documentation to maintain laboratory licenses at DMHAS-licensed agencies.
f. Providing laboratory policies and procedures to ensure accurate and uniform procedures at each of the locations where rapid HIV testing is provided.
g. Ensuring standard quality assurance policies are in place and reviewing the compliance within these policies.
h. Providing laboratory oversight of all personnel at designated DMHAS sites certified to perform laboratory testing.
i. Providing and reviewing the results of proficiency tests and assisting DMHAS site monitoring staff to develop corrective action plans, when necessary, as laboratory correction plans are developed, reviewed and updated.
j. Conducting monthly on-site reviews and inspections of locations where testing is provided to include, but not limited to the review of testing procedures, storage area compliance, controls, inventory of test kits, unusual events, staff certification, etc.
k. Conducting on-site reviews to assist the sites in developing work flows to better incorporate rapid HIV testing in daily operations.
l. Ensuring the personnel training programs are in place so that personnel conducting rapid HIV tests are trained in the appropriate testing procedures.
m. Being available by telephone to answer calls from agency staff performing tests in locations where rapid HIV testing is provided; and reviewing any problems identified above with the DMHAS, or other designated parties.
n. Following-up on all discordant results (clients with confirmatory test results that are not consistent with the initial positive rapid test) including but not limited to telephone consultation with a physician, consultation with a patient, specimen pickup and database management.
o. Training and implementation of the rapid-rapid algorithm at all sites when

comfortable with the primary rapid testing process.

p. Assuming the role of inventory manager purchasing all reagent test kits and controls and other bulk laboratory supplies on behalf of the DMHAS and distributing orders to the sites complete with appropriate monitoring systems.
q. Collecting data and maintaining reporting systems for all sites performing laboratory tests, to facilitate for monthly reporting of all activity to DMHAS.
r. Monthly performance reporting for all State-licensed substance use disorder treatment programs(RWJ licensed and non-RWJ licensed) to include a report of tests offered, conducted and declined, as well as a report of all aggregate test results.
s. Quarterly reporting of all expenditures to DMHAS.
t. Participating on behalf of DMHAS in eligible protocols from other agencies such as SAMHSA, CDC, etc.
u. Developing and implementing a comprehensive procedure manual for substance use disorder treatment programs, with final approval from DMHAS. The manual shall explain the process of becoming a rapid HIV testing provider as well as the policies and procedures programs must follow when engaged as an active provider in the initiative.
v. Coordinating and providing training /conferences as directed by DMHAS and as applicable to the provision of best practices in HIV testing and counseling services.

5. A copy of all reports, including but not limited to, status reports of desk audits and interim and final reports shall be available for review by DMHAS as requested or required.

6. In addition to the above, UMDNJ-RWJ is required to abide by all General Provisions and requirements contained in Sections II, III and IV of this agreement.

(B.) University of Medicine and Dentistry of New Jersey- Robert Wood Johnson Medical School Rights

1. UMDNJ-RWJ shall not be required to fulfill its obligations should funding from DMHAS not be made available.

2. Work Product. All data, technical information, materials gathered, originated, developed, prepared, used or obtained in the performance of the requested services, including but not limited to, all papers, reports, surveys, plans, charts, records, analyses or publications produced for or as a result of this Agreement shall bear an acknowledgment of the support of DMHAS. No work product produced utilizing funds or data obtained under this Agreement shall be released to the public without the prior written consent of both DMHAS and UMDNJ-RWJ. UMDNJ-RWJ shall have the right to edit and shall further have the right to add disclaimers as they deem appropriate.

III. **Compliance Obligations By The Parties.**

1. (a) Each party certifies that it shall not violate the federal anti-kickback statute, set forth at 42 U.S.C. §1320a-7b(b) ("Anti-Kickback Statute"), or the federal "Stark Law," set forth at 42 U.S.C. § 1395nn ("Stark Law"), with respect to the performance of its obligations under this Agreement.

2. (b) DMHAS has received a copy of UMDNJ's Code of Conduct and UMDNJ's Stark Law and Anti-Kickback Statute Policies and Procedures. UMDNJ's Code of Conduct is available at http://www.umdnj.edu/complweb/code/conduct.pdf. UMDNJ's Stark Law and Anti-Kickback Statute Policies and Procedures are available at the following web addresses:
http://www.umdnj.edu/oppmweb/university_policies/ethics_compliance/PDF/00-01-15-60_05.pdf;
http://www.umdnj.edu/oppmweb/university_policies/ethics_compliance/PDF/00-01-15-60_10.pdf; and,
http://www.umdnj.edu/oppmweb/university_policies/ethics_compliance/PDF/00-01-15-60_15.pdf.

3. (c) Each party shall ensure that its individuals providing service under the agreement who meet the definition of "Covered Persons" (as such term is defined in the "Corporate Integrity Agreement between the Office of Inspector General of the Department of Health and Human Services and the University of Medicine and Dentistry of New Jersey" available at http://www.umdnj.edu/presweb/president/UMDNJ-CIA.pdf) shall comply with UMDNJ's Compliance Program, including the training related to the Anti-Kickback Statute and the Stark Law.

III. General Provisions

(A.) Mandatory General Provisions

1. During the term of this Agreement, DMHAS and UMDNJ-RWJ shall comply with all Federal, State and municipal laws, rules and regulations generally applicable to the activities performed pursuant to this Agreement.

2. DMHAS and UMDNJ-RWJ shall maintain accurate books and records of all disbursements, funds received, funds spent and funds available as a result of this Agreement.

3. DMHAS and UMDNJ-RWJ are independent entities, and neither party shall hold itself out as an agent, partner or representative of the other.

4. Failure by either party to exercise any right or demand performance of any obligation under this Agreement shall not be deemed a waiver of such right or obligation.

5. If any of the provisions of this Agreement are, or become invalid, to any extent, the other provisions of this Agreement shall not be effected thereby. In the event of the invalidity of a provision, the parties agree to accept a provision which reflects as closely as possible the intention of the invalid provision.

6. This Agreement may not be assigned without the prior written consent of all parties.

7. The laws of the State of New Jersey govern this agreement.

8. This agreement may be modified in accordance with the provisions of Attachment

A, Section III, which includes extensions, budget revisions and modifications to this agreement, with the approval of the Program Management Officers (PMOs) and Grant Management Officers (GMOs) identified in Section V.

9. Monthly programmatic reports must be submitted to the HIV Program Coordinator within 20 days following the end of each month in the MOA cycle. Fiscal reports must be submitted quarterly and be submitted by the end of the month following the close of the quarter. The expenditure report for the month ending September 30th for each year in 2013, 2014 and 2015 must show the disposition of all Agreement funds. All funds must be expended and a final expenditure report must be submitted to DMHAS within 60 days of September 30th in the years of 2013, 2014 and 2015. Any funds not expended or obligated by September 30, 2015 shall be returned to DMHAS.

10. All expenditure reports and audit reports related to this allocation shall be submitted to Adam Bucon, HIV Program Coordinator, Office of Care Management, DMHAS.

11. DMHAS and the UMDNJ-RWJ reserve a royalty-free, non-exclusive, and irrevocable license to reproduce, publish or otherwise use, and to authorize others to use, the copyright in any work developed under the agreement.

12. The parties agree all data resulting from this agreement are to be considered confidential and shall be solely used for purposes as outlined above. All parties are required to use reasonable care to protect the confidentiality of the data and comply with HIPAA and 42 CFR, Part 2.

13. Any research resulting from this Agreement which is subject to the Institutional Review Boards of either of the parties shall be confidential. Each party is responsible for adhering to the rules of the Institutional Review Board which are hereby incorporated by reference.

IV. Terms and Termination

(A.) Subject to any rights of termination hereinafter set forth, this Agreement shall become effective on October 1, 2012 and shall remain valid through September 30, 2015. A portion of the project period is retroactive and neither party will incur penalties as a result of any non-compliance prior to the execution of this Agreement.

(B.) This Agreement may be terminated by either of the parties to this agreement with or without cause upon sixty (60) days advance written notice.

(C.) Notice of termination shall be delivered via U.S. mail, return receipt requested, and shall be effective upon receipt. Notice shall be sent to the appropriate contact person identified in Section V.

(D.) Upon the issuance of notice of termination by DMHAS or UMDNJ-RWJ, or automatic termination under Section IV (A), all unexpended funds appropriated by DMHAS to UMDNJ-RWJ, in any account whatsoever, shall be returned to DMHAS through the contact person identified in Section V without any further assessment or

expenditure except as specifically approved by DMHAS in writing.

IV. Successor

Notwithstanding anything stated in this Agreement to the contrary, any and all right, title and interest of UMDNJ in and to the terms and conditions in this Agreement shall automatically transfer to Rutgers University, the State University of New Jersey, as UMDNJ's successor-in-interest by operation of law. The transfer shall occur without further action and/or consent of the parties to the Agreement.

VI. Principal Contacts

The principal contacts for all notifications required or otherwise necessary under this Agreement shall be as follows:

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

Program Management Officer
Adam Bucon, HIV Program Coordinator
Office of Quality Assurance
Division of Mental Health and Addiction Services
120 South Stockton Street, 3rd floor
P.O. Box 362
Trenton, NJ 08625-0362
609-984-3316 (office)
609-292-3816 (fax)

Fiscal Officer
Steve Adams, Director
Administrative Services
Division of Mental Health and Addiction Services
120 South Stockton Street, 3rd floor
P.O. Box 727
Trenton, NJ 08625-0362
609-777-0787 (office)

University of Medicine and Dentistry of NJ- Robert Wood Johnson Medical School:

University Representative
Denise Mulkern
Senior Vice President for Finance
University of Medicine and Dentistry of New Jersey, Suite 1419
65 Bergen Street, P.O. Box 1709
Newark, New Jersey 07107-1709
973 972-7981 (office)
973-972-7670 (fax)

Grants Manager
Anthony Mayo, Manager, Grants and Contracts
Liberty Plaza

335 George Street
New Brunswick, NJ 08903
732-235-9358 (office)
732-235-9231 (fax)

VII. We, the undersigned, consent to the contents of this Agreement.

New Jersey Department of Human Services:

Signature: _____ _____

Lynn Kovich — Date
DMHAS Assistant Commissioner

UMDNJ/ Robert Wood Johnson Medical School:

Signature: Celine Gelinas — 2/28/13

Celine Gelinas, Ph.D. — Date
Associate Dean for Research

Attachment A

Attachment A is hereby incorporated to and provides for additional provisions and conditions between the New Jersey Department of Human Services, Division of Mental Health and Addiction Services and the University of Medicine and Dentistry of New Jersey-Robert Wood Johnson Medical School for a Memorandum of Agreement entitled, "Rapid HIV Testing Services."

I. Method of Payment

Cost reimbursement payments shall be made by the Funding Agency on the following basis:
[ ] Monthly
[X] Quarterly
[ ] Lump Sum
[X] Based on submission of the quarterly fiscal report.

II. Financial and Performance Reporting and MOA Monitoring

A. Expenditure reports are required. If applicable, these will be submitted, by the Service Provider agency no later than 30 days after the end of each:

[ ] Initial [ ] Monthly [X] Quarterly [ ] Final [ ] Other (Describe)

B. Performance reports are required. Performance reports shall be in the form specified by the Funding Agency and shall be submitted on a:

[ ] Initial [X] Monthly [ ] Quarterly [ ] Final [ ] Other (Describe)

C. The Funding Agency will provide technical assistance meetings with the Service Provider Agency on the following basis:

[ ] Initial [ ] Monthly [X] Quarterly [ ] Final [ ] Other (Describe)

D. The Service Provider Agency will provide technical assistance meetings with the Funding Agency on the following basis:

[ ] Initial [ ] Monthly [X] Quarterly [ ] Final [ ] Other (Describe)

E. Other Financial, Reporting or Monitoring Requirements

1. Particular forms are not required to be utilized. If applicable these are attached.

No special forms are required.

MEMORANDUM OF AGREEMENT

BETWEEN

THE DEPARTMENT OF HUMAN SERVICES (DHS)
DIVISION OF MENTAL HEALTH AND ADDICTION SERVICES (DMHAS)

AND

THE DEPARTMENT OF EDUCATION (NJDOE)
DIVISION OF STUDENT AND FIELD SERVICES

Purpose

The Division of Mental Health and Addiction Services (DMHAS) and the Department of Education agree to implement a Student Health Survey on health behaviors in New Jersey high school students. Included in the survey items will be substance use questions and questions regarding factors protecting and posing risk to adolescent substance use. This will assist in prevention and treatment planning, community organization and coalition building and school planning via the New Jersey Student Health (High School) Survey.

Term

The agreement is in effect for the period November 16, 2012 through September 30, 2014.

Contract Management

NJDOE shall be responsible for the management of the specific contract which is the subject of this Agreement including payments to survey administrators, contract modifications and report dissemination. In the event that contract services funded in part by this Agreement are disrupted or not delivered, for any significant period of time, it is the responsibility of NJDOE to notify DMHAS and modify the Agreement, as necessary.

The contract services to be funded through this Agreement are: personnel and travel costs associated with the recruitment of schools and administration of the survey; incentives to schools to participate; and incentives to students to return the parental permission slip (see Attachment A). The contractor, in the mid-project and final progress reports submitted to the NJDOE, will detail the expenses incurred in the budget lines covered in Attachment A to this MOA.

Modification and/or Termination

This Agreement may be modified at any time, or terminated with 60 days' notice, by agreement of both parties, as evidenced by an exchange of correspondence or document signed by representatives of DMHAS and NJDOE.

Provision of Funding for Services

DMHAS shall make available the funding amount of $50,000 to provide financial assistance for

the implementation of the Student Health Survey no later than November 16, 2012. This payment will be a single credit transaction.

Planning for Collaboration

DMHAS and NJDOE agree to continually work cooperatively in order to improve survey, development, protocol, implementation and methods. A significant example of this interdivisional collaboration is the Interdepartmental Working Group on Student Surveys headed by NJDOE when planning to implement this survey. This workgroup consists of members from NJDOE, DMHAS, the Department of Health and The GCADA, the Department of Law and Public Safety. The NJDOE has conducted this survey among public high school students every other year since 1993. To ensure data are collected on substance use and risk and protective factors valuable to Mental Health and Addiction Services planning and funding initiatives, DMHAS has been a part of the Interdepartmental Workgroup. The findings of this survey helps parents, schools, youth-serving agencies, including DMHAS maintain awareness of current trends among teens and provide feedback on the impact of large-scale programs to influence teen behavior.

DMHAS will be consulted on any issues concerning the addition, deletion or modification of questions related to substance use and risk and protective factors and agreement will be reached between both parties prior to inclusion in the Student Health Survey. DMHAS will also be provided with a draft copy of the final survey report for comment.

The final report for the 2013 Survey will be available in the spring 2014.

WE, THE UNDERSIGNED, CONSENT TO THE CONTENTS OF THIS AGREEMENT.

Jennifer Velez
Commissioner
New Jersey Department of Human Services

11/13/12
Date

Christopher D. Cerf
Commissioner
New Jersey Department of Education

9/26/12
Date

Attachment A

Attachment A

Budget - Shared Costs

FY 2013-2014

New Jersey Student Health Survey

	NJDOE	*DMHAS*	*Total*
2013 NJSHS			
A. Recruit schools and administer survey - Personnel	$42,836	$42,836	$85,672
B. Travel	$4,500	$0	$4,500
C. School Incentives	$7,836	$7,164	$15,000
D. Teacher Incentives	$3,550	$0	$3,550
E. Supplies/postage/printing	$2,750	$0	$2,750
F. Indirect/other Costs	$7,434	$0	$7,434
Subtotal, FY 2013-14	**$68,906**	**$50,000**	**$118,906**

MEMORANDUM OF AGREEMENT

BETWEEN

THE NEW JERSEY DEPARTMENT OF HUMAN SERVICES (NJDHS)
DIVISION OF MENTAL HEALTH & ADDICTION SERVICES (DMHAS)
AND

Rutgers Center of Alcohol Studies, Professional Development Division
FOR
Alcohol and Drug Counselor Education

WHEREAS the New Jersey Department of Human Services (NJDHS), Division of Mental Health & Addiction Services (DMHAS); Rutgers Center of Alcohol Studies, Professional Development Division wishes to provide renewal/recertification alcohol and drug counseling education courses for credentialed behavioral healthcare professionals, alcohol and drug counselors, and prevention specialists in the State of New Jersey.

WHEREAS the NJDHS/DMHAS has the statutory authority under its federal block grant to plan, develop, and administer a statewide system of services to meet the needs of residents' addiction problems by providing access to treatment by qualified treatment professionals; and

WHEREAS the NJDHS/DMHAS as part its on-going responsibility to address areas of concern that affect service access, quality, and outcomes by enhancing the competency of its addiction and behavioral healthcare workforce by providing educational opportunities for credentialing and specialization.

NOW, THEREFORE, THE PARTIES HERETO AGREE AS FOLLOWS:

I. **Under this Agreement**, the NJDHS/DMHAS hereafter referred to as **"the Funding Agency"** and the Rutgers Center of Alcohol Studies, Professional Development Division, is hereafter referred to as "the Service Provider Agency."

II. Obligations and Rights of Funding Agency

(A.) NJDHS/DMHAS Obligations

All of the requirements of this section apply to **the Funding Agency**:

1. The NJDHS/DMHAS shall provide funding in an amount not to exceed $39,700. Payment is contingent upon the satisfactory delivery of services as described herein in this MOA, Section III (A) "Obligations and Rights of Service Provider." Payment obligations, as well as reporting and monitoring requirements, and other special conditions to this agreement, are contained in ANNEX A, and incorporated herewith

by reference. Payments shall be made in accordance with the provisions ANNEX A, Section I. Payments will be made for approved budget costs, contained in ANNEX B, incorporated herein by reference.

2. The NJDHS/DMHAS shall monitor the progress of this project to ensure that services are being provided in accordance with Section III (A), which establishes the work products that must be completed in order for funds to be provided, and the time-lines for completion. All financial, performance and MOA monitoring requirements are contained in ANNEX A sections II, III and IV. Phone contact and email correspondence occur as needed. The Parties recognize and agree that this Agreement is expressly dependent upon the availability of DHS/DMHAS funding. The DHS/DMHAS shall not be held liable for any termination of this agreement due to the absence of available funding appropriations.

3. In addition to the above, the **Funding Agency** is required to abide by all general requirements contained in Sections IV and V of this Agreement.

(B.) NJDHS/DMHAS Rights

All of the rights outlined in this section are applicable to the **Funding Agency**.

1. **Audit:**
The **Funding Agency** shall have the right to at any time audit any and all accounts and/or records maintained by the recipient of these funds. To effectuate this provision, the funding agency shall be afforded, during normal business hours, access to all records and/or data of the **Service Provider Agency** indicated in Section III, which pertain to this Agreement. The provisions of this subparagraph shall continue for a period of seven years after the submission and acceptance of the financial and programmatic reports required under this Agreement. The following are applicable to this MOA:

2. **Work Product:**
All data, technical information, materials gathered, originated, developed, prepared, used or obtained in the performance of the requested services, including but not limited to, all papers, reports, surveys, plans, charts, records, analyses or publications produced for or as a result of this Agreement shall bear an acknowledgment of the support of the **Funding Agency**. No work product produced utilizing funds or data obtained under this Agreement shall be released to the public without the prior written consent of the **Funding Agency**. The **Funding Agency** shall have the right to add disclaimers to said work product as it, in its sole discretion, deems appropriate. Further, the **Funding Agency** shall have the right, in collaboration with the **Service Provider Agency**, to add co-authorship to said work product in reflection of its collaboration with the **Service Provider Agency** on the various elements of the research effort as set forth in the aforementioned Item II, (A.), paragraph 3. Finally,

the **Funding Agency** shall have the right to edit said work product as long as the edits do not, in the professional opinion of the **Service Provider Agency**, infringe upon the integrity of the work product itself."

3. **Other Rights of Funding Agency:**
NJDHS/DMHAS reserves the right to screen a list of staff retained to complete the scope of work described in this agreement to ensure that there are no real or perceived conflicts of interest for individuals employed under this contract.

III. Obligations and Rights of Service Provider Agency

(A.) Rutgers Center of Alcohol Studies, Professional Development Division

All of the requirements of this section apply to the **Service Provider Agency**:

1. The Rutgers Center of Alcohol Studies, Professional Development Division shall provide services in accordance with Section III (A) 4 that establishes the service deliverables that this agency must perform, in accordance with the established timeframes established for each item in SectionsIII (A) 4 and III (A) 5. The **Service Provider Agency** will adhere to the budget requirements as detailed in the approved cost proposal and as contained in ANNEX B.

2. The Rutgers Center of Alcohol Studies, Professional Development Division shall be required to submit expenditure, progress and final reports and state invoices in accordance with the requirements of ANNEX A included in this MOA.

3. The Rutgers Center of Alcohol Studies, Professional Development Division shall be required to maintain all records for a period of 7 years.

4. Services to be provided. In exchange for funding provided by the **Funding Agency** indicated in Section II (A), the **Service Provider Agency** agrees to perform the following:
   A. Provide renewal/recertification alcohol and drug counseling education courses approved by the Addiction Professional Certification Board of New Jersey and/or its designee and endorsed by DMHAS.
   B. Provide highly specialized 6 hour, one-day seminars for renewal/re certification and/or licensure approved by the Addiction Professionals Certification Board of New Jersey and/or its designee, the New Jersey Board of Marriage and Family Therapy Examiners' Alcohol and Drug Counselor Committee and Professional Counselor Committee, the New Jersey Board of Social Work Examiners, and other affiliated professional clinical boards, and endorsed by DMHAS.
   C. Ensure an open enrollment process and selection of individuals who meet eligibility criteria as set forth in ANNEX A.

D. CEUS are awarded and certificates of completion are distributed after each class.
E. All attendance rerecords, course outlines, instructor resumes, etc. are maintained for a period no less than less than 7 years.

5. Timeframe for Performance of Service Deliverables: This section contains the timetable for each of the services indicated in Section III (A) 4. The **Service Provider Agency** agrees that the service deliverables indicated in Section III (A) 4 will be performed by the corresponding date or time period indicated in Section III (A) 5:

The **Service Provider Agency** seeks to provide recertification education hours for credentialed behavioral healthcare professionals, alcohol and drug counselors, and prevention specialists in the State of New Jersey.

June 10-15, 2012 Institute of Addiction Studies: 'The Summer School'

Provide a one-week, 45-hour (4.5 CEUS) program in drug and alcohol counseling education that can be applied towards recertification or renewal hours for alcohol and drug counselors and behavioral healthcare professionals working within the addiction treatment field. Three certificates can be earned by individuals who attend the 2013 Institute of Addiction Studies: 'The Summer School' -- a certificate of 3.6 CEUs (i.e., 36 hours) will be awarded to those who individuals who complete three Summer School courses; a second certificate of .6 (i.e., 6 hours) will be awarded to those individuals who attend the six hour Sunday lecture series, and a third certificate of .6 CEUs (i.e., 6 hours) will be awarded to those individuals who take a six hour mini-course. Depending on the number of activities an individual participates during this year's Summer School, the person can obtain one certificate (3.6 CEUs or 36 hours) or two certificates, which would total 4.2 CEUs or 42 hours; or 3 certificates, which would total 4.8 CEUs or 48 hours.

Fall 2012 Continuing Professional Development: Seminars: Oct. 25 to Dec. 10, 2012
Spring 2013 Continuing Professional Development Seminars: Jan. 14, to May 30, 2013

The Continuing Professional Development Seminars in alcohol and drug studies are one-day seminars for addiction and behavioral healthcare professionals that are conducted during the academic year. Each seminar is approved for .6 Continuing Education Units (CEUs) by Rutgers University, The Professional Development Division. Course work for licensure and recertification renewal will be submitted to the Alcohol and Drug Counselor Committee, State Board of Marriage and Family Therapy Examiners' Division of Consumer Affairs, and other affiliated behavioral healthcare professional licensure boards for approval.

Additional Services (continuous) 6/01/12 – 05/31/13

6. In addition to the above, the **Service Provider Agency** is required to abide by all general requirements contained in Sections IV and V of this Agreement.

(B.) Rutgers Center of Alcohol Studies, Professional Development Division
All of the rights of this section apply to the **Service Provider Agency**:

IV. General Provisions

(A.) Mandatory General Provisions

1. During the term of this Agreement, **both parties** shall comply with all federal, state and municipal laws, rules and regulations generally applicable to the activities performed pursuant to this Agreement. The award of funds is based on the **Service Provider Agency's** submission, and the Funding Agency's acceptance, of a Cost Proposal, which is incorporated herewith by reference to this Agreement.

2. **Each party** shall maintain accurate books and records of all disbursements, funds received, funds spent and funds available as a result of this Agreement.

3. **Each of the parties** is an independent entity and neither party shall hold itself out as an agent, partner or representative of the other.

4. Failure by either party to exercise any right or demand performance of any obligation under this Agreement shall not be deemed a waiver of such right or obligation.

5. If any of the provisions of this Agreement are, or become invalid, to any extent, the other provisions of this Agreement shall not be affected thereby. In the event of the invalidity of a provision, the parties agree to accept a provision that reflects as closely as possible the intention of the invalid provision.

6. This Agreement may not be assigned without prior written consent of the NJDHS/DMHAS.

7. The laws of the State of New Jersey govern this agreement.

8. This agreement may be modified in accordance with the provisions of ANNEX A III.

(B.) Optional General Provisions

Not Applicable	Applicable
☐	☒ The **Funding Agency** reserves a royalty-free, nonexclusive, and irrevocable license to reproduce, publish or otherwise use, and to authorize others to use, the copyright in any work developed under the Agreement.

☐ ☒ The parties agree that all data resulting from this Agreement are to be considered confidential and shall be solely used for the purposes as outlined above. All parties are required to use reasonable care to protect the confidentiality of the data.

☐ ☒ Any research resulting from this Agreement that is subject to the Institutional Review Boards of either of the parties shall be confidential. Each party is responsible for adhering to the rules of the Institutional Review Board that are hereby incorporated by reference.

V. Terms and Termination

(A.) Subject to any rights of termination hereinafter set forth, this Agreement shall become effective on June 1, 2012 and shall remain valid through May 31, 2013.

(B.) This Agreement may be terminated by either party with or without cause upon thirty (30) days advance written notice.

(C.) Notice of termination shall be delivered via U.S. mail, return receipt requested, and shall be effective upon receipt. Notice shall be sent to the appropriate contact person identified at Section VI.

(D.) Upon the issuance of notice of termination by the **Funding Agency** or, automatic termination under Section V(B), upon receipt of the **Funding Agency's** notice of termination, all unexpended funds appropriated by the **Funding Agency** to the **Service Provider Agency**, in any account whatsoever shall be immediately returned to the **Funding Agency** through the contact person identified at Section VI without any further assessment or expenditure except as specifically approved by the **Funding Agency** in writing.

VI. Principal Contacts

The principal contacts for all notifications required or otherwise necessary under this Agreement shall be as follows:

For the New Jersey Department of Human Services/Division Mental Health & Addiction Services:

Program Management Officer
Elizabeth Conte, LPC, LCADC
Division of Mental Health & Addiction Services
222 S. Warren Street, PO Box 367
Trenton, NJ 08625-0362

Fiscal Officer
Steven J. Adams
Chief Financial Officer
Division of Mental Health & Addiction Services
50 E. State Street; P.O. Box 727
Trenton, NJ 08625

For Rutgers Center of Alcohol Studies, Professional Development Division

Program Officer
Nancy Violette
Assistant Professor
Center of Alcohol Studies
Rutgers, The State University
607 Allison Road
Piscataway, NJ 08854-8001

Fiscal Officer
Michele Conlin, Assistant Controller
Grant and Contract Accounting
3 Rutgers Plaza
New Brunswick, NJ 08901

VII. We, the undersigned, consent to the contents of this Agreement.

New Jersey Department of Human Services/Division Mental Health & Addiction Services:

Signature: _____ 2/28/13
Lynn Kovich — Date
Assistant Commissioner

For Rutgers Center of Alcohol Studies

Signature: _____ 12/17/12
Sheryl N. Goldberg, Director — Date
Office of Research & Sponsored Programs
3 Rutgers Plaza
New Brunswick, NJ 08901

ANNEX A

ANNEX A is attached and herein incorporated to and provides for additional provisions and conditions between the New Jersey Department of Human Services (DHS) and the Division of Mental Health & Addiction Services (DMHAS) and the Rutgers Center of Alcohol Studies, Professional Development Division, for a Memorandum of Agreement entitled "Alcohol and Drug Counselor Education."

I. Method of Payment

Cost reimbursement payments shall be made by the Funding Agency on the following basis:

- ☐ Monthly
- ☒ Quarterly
- ☐ Lump Sum
- ☐ Based on submission of the following reports (Please describe below)

The final payment will be withheld pending receipt of final reports.

II. Financial and Performance Reporting and MOA Monitoring

(Circle, check and complete as applicable)

A. Expenditure reports are required. If applicable, these will be submitted, by the Service Provider agency no later than days after the end of each
☐ Monthly ☒ Quarterly ☐ Final ☐ Other reporting period.

B. Narrative reports are required. These reports shall be in the form specified by the Funding Agency and shall be submitted on a
☐ Monthly ☒ Quarterly ☐ Final ☐ Other report period.

C. The Funding Agency conducts technical assistance meetings with the Service Provider Agency on the following basis:
☐ Initial ☐ Monthly ☒ Quarterly ☐ Final ☐ Other (Describe)

D. Other Financial, Reporting or Monitoring Requirements

1. Particular forms are required to be utilized. If applicable these, are attached.

III. Modifications to the Agreement

This document represents the entire Agreement between the parties and shall not be amended except by the express written consent of both parties, except as stated herein:

1. MOA extensions may not be made to this agreement. If allowed, approval may be granted by the Program Management Officer and Fiscal Officer identified in Section VI.

2. Budget revisions may be made to this agreement. If allowed, approval may be granted by the Program Management Officer and Fiscal Officer identified in Section VI.

3. Modifications to Subsection III of the MOA, regarding service deliverables to be performed under Section III. (A.) may be made with the approval of the Program Management Officer identified in Section VI.

IV. Special Conditions (as applicable)

1. This MOA includes no special conditions.

V. Multi-Year Agreements

This is not a multi year MOA.

ANNEX B

ANNEX B is attached and herein incorporated to and provides a description of the budget/cost proposal for the Memorandum of Agreement between the New Jersey Department of Human Services/Division of Mental Health & Addiction Services and Rutgers Center of Alcohol Studies, Professional Development Division, entitled "Alcohol and Drug Counselor Education."

Brief Budget Explanation.
The funds authorized under this MOA will be used to pay program expenses as outlined in the attached budget summary.

Rutgers Center of Alcohol Studies, Professional Development Division
607 Allison Road; Piscataway, NJ 08854-8001

Alcohol and Drug Counselor Education

Budget Period:

ANNEX B

June 1, 2012 to May 31, 2013

Alcohol and Drug Counselor Education

Total: $39,700

	BUDGET
Rutgers Institute of Addiction Studies 'Summer School' June 10-15, 2012	
26 individuals to receive tuition support (scholarships) @ $950 each.	$24,700
Continuing Education Seminar Fall 2012 & Spring 2013	
150 individuals to attend a one-day seminar @ $100 for each registration	$15,000
Subtotal	$39,700
Grand total	$39,700

Rutgers Institute of Addiction Studies, Professional Development Division
607 Allison Road; Piscataway, NJ 08854-8001

Agency Request for Professional Services
OMB Requirements Checklist
Explanation for no bid competition
Alcohol and Drug Counselor Education

Alcohol and Drug Counselor Education will be delivered by the Rutgers Center of Alcohol Studies, Professional Development Division. Rutgers University is considered a Quasi-State agency. Because this institution is part of the State system, it is exempt from the bid competition requirement.

MEMORANDUM OF AGREEMENT

BETWEEN

THE NEW JERSEY DEPARTMENT OF HUMAN SERVICES (NJDHS)
DIVISION OF MENTAL HEALTH & ADDICTION SERVICES (DMHAS)
AND

Rutgers Center of Alcohol Studies, Professional Development Division

FOR

"Alcohol and Drug Counselor Education"

6/01/12 – 5/31/13

ANNEX A

In accordance with the Department of Human Services, Division of Mental Health & Addiction Services' Workforce Development Initiative to enhance the status of credentialed and licensed alcohol and drug counselors, behavioral healthcare professionals, and prevention specialists currently working in the addiction field by offering renewal/recertification courses, the Rutgers Center of Alcohol Studies, Professional Development Division, will provide the following deliverables during the period June 1, 2012 through May 31, 2013:

1. Fund scholarships for twenty-six (26) behavioral healthcare, substance abuse and prevention treatment professionals to attend the 2012 Rutgers Center of Alcohol Studies, Professional Development Division, Institute of Addiction Studies: 'The Summer School." Scholarships will be selected based on eligibility criteria as outlined in No. 5.

2. Fund paid registrations for 150 individuals to attend the Rutgers Center of Alcohol Studies, Professional Development Division, Continuing Professional Development Seminar Series during the fall 2012 and spring 2013 semesters.

3. Ensure that the school's curriculum is structured with specialized courses, led by highly competent and experienced Instructors.

4. Provide general lectures and special interest seminars to support and supplement the course work.

5. Ensure an open enrollment process and selection of individuals who meet scholarship criteria as set forth below:

a. Applicants must be a resident of New Jersey.
b. Priority will be given to those individuals who are employed at a DMHAS licensed addiction treatment or prevention program.
c. Priority will be given to those individuals who are required to maintain continuing education of a New Jersey State license, certification, or recertification as a LCADC, CADC, CDA, CCS, CPS, LPC, LCSW, LMFT, APN, LSW, LAC, psychologist, or other behavioral healthcare professional working in a substance abuse treatment agency. The candidate's application and/or follow up letter should state their credential, license or certification number and their DMHAS agency license number.
d. Applicants with salaries less than $50,000 will be given priority eligibility.
e. The applicant will complete (1) a separate application; (2) provide a short letter co-signed by the immediate supervisor stating length of employment at the program, the applicant's role and population serviced by the treatment program and certify that the applicant meets the above criteria; and, (3) Two hundred word essay stating why the scholarship would be important for your professional growth with the particular population you work. Also indicate how the educational hours will benefit your function and responsibilities at their agency.
f. Applicants may not presently be employed by the State of New Jersey (except for a maximum of 5% of the total grant amount to be awarded to DMHAS employees to attend such trainings).

The following may be used as a checklist method in determining a candidates' eligibility for tuition assistance:

a. Applicants required to maintain certification or licensure as a LCADC or CADC
b. Applicants required to maintain licensure as a LPC, LAC, LCSW, LSW, LMFT, APN, clinical psychologist, or other behavioral healthcare specialist working in a substance abuse treatment agency.
c. Behavioral healthcare clinicians who want to obtain a LCADC or CADC.
d. Applicants needing courses for another addiction certification (CDA, CPS, CCS, etc.)

6. Obtain recertification renewal hours approved by the State Board of Marriage and Family Therapy Examiners' Alcohol and Drug Counselor Committee and Professional Counselors Committee, the New Jersey Board of Social Work Examiners, and other affiliated professional clinical licensing boards.

7. Distribute certificates of completion with approval numbers after each class and maintain all attendance records, applications, course outlines, instructor resumes, etc. for a period no less than 7 years.

8. Provide quarterly reports and a year-end report to DMHAS documenting completion of all of the above-named activities.

9. Submit copies of all applications as approved.

10. Provide additional activities and trainings as directed by DMHAS and utilizing funding within the grant that will be diverted from other activities or by the addition of sufficient funds needed to provide additional activities and trainings through budget modification.

MEMORANDUM OF AGREEMENT

RUTGERS, THE STATE UNIVERSITY

MODIFICATIONS TO ATTACHED STANDARD TERMS AND CONDITIONS

Paragraph 4.1 (a) is replaced by the following: Between the DHS/DMHAS and Rutgers University (RU), the DHS/DMHAS, subject to the provisions of the New Jersey Tort Claims Act and the New Jersey Contractual Liability Act, shall be responsible for, and shall at its own expense, defend itself against any and all suits, claims, losses, demands or damages of whatsoever kind or nature, arising out of or in connection with any act or omission of the DHS/DMHAS, its employees, agents or contractors, in the performance of the obligations assumed by the DHS/DMHAS pursuant to this MOA. The DHS/DMHAS hereby releases RU from any and all liabilities, claims, losses, costs, expenses and demands of any kind or nature whatsoever, arising under State or Federal law, solely out of or in connection with the DHS/DMHAS' s performance of the obligations assumed by the DHS/DMHAS pursuant to the MOA.

4.1(b) is replaced by the following: Between the DHS/DMHAS and RU, RU, subject to the provisions of the New Jersey Tort Claims Act and the New Jersey Contractual Liability Act, shall be responsible for, and shall at its own expense, defend itself against any and all suits, claims, losses, demands or damages of whatsoever kind or nature, arising out of or in connection with any act or omission of RU, its employees, agents or contractors, in the performance of the obligations assumed by RU pursuant to this MOA. RU hereby releases the DHS/DMHAS from any and all liabilities, claims, losses, costs, expenses and demands of any kind of nature whatsoever, arising under State of Federal law, solely out of or in connection with RU's performance of the obligations assumed by RU to this MOA.

Changes to paragraph 4.2 are as follows:

1. 60 (sixty) days is replaced by 30 (thirty) days
2. 4.2(a) changes the words "name(d)" to "include(d)"
3. Changes to 4.2(c) adding the self-insurance for worker's compensation and commercially purchased Employer Liability insurance

State of New Jersey
Standard Terms and Conditions

1. **STANDARD TERMS AND CONDITIONS APPLICABLE TO THE CONTRACT-** Unless the bidder/offeror is specifically instructed otherwise in the Request for Proposals (RFP), the following terms and conditions shall apply to all contracts or purchase agreements made with the State of New Jersey. These terms are in addition to the terms and conditions set forth in the RFP and should be read in conjunction with same unless the RFP specifically indicates otherwise. In the event that the bidder/offeror would like to present terms and conditions that are in conflict with either these terms and conditions or those set forth in the RFP, the bidder/offeror must present those conflicts during the Question and Answer period for the State to consider. Any conflicting terms and conditions that the State is willing to accept will be reflected in an addendum to the RFP. The State's terms and conditions shall prevail over any conflicts set forth in a bidder/offeror's proposal that were not submitted through the question and answer process and approved by the State. Nothing in these terms and conditions shall prohibit the Director of the Division of Purchase and Property (Director) from amending a contract when the Director determines it is in the best interests of the State.

2. **STATE LAW REQUIRING MANDATORY COMPLIANCE BY ALL CONTRACTORS** - The statutes, laws or codes cited herein are available for review at the New Jersey State Library, 185 West State Street, Trenton, New Jersey 08625.

2.1 **BUSINESS REGISTRATION** – Pursuant to N.J.S.A. 52:32-44, the State is prohibited from entering into a contract with an entity unless the bidder and each subcontractor named in the proposal have a valid Business Registration Certificate on file with the Division of Revenue.

The contractor and any subcontractor providing goods or performing services under the contract, and each of their affiliates, shall, during the term of the contract, collect and remit to the Director of the Division of Taxation in the Department of the Treasury the use tax due pursuant to the "Sales and Use Tax Act, P.L. 1966, c. 30 (N.J.S.A. 54:32B-1 et seq.) on all their sales of tangible personal property delivered into the State. Any questions in this regard can be directed to the Division of Revenue at (609) 292-1730. Form NJ-REG can be filed online at http://www.state.nj.us/treasury/revenue/busregcert.shtml.

2.2 **ANTI-DISCRIMINATION** - All parties to any contract with the State agree not to discriminate in employment and agree to abide by all anti-discrimination laws including those contained within N.J.S.A. 10:2-1 through N.J.S.A. 10:2-4, N.J.S.A. l0:5-1 et seq. and N.J.S.A. l0:5-31 through 10:5-38, and all rules and regulations issued thereunder are hereby incorporated by reference.

2.3 **PREVAILING WAGE ACT** - The New Jersey Prevailing Wage Act, N.J.S.A. 34: 11-56.26 et seq. is hereby made part of every contract entered into on behalf of the State of New Jersey through the Division of Purchase and Property, except those contracts which are not within the contemplation of the Act. The bidder's signature on [this proposal] is his guarantee that neither he nor any subcontractors he might employ to perform the work covered by [this proposal] has been suspended or debarred by the Commissioner, Department of Labor for violation of the provisions of the Prevailing Wage Act and/or the Public Works Contractor Registration Acts; the bidder's signature on the proposal is also his guarantee that he and any subcontractors he might employ to perform the work covered by [this proposal] shall comply with the provisions of the Prevailing Wage and Public Works Contractor Registration Acts, where required.

2.4 **AMERICANS WITH DISABILITIES ACT** - The contractor must comply with all provisions of the Americans with Disabilities Act (ADA), P.L 101-336, in accordance with 42 U.S.C. 12101, et seq.

2.5 **MACBRIDE PRINCIPLES** – The bidder must certify pursuant to N.J.S.A. 52:34-12.2 that it either has no ongoing business activities in Northern Ireland and does not maintain a physical presence therein or that it will take lawful steps in good faith to conduct any business operations it has in Northern Ireland in accordance with the MacBride principles of nondiscrimination in employment as set forth in N.J.S.A. 52:18A-89.5 and in conformance with the United Kingdom's Fair Employment (Northern Ireland) Act of 1989, and permit independent monitoring of their compliance with those principles.

2.6 **PAY TO PLAY PROHIBITIONS** – Pursuant to N.J.S.A. 19:44A-20.13 et seq (L.2005, c. 51), and specifically, N.J.S.A. 19:44A-20.21, it shall be a breach of the terms of the contract for the business entity to:

a. make or solicit a contribution in violation of the statute;
b. knowingly conceal or misrepresent a contribution given or received;
c. make or solicit contributions through intermediaries for the purpose of concealing or misrepresenting the source of the contribution;

d. make or solicit any contribution on the condition or with the agreement that it will be contributed to a campaign committee or any candidate of holder of the public office of Governor, or to any State or county party committee;
e. engage or employ a lobbyist or consultant with the intent or understanding that such lobbyist or consultant would make or solicit any contribution, which if made or solicited by the business entity itself, would subject that entity to the restrictions of the Legislation;
f. fund contributions made by third parties, including consultants, attorneys, family members, and employees;
g. engage in any exchange of contributions to circumvent the intent of the Legislation; or
h. directly or indirectly through or by any other person or means, do any act which would subject that entity to the restrictions of the Legislation.

2.7 **POLITICAL CONTRIBUTION DISCLOSURE** – The contractor is advised of its responsibility to file an annual disclosure statement on political contributions with the New Jersey Election Law Enforcement Commission (ELEC), pursuant to N.J.S.A. 19:44A-20.27 (L. 2005, c. 271, §3 as amended) if in a calendar year the contractor receives one or more contracts valued at $50,000.00 or more. It is the contractor's responsibility to determine if filing is necessary. Failure to file can result in the imposition of penalties by ELEC. Additional information about this requirement is available from ELEC by calling 1(888) 313-3532 or on the internet at http://www.elec.state.nj.us/.

2.8 **STANDARDS PROHIBITING CONFLICTS OF INTEREST** - The following prohibitions on contractor activities shall apply to all contracts or purchase agreements made with the State of New Jersey, pursuant to Executive Order No. 189 (1988).

a. No vendor shall pay, offer to pay, or agree to pay, either directly or indirectly, any fee, commission, compensation, gift, gratuity, or other thing of value of any kind to any State officer or employee or special State officer or employee, as defined by N.J.S.A. 52:13D-13b. and e., in the Department of the Treasury or any other agency with which such vendor transacts or offers or proposes to transact business, or to any member of the immediate family, as defined by N.J.S.A. 52:13D-13i., of any such officer or employee, or partnership, firm or corporation with which they are employed or associated, or in which such officer or employee has an interest within the meaning of N.J.S.A. 52: 13D-13g.
b. The solicitation of any fee, commission, compensation, gift, gratuity or other thing of value by any State officer or employee or special State officer or employee from any State vendor shall be reported in writing forthwith by the vendor to the Attorney General and the Executive Commission on Ethical Standards.
c. No vendor may, directly or indirectly, undertake any private business, commercial or entrepreneurial relationship with, whether or not pursuant to employment, contract or other agreement, express or implied, or sell any interest in such vendor to, any State officer or employee or special State officer or employee having any duties or responsibilities in connection with the purchase, acquisition or sale of any property or services by or to any State agency or any instrumentality thereof, or with any person, firm or entity with which he is employed or associated or in which he has an interest within the meaning of N.J.S.A. 52: 130-13g. Any relationships subject to this provision shall be reported in writing forthwith to the Executive Commission on Ethical Standards, which may grant a waiver of this restriction upon application of the State officer or employee or special State officer or employee upon a finding that the present or proposed relationship does not present the potential, actuality or appearance of a conflict of interest.
d. No vendor shall influence, or attempt to influence or cause to be influenced, any State officer or employee or special State officer or employee in his official capacity in any manner which might tend to impair the objectivity or independence of judgment of said officer or employee.
e. No vendor shall cause or influence, or attempt to cause or influence, any State officer or employee or special State officer or employee to use, or attempt to use, his official position to secure unwarranted privileges or advantages for the vendor or any other person.
f. The provisions cited above in paragraphs 2.8a through 2.8e shall not be construed to prohibit a State officer or employee or Special State officer or employee from receiving gifts from or contracting with vendors under the same terms and conditions as are offered or made available to members of the general public subject to any guidelines the Executive Commission on Ethical Standards may promulgate under paragraph 3c of Executive Order No. 189.

2.9 **NOTICE TO ALL CONTRACTORS SET-OFF FOR STATE TAX NOTICE** - Pursuant to L 1995, c. 159, effective January 1, 1996, and notwithstanding any provision of the law to the contrary, whenever any taxpayer, partnership or S corporation under contract to provide goods or services or construction projects to the State of New Jersey or its agencies or instrumentalities, including the legislative and judicial branches of State government, is entitled to payment for those goods or services at the same time a taxpayer, partner or shareholder of that entity is indebted for any State tax, the Director of the Division of Taxation shall seek to set

off that taxpayer's or shareholder's share of the payment due the taxpayer, partnership, or S corporation. The amount set off shall not allow for the deduction of any expenses or other deductions which might be attributable to the taxpayer, partner or shareholder subject to set-off under this act.

The Director of the Division of Taxation shall give notice to the set-off to the taxpayer and provide an opportunity for a hearing within thirty (30) days of such notice under the procedures for protests established under R.S. 54:49-18. No requests for conference, protest, or subsequent appeal to the Tax Court from any protest under this section shall stay the collection of the indebtedness. Interest that may be payable by the State, pursuant to P.L. 1987, c.184 (c.52:32-32 et seq.), to the taxpayer shall be stayed.

2.10 **COMPLIANCE - LAWS** - The contractor must comply with all local, State and Federal laws, rules and regulations applicable to this contract and to the goods delivered and/or services performed hereunder.

2.11 **COMPLIANCE - STATE LAWS** - It is agreed and understood that any contracts and/or orders placed as a result of [this proposal] shall be governed and construed and the rights and obligations of the parties hereto shall be determined in accordance with the laws of the STATE OF NEW JERSEY.

3. STATE LAW REQUIRING MANDATORY COMPLIANCE BY CONTRACTORS UNDER CIRCUMSTANCES SET FORTH IN LAW OR BASED ON THE TYPE OF CONTRACT

3.1 **COMPLIANCE - CODES** – The contractor must comply with NJUCC and the latest NEC70, B.O.C.A. Basic Building code, OSHA and all applicable codes for this requirement. The contractor shall be responsible for securing and paying all necessary permits, where applicable.

3.2 **PUBLIC WORKS CONTRACTOR REGISTRATION ACT** - The New Jersey Public Works Contractor Registration Act requires all contractors, subcontractors and lower tier subcontractor(s) who engage in any contract for public work as defined in N.J.S.A. 34:11-56.26 be first registered with the New Jersey Department of Labor and Workforce Development. Any questions regarding the registration process should be directed to the Division of Wage and Hour Compliance at (609) 292-9464.

3.3 **PUBLIC WORKS CONTRACT - ADDITIONAL AFFIRMATIVE ACTION REQUIREMENTS** - N.J.S.A. 10:5-33 and N.J.A.C. 17:27-3.5 require that during the performance of this contract, the contractor must agree as follows:

a) The contractor or subcontractor, where applicable, will not discriminate against any employee or applicant for employment because of age, race, creed, color, national origin, ancestry, marital status, affectional or sexual orientation, gender identity or expression, disability, nationality or sex. Except with respect to affectional or sexual orientation and gender identity or expression, the contractor will take affirmative action to ensure that such applicants are recruited and employed, and that employees are treated during employment, without regard to their age, race, creed, color, national origin, ancestry, marital status, affectional or sexual orientation, gender identity or expression, disability, nationality or sex. Such action shall include, but not be limited to the following: employment, upgrading, demotion, or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and selection for training, including apprenticeship. The contractor agrees to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the contracting officer setting forth the provisions of this nondiscrimination clause;

b) The contractor or subcontractor, where applicable will, in all solicitations or advertisements for employees placed by or on behalf of the contractor, state that all qualified applicants will receive consideration for employment without regard to age, race, creed, color, national origin, ancestry, marital status, affectional or sexual orientation, gender identity or expression, disability, nationality or sex;

c) The contractor or subcontractor where applicable, will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding, a notice, to be provided by the agency contracting officer, advising the labor union or workers' representative of the contractor's commitments under this act and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

N.J.A.C. 17:27-3.7 requires all contractors and subcontractors, if any, to further agree as follows;

1. The contractor or subcontractor agrees to make good faith efforts to meet targeted county employment goals established in accordance with N.J.A.C. 17:27-5.2.
2. The contractor or subcontractor agrees to inform in writing its appropriate recruitment agencies including, but not limited to, employment agencies, placement bureaus, colleges, universities, and labor unions, that it does not discriminate on the basis of age, race, creed, color, national origin, ancestry, marital status, affectional or sexual orientation, gender identity or expression, disability, nationality or sex, and that it will discontinue the use of any recruitment agency which engages in direct or indirect discriminatory practices.
3. The contractor or subcontractor agrees to revise any of its testing procedures, if necessary, to assure that all personnel testing conforms with the principles of job-related testing, as established by the statutes and court decisions of the State of New Jersey and as established by applicable Federal law and applicable Federal court decisions.
4. In conforming with the targeted employment goals, the contractor or subcontractor agrees to review all procedures relating to transfer, upgrading, downgrading and layoff to ensure that all such actions are taken without regard to age, race, creed, color, national origin, ancestry, marital status, affectional or sexual orientation, gender identity or expression, disability, nationality or sex, consistent with the statutes and court decisions of the State of New Jersey, and applicable Federal law and applicable Federal court decisions.

3.4 **BUILDING SERVICE** – Pursuant to N.J.S.A. 34:11-56.58 et seq., in any contract for building services, as defined in N.J.S.A. 34:11-56.59, the employees of the contractor or subcontractors shall be paid prevailing wage for building services rates, as defined in N.J.S.A. 34:11.56.59. The prevailing wage shall be adjusted annually during the term of the contract.

3.5 **THE WORKER AND COMMUNITY RIGHT TO KNOW ACT** - The provisions of N.J.S.A. 34:5A-I et seq. which require the labeling of all containers of hazardous substances are applicable to this contract. Therefore, all goods offered for purchase to the State must be labeled by the contractor in compliance with the provisions of the statute.

3.6 **SERVICE PERFORMANCE WITHIN U.S.** – Under N.J.S.A. 52:34-13.2, all contracts primarily for services awarded by the Director shall be performed within the United States, except when the Director certifies in writing a finding that a required service cannot be provided by a contractor or subcontractor within the United States and the certification is approved by the State Treasurer.

A shift to performance of services outside the United States during the term of the contract shall be deemed a breach of contract. If, during the term of the contract, the contractor or subcontractor, proceeds to shift the performance of any of the services outside the United States, the contractor shall be deemed to be in breach of its contract, which contract shall be subject to termination for cause pursuant to Section 5.7(b)(1) of the Standard Terms and Conditions, unless previously approved by the Director and the Treasurer.

3.7 **BUY AMERICAN** – Pursuant to N.J.S.A. 52:32-1, if manufactured items or farm products will be provided under this contract to be used in a public work, they shall be manufactured or produced in the United States and the contractor shall be required to so certify.

4. INDEMNIFICATION AND INSURANCE

4.1 **INDEMNIFICATION** - The contractor's liability to the State and its employees in third party suits shall be as follows:

(a) Indemnification for Third Party Claims - The contractor shall assume all risk of and responsibility for, and agrees to indemnify, defend, and save harmless the State of New Jersey and its employees from and against any and all claims, demands, suits, actions, recoveries, judgments and costs and expenses in connection therewith which shall arise from or result directly or indirectly from the work and/or materials supplied under this contract, including liability of any nature or kind for or on account of the use of any copyrighted or uncopyrighted composition, secret process, patented or unpatented invention, article or appliance furnished or used in the performance of this contract.

(b) The contractor's indemnification and liability under subsection (a) is not limited by, but is in addition to the insurance obligations contained in Section 4.2 of these Terms and Conditions.

(c) In the event of a patent and copyright claim or suit, the contractor, at its option, may: (1) procure for the State of New Jersey the legal right to continue the use of the product; (2) replace or modify the product to provide a non-infringing product that is the functional equivalent; or (3) refund the purchase price less a reasonable allowance for use that is agreed to by both parties.

4.2 **INSURANCE** - The contractor shall secure and maintain in force for the term of the contract insurance as provided herein. All required insurance shall be provided by insurance companies with an A- VIII or better rating by A.M. Best & Company. The contractor shall provide the State with current certificates of insurance for all coverages and renewals thereof, and the certificates shall reflect that the insurance policies shall not be canceled for any reason except after sixty (60) days written notice to the State. Certificates of renewals shall be provided within thirty (30) days of the expiration of the insurance. The contractor shall not begin to provide services or goods to the State until evidence of the required insurance is provided. The certificates of insurance shall indicate the contract number or purchase order number and title of the contract in the Description of Operations box and shall list the State of New Jersey, Department of the Treasury, Division of Purchase & Property, Contract Compliance & Audit Unit, PO Box 236, Trenton, New Jersey 08625 in the Certificate Holder box. The certificates and any notice of cancelation shall be emailed to the State at:

ccau.certificate@treas.state.nj.us

The insurance to be provided by the contractor shall be as follows:

a. Occurrence Form Comprehensive General Liability Insurance or its equivalent: The minimum limit of liability shall be $1,000,000 per occurrence as a combined single limit for bodily injury and property damage. The above required Comprehensive General Liability Insurance policy or its equivalent shall name the State, its officers, and employees as "Additional Insureds" and include the blanket additional insured endorsement or its equivalent. The coverage to be provided under these policies shall be at least as broad as that provided by the standard basic, unamended, and unendorsed Comprehensive General Liability Insurance occurrence coverage forms or its equivalent currently in use in the State of New Jersey, which shall not be circumscribed by any endorsement limiting the breadth of coverage.

b. Automobile Liability Insurance which shall be written to cover any automobile used by the insured. Limits of liability for bodily injury and property damage shall not be less than $1 million per occurrence as a combined single limit. The State must be named as an "Additional Insured" and a blanket additional insured endorsement or its equivalent must be provided when the services being procured involve vehicle use on the State's behalf or on State controlled property.

c. Worker's Compensation Insurance applicable to the laws of the State of New Jersey and Employers Liability Insurance with limits not less than:

$1,000,000 BODILY INJURY, EACH OCCURRENCE
$1,000,000 DISEASE EACH EMPLOYEE
$1,000,000 DISEASE AGGREGATE LIMIT

d. This $1 million amount may have been raised by the RFP when deemed necessary by the Director.

e. In the case of a contract entered into pursuant to N.J.S.A. 52:32-17, et.seq., (small business set asides) the minimum amount of insurance coverage in subsections a., b., and c. above may have been lowered in the RFP for certain commodities when deemed in the best interests of the State by the Director.

5. TERMS GOVERNING ALL CONTRACTS

5.1 **CONTRACTOR IS INDEPENDENT CONTRACTOR** – The contractor's status shall be that of any independent contractor and not as an employee of the State.

5.2 **CONTRACT AMOUNT** - The estimated amount of the contract(s), when stated on the RFP form, shall not be construed as either the maximum or minimum amount which the State shall be obliged to order as the result of the RFP or any contract entered into as a result of the RFP.

5.3 **CONTRACT TERM AND EXTENSION OPTION** - If, in the opinion of the Director, it is in the best interest of the State to extend a contract, the contractor shall be so notified of the Director's Intent at least thirty (30) days prior to the expiration date of the existing contract. The contractor shall have fifteen (15) calendar days to respond to the Director's request to extend the term and period of performance of the contract. If the contractor agrees to the extension, all terms and conditions including pricing of the original contract shall apply unless more favorable terms for the State have been negotiated.

5.4 **STATE'S OPTION TO REDUCE SCOPE OF WORK** – The State has the option, in its sole discretion, to reduce the scope of work for any deliverable, task or subtask called for under this contract. In such an event, the Director shall provide to the contractor advance written notice of the change in scope of work and what the

Director believes should be the corresponding adjusted contract price. Within five (5) business days of receipt of such written notice, if either is applicable:

(a) If the contractor does not agree with the Director's proposed adjusted contract price, the contractor shall submit to the Director any additional information that the contractor believes impacts the adjusted contract price with a request that the Director reconsider the proposed adjusted contract price. The parties shall negotiate the adjusted contract price. If the parties are unable to agree on an adjusted contract price, the Director shall make a prompt decision taking all such information into account, and shall notify the contractor of the final adjusted contract price.

(b) If the contractor has undertaken any work effort toward a deliverable, task or subtask that is being changed or eliminated such that it would not be compensated under the adjusted contract, the contractor shall be compensated for such work effort according to the applicable portions of its price schedule and the contractor shall submit to the Director an itemization of the work effort already completed by deliverable, task or subtask within the scope of work, and any additional information the Director may request. The Director shall make a prompt decision taking all such information into account, and shall notify the contractor of the compensation to be paid for such work effort.

5.5 **CHANGE IN LAW** – Whenever a change in applicable law or regulation affects the scope of work, the Director shall provide written notice to the contractor of the change and the Director's determination as to the corresponding adjusted change in the scope of work and corresponding adjusted contract price. Within five (5) business days of receipt of such written notice, if either is applicable:

(a) If the contractor does not agree with the adjusted contract price, the contractor shall submit to the Director any additional information that the contractor believes impacts the adjusted contract price with a request that the Director reconsider the adjusted contract price. The Director shall make a prompt decision taking all such information into account, and shall notify the contractor of the final adjusted contract price.

(b) If the contractor has undertaken any work effort toward a deliverable, task or subtask that is being changed or eliminated such that it would not be compensated under the adjusted contract, the contractor shall be compensated for such work effort according to the applicable portions of its price schedule and the contractor shall submit to the Director an itemization of the work effort already completed by deliverable, task or subtask within the scope of work, and any additional information the Director may request. The Director shall make a prompt decision taking all such information into account, and shall notify the contractor of the compensation to be paid for such work effort.

5.6 **SUSPENSION OF WORK** - The State may, for valid reason, issue a stop order directing the contractor to suspend work under the contract for a specific time. The contractor shall be paid for goods ordered, goods delivered, or services requested and performed until the effective date of the stop order. The contractor shall resume work upon the date specified in the stop order, or upon such other date as the State Contract Manager may thereafter direct in writing. The period of suspension shall be deemed added to the contractor's approved schedule of performance. The Director shall make an equitable adjustment, if any is required, to the contract price. The contractor shall provide whatever information that Director may require related to the equitable adjustment.

5.7 **TERMINATION OF CONTRACT**

a. For Convenience

Notwithstanding any provision or language in this contract to the contrary, the Director may terminate this contract at any time, in whole or in part, for the convenience of the State, upon no less than thirty (30) days written notice to the contractor.

b. For Cause

1. Where a contractor fails to perform or comply with a contract or a portion thereof, and/or fails to comply with the complaints procedure in N.J.A.C. 17: 12-4.2 et seq., the Director may terminate the contract, in whole or in part, upon ten (10) days notice to the contractor with an opportunity to respond.

2. Where in the reasonable opinion of the Director, a contractor continues to perform a contract poorly as demonstrated by e.g., formal complaints, late delivery, poor performance of service, short-shipping, so that the Director is required to use the complaints procedure in N.J.A.C. 17:12-4.2 et seq., and there has been a failure on the part of the contractor to make progress towards ameliorating the issue(s) or problem(s) set forth in the complaint, the Director may terminate the contract, in whole or in part, upon ten (10) days notice to the contractor with an opportunity to respond.

c. In cases of emergency the Director may shorten the time periods of notification and may dispense with an opportunity to respond.

d. In the event of termination under this section, the contractor shall be compensated for work performed in accordance with the contract, up to the date of termination. Such compensation may be subject to adjustments.

5.8 SUBCONTRACTING OR ASSIGNMENT –

a. Subcontracting: The contractor may not subcontract other than as identified in the contractor's proposal without the prior written consent of the Director. Such consent, if granted in part, shall not relieve the contractor of any of his responsibilities under the contract, nor shall it create privity of contract between the State and any subcontractor. If the contractor uses a subcontractor to fulfill any of its obligations, the contractor shall be responsible for the subcontractor's: (a) performance; (b) compliance with all of the terms and conditions of the contract; and (c) compliance with the requirements of all applicable laws.

b. Assignment: The contractor may not assign its responsibilities under the contract, in whole or in part, without the prior written consent of the Director.

5.9 NO CONTRACTUAL RELATIONSHIP BETWEEN SUBCONTRACTORS AND STATE - Nothing contained in any of the contract documents, including the RFP and vendor's bid or proposal shall be construed as creating any contractual relationship between any subcontractor and the State.

5.10 MERGERS, ACQUISITIONS - If, during the term of this contract, the contractor shall merge with or be acquired by another firm, the contractor shall give notice to the Director as soon as practicable and in no event longer than thirty (30) days after said merger or acquisition. The contractor shall provide such documents as may be requested by the Director, which may include but need not be limited to the following: corporate resolutions prepared by the awarded contractor and new entity ratifying acceptance of the original contract, terms, conditions and prices; updated information including ownership disclosure and Federal Employer Identification Number. The documents must be submitted within thirty (30) days of the request. Failure to do so may result in termination of the contract for cause.

If, at any time during the term of the contract, the contractor's partnership, limited liability company, limited liability partnership, professional corporation, or corporation shall dissolve, the Director must be so notified. All responsible parties of the dissolved business entity must submit to the Director in writing, the names of the parties proposed to perform the contract, and the names of the parties to whom payment should be made. No payment shall be made until all parties to the dissolved business entity submit the required documents to the Director.

5.11 PERFORMANCE GUARANTEE OF CONTRACTOR - The contractor hereby certifies that:

a. The equipment offered is standard new equipment, and is the manufacturer's latest model in production, with parts regularly used for the type of equipment offered; that such parts are all in production and not likely to be discontinued; and that no attachment or part has been substituted or applied contrary to manufacturer's recommendations and standard practice.

b. All equipment supplied to the State and operated by electrical current is UL listed where applicable.

c. All new machines are to be guaranteed as fully operational for the period stated in the contract from time of written acceptance by the State. The contractor shall render prompt service without charge, regardless of geographic location.

d. Sufficient quantities of parts necessary for proper service to equipment shall be maintained at distribution points and service headquarters.

e. Trained mechanics are regularly employed to make necessary repairs to equipment in the territory from which the service request might emanate within a 48-hour period or within the time accepted as industry practice.

f. During the warranty period the contractor shall replace immediately any material which is rejected for failure to meet the requirements of the contract.

g. All services rendered to the State shall be performed in strict and full accordance with the specifications stated in the contract. The contract shall not be considered complete until final approval by the State's using agency is rendered.

5.12 DELIVERY REQUIREMENTS -

a. Deliveries shall be made at such time and in such quantities as ordered in strict accordance with conditions contained in the contract.

b. The contractor shall be responsible for the delivery of material in first class condition to the State's using agency or the purchaser under this contract and in accordance with good commercial practice.

c. Items delivered must be strictly in accordance with the contract.

d. In the event delivery of goods or services is not made within the number of days stipulated or under the schedule defined in the contract, the using agency shall be authorized to obtain the material or service from any available source, the difference in price, if any, to be paid by the contractor.

5.13 **APPLICABLE LAW AND JURISDICTION** - This contract and any and all litigation arising therefrom or related thereto shall be governed by the applicable laws, regulations and rules of evidence of the State of New Jersey without reference to conflict of laws principles and shall be filed in the appropriate Division of the New Jersey Superior Court.

5.14. **CONTRACT AMENDMENT** – Except as provided herein, the contract may only be amended by written agreement of the State and the contractor.

5.15 **MAINTENANCE OF RECORDS** - The contractor shall maintain records for products and/or services delivered against the contract for a period of five (5) years from the date of final payment unless otherwise specified in the RFP. Such records shall be made available to the State, including the Comptroller, for audit and review.

5.16 **ASSIGNMENT OF ANTITRUST CLAIM(S)** - The contractor recognizes that in actual economic practice, overcharges resulting from antitrust violations are in fact usually borne by the ultimate purchaser. Therefore, and as consideration for executing this contract, the contractor, acting herein by and through its duly authorized agent, hereby conveys, sells, assigns, and transfers to the State of New Jersey, for itself and on behalf of its political subdivisions and public agencies, all right, title and interest to all claims and causes of action it may now or hereafter acquire under the antitrust laws of the United States or the State of New Jersey, relating to the particular goods and services purchased or acquired by the State of New Jersey or any of its political subdivisions or public agencies pursuant to this contract.

In connection with this assignment, the following are the express obligations of the contractor:

a. It shall take no action that will in any way diminish the value of the rights conveyed or assigned hereunder.

b. It shall advise the Attorney General of New Jersey:
   1. in advance of its intention to commence any action on its own behalf regarding any such claim or cause(s) of action;
   2. immediately upon becoming aware of the fact that an action has been commenced on its behalf by some other person(s) of the pendency of such action.

c. It shall notify the defendants in any antitrust suit of the within assignment at the earliest practicable opportunity after the contractor has initiated an action on its own behalf or becomes aware that such an action has been filed on its behalf by another person. A copy of such notice shall be sent to the Attorney General of New Jersey.

d. It is understood and agreed that in the event any payment under any such claim or cause of action is made to the contractor, it shall promptly pay over to the State of New Jersey the allotted share thereof, if any, assigned to the State hereunder.

6. TERMS RELATING TO PRICE AND PAYMENT

6.1 **PRICE FLUCTUATION DURING CONTRACT** - Unless otherwise agreed to in writing by the State, all prices quoted shall be firm through issuance of contract or purchase order and shall not be subject to increase during the period of the contract.

In the event of a manufacturer's or contractor's price decrease during the contract period, the State shall receive the full benefit of such price reduction on any undelivered purchase order and on any subsequent order placed during the contract period. The Director must be notified, in writing, of any price reduction within five (5) days of the effective date.

Failure to report price reductions may result in cancellation of contract for cause, pursuant to provision 5.7(b)1.

6.2 **TAX CHARGES** - The State of New Jersey is exempt from State sales or use taxes and Federal excise taxes. Therefore, price quotations must not include such taxes. The State's Federal Excise Tax Exemption number is 22-75-0050K.

6.3 **PAYMENT TO VENDORS** -

a. The using agency(ies) is (are) authorized to order and the contractor is authorized to ship only those items covered by the contract resulting from the RFP. If a review of orders placed by the using agency(ies) reveals that goods and/or services other than that covered by the contract have been ordered and delivered, such delivery shall be a violation of the terms of the contract and may be considered by the Director as a basis to terminate the contract and/or not award the contractor a subsequent contract. The Director may take such steps as are necessary to have the items returned by

the agency, regardless of the time between the date of delivery and discovery of the violation. In such event, the contractor shall reimburse the State the full purchase price.

b. The contractor must submit invoices to the using agency with supporting documentation evidencing that work or goods for which payment is sought has been satisfactorily completed or delivered. For commodity contracts, the invoice, together with the original Bill of Lading, express receipt and other related papers must be sent to the State Contract Manager or using agency on the date of each delivery. For contracts featuring services, invoices must reference the tasks or subtasks detailed in the Scope of Work section of the RFP and must be in strict accordance with the firm, fixed prices submitted for each task or subtask on the RFP pricing sheets. When applicable, invoices should reference the appropriate RFP price sheet line number from the contractor's bid proposal. All invoices must be approved by the State Contract Manager or using agency before payment will be authorized.

c. In all time and materials contracts, the State Contract Manager or designee shall monitor and approve the hours of work and the work accomplished by contractor and shall document both the work and the approval. Payment shall not be made without such documentation. A form of timekeeping record that should be adapted as appropriate for the Scope of Work being performed can be found at www.nj.gov/treasury/purchase/forms/Vendor_Timesheet.xls.

d The contractor shall provide, on a monthly and cumulative basis, a breakdown in accordance with the budget submitted, of all monies paid to any small business, minority or woman-owned subcontractor(s). This breakdown shall be sent to the Chief of Operations, Division of Revenue, P.O. Box 628, Trenton, NJ 08646.

6.4 **OPTIONAL PAYMENT METHOD: P-CARD** - The State offers contractors the opportunity to be paid through the MasterCard procurement card (p-card). A contractor's acceptance and a State agency's use of the p-card are optional. P-card transactions do not require the submission of a contractor invoice; purchasing transactions using the p-card will usually result in payment to a contractor in three (3) days. A contractor should take note that there will be a transaction-processing fee for each p-card transaction. To participate, a contractor must be capable of accepting the MasterCard. Additional information can be obtained from banks or merchant service companies.

6.5 **NEW JERSEY PROMPT PAYMENT ACT** - The New Jersey Prompt Payment Act, N.J.S.A. 52:32-32 et seq., requires state agencies to pay for goods and services within sixty (60) days of the agency's receipt of a properly executed State Payment Voucher or within sixty (60) days of receipt and acceptance of goods and services, whichever is later. Properly executed performance security, when required, must be received by the State prior to processing any payments for goods and services accepted by state agencies. Interest will be paid on delinquent accounts at a rate established by the State Treasurer. Interest shall not be paid until it exceeds $5.00 per properly executed invoice.

Cash discounts and other payment terms included as part of the original agreement are not affected by the Prompt Payment Act.

6.6 **AVAILABILITY OF FUNDS** – The State's obligation to make payment under this contract is contingent upon the availability of appropriated funds and receipt of revenues from which payment for contract purposes can be made. No legal liability on the part of the State for payment of any money shall arise unless and until funds are appropriated each fiscal year to the using agency by the State Legislature and made available through receipt of revenues.

VII. **We, the undersigned, consent to the contents of this Agreement.**

New Jersey Department of Human Services:

Signature: _____ 2/25/13
Lynn Kovich Date
Assistant Commissioner, Division of Mental Health and Addiction Services

Rutgers, the State University of New Jersey:

Signature: _____ 1/29/13
Sheryl N. Goldberg, Director Date
Office of Research and Sponsored Programs
Rutgers, The State University of New Jersey
3 Rutgers Plaza, ASB III 2nd Floor
New Brunswick, NJ 08901-8559

MEMORANDUM OF AGREEMENT

BETWEEN

THE NEW JERSEY DEPARTMENT OF HUMAN SERVICES (NJDHS)
DIVISION OF MENTAL HEALTH & ADDICTION SERVICES (DMHAS)

AND

RUTGERS, THE STATE UNIVERSITY OF NEW JERSEY, SCHOOL OF SOCIAL WORK, OFFICE OF CONTINUING EDUCATION

FOR

THE PROVISION OF A PROGRAM OF EDUCATION LEADING TO THE

RUTGERS SCHOOL OF SOCIAL WORK
CERTIFICATE IN COMMUNITY-BASED PLANNING

WHEREAS the New Jersey Department of Human Services (NJDHS), Division of Mental Health & Addiction Services (DMHAS) and Rutgers, The State University of New Jersey, School of Social Work, Office of Continuing Education (OCE), wish to provide education, training, and technical assistance to professional behavioral healthcare planners, including but not limited to county alcoholism and drug abuse directors, in the State of New Jersey, leading to THE RUTGERS SCHOOL OF SOCIAL WORK CERTIFICATE IN COMMUNITY-BASED PLANNING; and

WHEREAS the NJDHS/DMHAS has the statutory authority under its federal block grant to plan, develop, and administer training programs to meet the needs of state, county, and municipal planning administrators and citizens; and

WHEREAS the NJDHS/DMHAS as part of its on-going responsibility to address areas of concern that affect service access, quality, and outcomes by enhancing the competency of its addiction and behavioral healthcare planning workforce by providing educational opportunities for credentialing and specialization,

NOW, THEREFORE, THE PARTIES HERETO AGREE AS FOLLOWS:

I. Under this Agreement, the NJDHS/DMHAS, is hereafter referred to as **"the Funding Agency"** and Rutgers, The State University of New Jersey, School of Social Work, Office of Continuing Education, is hereafter referred to as "**the Service Provider Agency.**"

II. **Obligations and Rights of Funding Agency**

(A.) **NJDHS/DMHAS Obligations**

All of the requirements of this section apply to **the Funding Agency**:

1. The NJDHS/DMHAS shall provide funding in an amount not to exceed $99,587. Payment is contingent upon the satisfactory delivery of up to three education, training, and technical assistance programs for cohorts of 30 participants each as 1) identified by DMHAS and b) described in Service Provider's proposal dated September 13, 2012 which is incorporated in its entirety herewith by reference.

   Payment obligations, as well as reporting and monitoring requirements, and other

conditions of this agreement, are contained in "A," and incorporated herewith by reference. Payments shall be made in accordance with the provisions A Section I. Payments will be made for approved budget costs, contained in B, incorporated herein by reference.

2. The NJDHS/DMHAS shall monitor the progress of this project to ensure that services are being provided in accordance with Section III (A), which establishes the work products that must be completed in order for funds to be provided, and the time-lines for completion. All financial, performance and MOA monitoring requirements are contained in "A," sections II, III and IV. Phone contact and email correspondence occur as needed. The Parties recognize and agree that this Agreement is expressly dependent upon the availability of DHS/DMHAS funding. The DHS/DMHAS shall not be held liable for any termination of this agreement due to the absence of available funding appropriations.

3. In addition to the above, the **Funding Agency** is required to abide by all general requirements contained in Sections IV and V of this Agreement.

(B.) NJDHS/DMHAS Rights

All of the rights outlined in this section are applicable to the **Funding Agency**.

1. **Audit:**

The **Funding Agency** shall have the right to at any time audit any and all accounts and/or records maintained by the recipient of these funds. To effectuate this provision, the funding agency shall be afforded, during normal business hours, access to all records and/or data of the **Service Provider Agency** indicated in Section III, which pertain to this Agreement. The provisions of this subparagraph shall continue for a period of seven years after the submission and acceptance of the financial and programmatic reports required under this Agreement. The following are applicable to this MOA:

2. **Work Product:**

All data, technical information, materials gathered, originated, developed, prepared, used or obtained in the performance of the requested services, including but not limited to, all papers, reports, surveys, plans, charts, records, analyses or publications produced for or as a result of this Agreement shall bear an acknowledgment of the support of the **Funding Agency**. No work product produced utilizing funds or data obtained under this Agreement shall be released to the public without the prior written consent of the **Funding Agency**. The **Funding Agency** shall have the right to add any disclaimers to said work product as it, in its sole discretion, deems appropriate. Further, the **Funding Agency** shall have the right, in collaboration with the **Service Provider Agency**, to add co-authorship to said work product in reflection of its collaboration with the **Service Provider Agency** on the various elements of the research effort as set forth in the aforementioned Item II, (A.), paragraph 3. Finally, the **Funding Agency** shall have the right to edit said work product as long as the edits do not, in the professional opinion of the **Service Provider Agency**, infringe upon the integrity of the work product itself.

3. **Other Rights of Funding Agency:**

NJDHS/DMHAS reserves the right to screen a list of staff retained to complete the scope of work described in this agreement to ensure that there are no real or perceived conflicts of interest for individuals employed under this contract.

III. Obligations and Rights of Service Provider Agency

(A.) Rutgers, The State University of New Jersey, School of Social Work, Office of Continuing Education:

All of the requirements of this section apply to the **Service Provider Agency**:

1. shall provide all services referenced in the aforementioned proposal establishes the service deliverables that this agency must perform, in accordance with the timeframes established for each item in Sections III (A) 4 and III (A) 5;
1. will adhere to the budget requirements as detailed in the approved cost proposal and as contained in B;
2. shall be required to submit expenditure, progress and final reports and state invoices in accordance with the requirements of A included in this MOA;
3. shall be required to maintain all participant records electronically in perpetuity;

(B.) Scope of services to be provided. In exchange for funding provided by the **Funding Agency** indicated in Section II (A), the **Service Provider Agency** agrees to perform the following as excerpted from the aforementioned proposal in each of three potential offerings:

1. Provide a combined in-class & online comprehensive learning experience to enhance the knowledge and skills of those working as county Alcoholism and Drug Abuse Directors in the State of New Jersey. The Certificate will cover foundational knowledge and instill professional level skills as required for competent planning practice.
2. The Certificate will be awarded upon satisfactory completion of a program consisting of five required in-class workshops, five companion online modules and an individualized planning project with technical assistance provided by the program faculty.
3. The curriculum and subject matter presented in the workshops and online modules will be developed, moderated and delivered by instructors with recognized expertise in community-based comprehensive behavioral health care planning, and with contributions and recommendations of **the funding agency** as well as participants in the program.
4. OCE will supply all learning materials and audiovisual equipment for each workshop, except when workshops are held at Department of Human Services facilities located in Trenton, in which case, DMHAS will supply, set up and break down audiovisual equipment only.
5. OCE will distribute a confidential evaluation tool co-designed by **the funding agency** to collect evaluation information at the conclusion of each workshop. The analysis of the collected information will be shared in confidence with the DMHAS.

6. Upon successful completion of each workshop, participants will receive a certificate in community-based behavioral health planning suitable for framing from Rutgers, The State University of New Jersey, School of Social Work, Office of Continuing Education.
7. The in-class training will be held at a location in New Jersey arranged by the Funding Agency and that best accommodates participants from the northern, southern, eastern and western parts of the state. Each workshop will hold a maximum of 30 participants. Each in-class workshop is designed to be delivered over a six-hour time period including breaks and lunch.

(C.) Timeframe for Performance of Service Deliverables: This section contains the timetable for each of the services referenced by the proposal and indicated in Section III (B).

The **Service Provider Agency** agrees that the service deliverables referenced by the proposal and indicated in Section III (B) will be performed by the corresponding date or time period indicated in Section III (C) for an initial cohort of no more than 30 participants:

1. February 28, 2013 to April 30, 2013, **the Service Provider,** with the assistance of **the Funding Source,** will assess student's needs, develop the curriculum for the 5 proposed in-class workshops and online companion modules, schedule classes at a specific, centrally-located facility, and register participants. The standards for successful completion of the coursework will be established independently by **the Service Provider** who will, nevertheless, consider the recommendations of **the Funding Source.**

2. May 1, 2013 to October 31, 2013. The in-class certificate workshops will be provided monthly and each workshop will last 6 hours on a single day. The online companion modules for each workshop will be available no later than the date of each in-class workshop and will be available for the duration of the training period. Following completion of the workshop series, overall program evaluation will be conducted and certificates of successful completion will be awarded.

(D) Additional Service Provision (overlapping or sequential) 5/01/13 – 6/30/14

1. The **Service Provider Agency** will provide the services both referenced and described in Section III for a maximum of two additional cohorts of participants, the composition of which will be established by **the Funding Agency** who will, nevertheless, consider the recommendations of **the Service Provider.** The **Funding Agency** will determine the timing of the two additional program offerings by mutual agreement with the **Funding Agency**.

2. In addition to the above, the **Service Provider Agency** is required to abide by all general requirements contained in Sections IV and V of this Agreement.

(E.) Rutgers, The State University of New Jersey, School of Social Work, Office of Continuing Education rights:

All of the rights of this section apply to the **Service Provider Agency**:

IV. General Provisions

(A.) Mandatory General Provisions

1. During the term of this Agreement, **both parties** shall comply with all federal, state and municipal laws, rules and regulations generally applicable to the activities performed pursuant to this Agreement. The award of funds is based on the **Service Provider Agency's** submission, and the Funding Agency's acceptance, of a Cost Proposal, which is incorporated herewith by reference to this Agreement.

2. **Each party** shall maintain accurate books and records of all disbursements, funds received, funds spent and funds available as a result of this Agreement.

3. **Each of the parties** is an independent entity and neither party shall hold itself out as an agent, partner or representative of the other.

4. Failure by either party to exercise any right or demand performance of any obligation under this Agreement shall not be deemed a waiver of such right or obligation.

5. If any of the provisions of this Agreement are, or become invalid, to any extent, the other provisions of this Agreement shall not be affected thereby. In the event of the invalidity of a provision, the parties agree to accept a provision that reflects as closely as possible the intention of the invalid provision.

6. This Agreement may not be assigned without prior written consent of the NJDHS/DMHAS.

7. The laws of the State of New Jersey govern this agreement.

8. This agreement may be modified in accordance with the provisions of A III.

(B.) Optional General Provisions

Not Applicable	Applicable	
☐	☒	The **Funding Agency** reserves a royalty-free, nonexclusive, and irrevocable license to reproduce, publish or otherwise use, and to authorize others to use, the copyright in any work developed under the Agreement.
☐	☒	The parties agree that all data resulting from this Agreement are to be considered confidential and shall be solely used for the purposes as outlined above. All parties are required to use reasonable care to protect the confidentiality of the data.
☐	☒	The **Provider Agency,** upon the consent of the **Funding Agency**, shall have a right, at its own expense, to reproduce and offer the proposed education, training and technical assistance program, referenced in detail in Section III.A above, for additional cohorts of trainees beyond the three referenced in this agreement.

V. Terms and Termination

(A.) Subject to any rights of termination hereinafter set forth, this Agreement shall become effective on February 28, 2013 and shall remain valid through June 30, 2014.

(B.) This Agreement may be terminated by either party with or without cause upon thirty (30) days advance written notice.

(C.) Notice of termination shall be delivered via U.S. mail, return receipt requested, and shall be effective upon receipt. Notice shall be sent to the appropriate contact person identified at Section VI.

(D.) Upon the issuance of notice of termination by the **Funding Agency** or, automatic termination under Section V(B), upon receipt of the **Funding Agency's** notice of termination, all unexpended funds appropriated by the **Funding Agency** to the **Service Provider Agency**, in any account whatsoever shall be immediately returned to the **Funding Agency** through the contact person identified at Section VI without any further assessment or expenditure except as specifically approved by the **Funding Agency** in writing.

VI. Principal Contacts

The principal contacts for all notifications required or otherwise necessary under this Agreement shall be as follows:

For the New Jersey Department of Human Services/Division Mental Health & Addiction Services:

Program Officer
Suzanne Borys, Ed.D.
Director of the Office of Research, Planning and Evaluation (ORPE)
Division of Mental Health & Addiction Services
222 S. Warren St., 4th Floor; P.O. Box 362
Trenton, NJ 08625-0362

Fiscal Officer
Steven J. Adams
Chief Financial Officer
Division of Mental Health & Addiction Services
222 S. Warren St., 3rd Floor; P.O. Box 362
Trenton, NJ 08625-0362

For Rutgers, The State University of New Jersey, School of Social Work, Office of Continuing Education:

Program Officer
Doug Behan, LCSW
Director of Continuing Education
Institute for Families
School of Social Work
Rutgers, The State University of New Jersey
390 George St., 6th Floor
New Brunswick, NJ 08901

Fiscal Officer
Christina Maggio, MBA
Business Manager
School of Social Work
Rutgers, The State University of New Jersey
536 George Street
New Brunswick, NJ 08901-1167

VII. We, the undersigned, consent to the contents of this Agreement.

New Jersey Department of Human Services/Division Mental Health & Addiction Services:

Signature: _____ _____
Date

Lynn Kovich
Assistance Commissioner
Division of Mental Health & Addiction Services
222 S. Warren St., 4th Floor; P.O. Box 362
Trenton, NJ 08625-0362

For Rutgers, The State University of New Jersey, School of Social Work, Office of Continuing Education

Signature: _____ 2/13/12

Sheryl Goldberg, Director,
Office of Research and Sponsored Programs,
Rutgers - The State University of New Jersey,
3 Rutgers Plaza,
New Brunswick, NJ 08901

ANNEX A

ANNEX A is attached and herein incorporated to and provides for additional provisions and conditions between the New Jersey Department of Human Services (DHS)/Division of Mental Health & Addiction Services (DAS) and Rutgers, The State University of New Jersey, School of Social Work, Office of Continuing Education, for a Memorandum of Agreement entitled " CERTIFICATE IN COMMUNITY-BASED PLANNING."

I. Method of Payment

Cost reimbursement payments shall be made by the Funding Agency on the following basis:

- ☐ Monthly
- ☒ Quarterly
- ☐ Lump Sum
- ☐ Based on submission of the following reports (Please describe below)

The final payment will be withheld pending receipt of final course evaluation reports.

II. Financial and Performance Reporting and MOA Monitoring

(Circle, check and complete as applicable)

A. Expenditure reports are required. If applicable, these will be submitted, by the Service Provider agency no later than days after the end of each
☐ Monthly ☒ Quarterly ☐ Final ☐ Other reporting period.

B. Narrative reports are required. These reports shall be in the form specified by the Funding Agency and shall be submitted on a
☐ Monthly ☒ Quarterly ☐ Final ☐ Other report period.

C. The Funding Agency conducts technical assistance meetings with the Service Provider Agency on the following basis:
☒ Initial ☒ Monthly ☐ Quarterly ☐ Final ☐ Other (Describe)

D. Other Financial, Reporting or Monitoring Requirements

1. Particular forms are required to be utilized. If applicable, these are attached.

III. Modifications to the Agreement

This document represents the entire Agreement between the parties and shall not be amended except by the express written consent of both parties, except as stated herein:

1. MOA extensions may not be made to this agreement. If allowed, approval may be granted by the Program Management Officer and Fiscal Officer identified in Section VI.

2. Budget revisions may be made to this agreement. If allowed, approval may be granted by the Program Management Officer and Fiscal Officer identified in Section VI.

3. Modifications to Subsection III of the MOA, regarding service deliverables to be performed under Section III. (A.) may be made with the approval of the Program Management Officer identified in Section VI.

IV. Special Conditions (as applicable)

1. This MOA includes no special conditions.

V. Multi-Year Agreements

This is a multi-year MOA.

B

ANNEX B is attached and herein incorporated to and provides a description of the budget/cost proposal for the Memorandum of Agreement between the New Jersey Department of Human Services/Division of Mental Health & Addiction Services and Rutgers, The State University of New Jersey, School of Social Work, Office of Continuing Education, entitled "Certificate Program in Community-Based Planning."

Brief Budget Explanation

The funds authorized under this MOA will be used to pay program expenses as outlined in the attached budget.

Certificate Program in Community-Based Planning

Program Development and Initial Offering of Certificate Program
February 15, 2013 – February 14, 2014

Category			Work Effort	Costs
A: Salary and Wages				
Personnel				
Annual Salary				
Administrator	$78,055		20%	$15,611
Program Coordinator	$43,860		10%	$4,386
		Total Salaries		**$19,997**
Fringe				
Full-Time Fringe (38.2%)				$7,639
		Total Fringe		**$7,639**
		Subtotal Wages and Salary		**$27,635**
B: Direct Expenses				
Consultants and Professional Services				
Curriculum Development & Instructional Delivery				$24,200
Project Supplies				
Postage				$300
Supplies				$2,000
Travel				
Travel				$300
		Subtotal Direct Expenses		**$26,800**
Facilities & Administration - 10%				$5,444
TOTAL COSTS				**$59,879**

*Based on 30 participants

Cost Per Additional Run of the Certificate Program				
A: Salary and Wages				
Personnel				
Annual Salary				
Administrator	$78,055		5%	$3,903
Program Coordinator	$43,860		5%	$2,193
		Total Salaries		**$6,096**
Fringe				
Full-Time Fringe (38.2%)				$2,329
		Total Fringe		**$2,329**
		Subtotal Wages and Salary		**$8,424**
B: Direct Expenses				
Consultants and Professional Services				
Curriculum Adjustments, Consultation & Instructional Delivery				$7,025
Project Supplies				
Postage				$300
Supplies				$2,000
Travel				
Travel				$300
		Subtotal Direct Expenses		**$9,625**
Facilities & Administration - 10%				$1,805
TOTAL COSTS				**$19,854**
Total Cost per Participant, *Based on 30 participants				**$662**

TOTAL SUMMARY OF ALL COSTS

Certificate Program in Community-Based Planning
Program Development and Initial Offering of Certificate Program
February 28, 2013 –June 30, 2014

Total Cost Program Development and Initial Offering of Certificate Program	**$59,879**
Cost of second additional run of Certificate Program	**19,854**
Cost of third run of Certificate Program	**19,854**
TOTAL COSTS	**$ 99,587**

MEMORANDUM OF AGREEMENT
RUTGERS, THE STATE UNIVERSITY
SCHOOL OF SOCIAL WORK
CERTIFICATE PROGRAM IN COMMUNITY-BASED PLANNING
MODIFICATIONS TO ATTACHED STANDARD TERMS AND CONDITIONS

Paragraph 4.1 (a) is replaced by the following: Between the DHS/DMHAS and Rutgers University (RU), the DHS/DMHAS, subject to the provisions of the New Jersey Tort Claims Act and the New Jersey Contractual Liability Act, shall be responsible for, and shall at its own expense, defend itself against any and all suits, claims, losses, demands or damages of whatsoever kind or nature, arising out of or in connection with any act or omission of the DHS/DMHAS, its employees, agents or contractors, in the performance of the obligations assumed by the DHS/DMHAS pursuant to this MOA. The DHS/DMHAS hereby releases RU from any and all liabilities, claims, losses, costs, expenses and demands of any kind or nature whatsoever, arising under State or Federal law, solely out of or in connection with the DHS/DMHAS' s performance of the obligations assumed by the DHS/DMHAS pursuant to the MOA.

4.1(b) is replaced by the following: Between the DHS/DMHAS and RU, RU, subject to the provisions of the New Jersey Tort Claims Act and the New Jersey Contractual Liability Act, shall be responsible for, and shall at its own expense, defend itself against any and all suits, claims, losses, demands or damages of whatsoever kind or nature, arising out of or in connection with any act or omission of RU, its employees, agents or contractors, in the performance of the obligations assumed by RU pursuant to this MOA. RU hereby releases the DHS/DMHAS from any and all liabilities, claims, losses, costs, expenses and demands of any kind of nature whatsoever, arising under State of Federal law, solely out of or in connection with RU's performance of the obligations assumed by RU to this MOA.

Changes to paragraph 4.2 are as follows:

1. 60 (sixty) days is replaced by 30 (thirty) days
2. 4.2(a) changes the words "name(d)" to "include(d)"

Changes to 4.2(c) adding the self-insurance for worker's compensation and commercially purchased Employer Liability insurance

VII. We, the undersigned, consent to the contents of this Agreement.

New Jersey Department of Human Services/Division Mental Health & Addiction Services:

Signature: _____ 2/28/13
Date

Lynn Kovitch
Assistance Commissioner
Division of Mental Health & Addiction Services
222 S. Warren St., 4th Floor; P.O. Box 362
Trenton, NJ 08625-0362

For Rutgers, The State University of New Jersey, School of Social Work, Office of Continuing Education

Signature: _____ 2/15/13
Date

Sheryl Goldberg, Director
Office of Research and Sponsored Programs
Rutgers - The State University of New Jersey
3 Rutgers Plaza
New Brunswick, NJ 08901

IV: Narrative Plan

W. State Behavioral Health Advisory Council

Narrative Question:

Each state is required to establish and maintain a state Behavioral Health Advisory Council (Council) for services for individuals with a mental disorder. While many states have established a similar Council for individuals with a substance use disorders, that is not required. SAMHSA encourages states to expand their required Council's comprehensive approach by designing and use the same Council to review issues and services for persons with, or at risk of, substance abuse and substance use disorders. In addition to the duties specified under the MHBG statute, a primary duty of this newly formed Council will be to advise, consult with, and make recommendations to SMHAs and SSAs regarding their activities. The Council must participate in the development of the MHBG state plan and is encouraged to participate in monitoring, reviewing, and evaluating the adequacy of services for individuals with substance abuse and mental disorders within the state. SAMHSA's expectation is that the State will provide adequate guidance to the Council to perform their review consistent with the expertise of the members on the Council. States are strongly encouraged to include American Indians and/or Alaska Natives in the Council; however, their inclusion does not suffice as tribal consultation. In the space below describe how the state's Council was actively involved in the plan. Provide supporting documentation regarding this involvement (e.g., meeting minutes, letters of support, etc.)

Additionally, please complete the following forms regarding the membership of your state's Council. The first form is a list of the Council members for the state and second form is a description of each member of the Council.

There are strict state Council membership guidelines. States must demonstrate (1) that the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council and (2) that no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services. States must consider the following questions:

- What planning mechanism does the state use to plan and implement substance abuse services?
- How do these efforts coordinate with the SMHA and its advisory body for substance abuse prevention and treatment services?
- Was the Council actively involved in developing the State BG Plan? If so, please describe how it was involved.
- Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into the work of the Council?
- Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?
- Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families and other important stakeholders.

Footnotes:

W. State Behavioral Health Advisory Council

Prior to the enactment of the Federal mandate governing State Planning Councils, the New Jersey Community Mental Health Services Act (10:37-2.1), Chapter 37, established the New Jersey Mental Health Planning Council (hereinafter the Planning Council) as the *State Community Mental Health Citizen's Advisory Board.* Subchapter 2 of the Act describes the requirements for membership, function, power to establish committees and scope of authority. In 2003, the Planning Council updated its bylaws, with assistance from the DMHAS' legal counsel, to ensure the Planning Council's composition, purpose, principles and mission were in accordance with the federal requirements for Planning Councils. The State Ethics Commission met on October 10, 2012 with the Planning Council to facilitate compliance with the State Uniform Ethics Code.

Membership:
Members of the Community Mental Health Citizen's Advisory Board are appointed by the Governor of New Jersey. Planning Council members are appointed by Assistant Commissioner of the DMHAS. The Advisory Board and the Planning Council function together as the New Jersey Community Mental Health Planning Council. The Planning Council's membership is geographically representative of the State, and reflects the diversity of the State. A mandated minimum of 50% of the members of the Planning Council are mental health consumers, family members of adults with serious mental illnesses (SMI), family members of children with severe emotional disturbances (SED) or other non-state or provider members.

In light of the merger of the State Mental Health Authority (SMHA) and the Single State Authority on substance abuse (SSA), as well as recommendations from the Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Mental Health Services as well as Center for Substance Abuse Treatment, the Planning Council has worked to broaden the membership to include more individuals in addiction recovery and those with co-occurring disorders. The membership includes individuals in recovery from co-occurring disorders, recovery from addiction, providers who offer both mental health and addiction services, as well as tobacco and addiction prevention expertise, and a representative from the County Drug and Alcohol Association. In addition, a member of the SSA's Citizen's Advisory Council (CAC), which consists of consumers of addiction services as well as individuals in substance abuse recovery and family members, is an active member of the Planning Council. A notice of the call for new members in addiction recovery is available online (http://www.state.nj.us/humanservices/dmhs/boards/planning_council.html) and continues to be circulated among the addiction providers and consumer agencies to generate additional members.

Additionally, the Planning Council has representation from mental health providers, local and nongovernmental agencies, State agencies and other major stakeholders concerned with the provision and need for services, planning, operation, funding, and use of mental health services and related services. A number of provider agency Planning Council representatives are consumer/survivors, giving consumers an even greater participation than reflected in the Planning Council Membership Composition Chart. Many of the Planning Council representatives are actively involved in other Councils, Committees or Advocacy activities throughout the State. These unique qualities of the Planning Council foster interagency

collaboration, coordination of services, and alliances with other Councils and Committees. Council members have noted the good working relationships between consumers, family members, advocacy groups, and other agencies such as NAMI-NJ, the Mental Health Association of NJ, the County Mental Health Administrators, New Jersey Association of Mental Health and Addiction Agencies, DMAHS and other State Agencies.

Role:

The Planning Council serves in an advisory capacity to the DMHAS and is charged with the responsibility of advocating for adults with serious mental illness and children with severe emotional disturbances for community mental health services throughout the State. The role of the Planning Council is to fulfill a federal mandate to review state plans and submit any recommended modifications to the Community Mental Health Block Grant and participate in the planning for this joint application. Planning Council members monitor, review, and evaluate periodically the allocation and adequacy of mental health services. The Planning Council also reviewed the SAPT behavioral health report and the Synar report in 2012 as well in an effort to increase its understanding of the addiction portion of the Combined Block Grant.

The Planning Council gathers input from people in recovery, families and other important stakeholders through means of the meetings being open to the public. Guests routinely join the meetings to ask questions or become more informed about behavioral health services in the State. In addition, the Planning Council also makes use of a telephone call-in feature to make the meetings as accessible as possible. Multiple members of the Planning Council are representative of major stakeholders in the behavioral health community, as well as includes members who are in recovery or family members of those in recovery. This enables a broad spectrum of input and expertise available to the Planning Council.

The Planning Council was involved in developing the plan and reviewing the priorities. The entire Planning Council was advised of the revisions to the previous application that were unveiled during the Block Grant conference in the summer of 2012. In addition, the State provides guidance to the Council to perform their review of the Block Grant, by reviewing how to access and work within BGAS, and providing descriptive overviews of each section of the application. State staff developed responses to the various sections of the application and the Planning Council was provided presentations at the December 2012, January 2013, February 2013, March 2013, April 2013, May 2013, June 2013, July 2013 and August 2013 general meetings on the content being created, as well as in the multiple Block Grant subcommittee meetings that were held monthly. In addition, all Planning Council members were made aware of the BGAS website and encouraged to use the citizen login feature to review the application as it was currently drafted.

Highlights of Planning Council Activities for SFY 2012:

- Monthly updates regarding the merger of the Division of Addiction Services and the Division of Mental Health Services and the activities of the Merger Advisory Committee by two members who sit on that Committee and various DMHAS staff
- Received multiple presentations and updates from State staff and Planning Council members who participated in the Waiver Steering Group and various wavier subcommittees on the State's Medicaid Comprehensive Waiver application to CMS

- Received information on the SFY 2012 approved budget and the impact on the service system, as well as a presentation on the SFY 2013 proposed budget and its impact
- Information on the implementation of Involuntary Outpatient Commitment in New Jersey
- Received substance abuse specific information through presentations on medication assisted treatment, pay for performance measures, and outcomes measures, as well as Substance Abuse Prevention and Treatment Block Grant specific information
- Updates regarding the Olmstead Initiative in New Jersey
- A presentation on vocational rehabilitation services, including supported education and supported employment
- Information regarding the pending closure of Hagedorn Psychiatric Hospital
- Lively discussions of how to increase recruitment of consumers in recovery from addictions
- Information on consumer operated services in the State
- Information on services for youth involved in the juvenile justice system
- Update on services available to youth in the Children's System of Care, including the plans for all adolescent substance abuse treatment services to be transitioned from the SSA/SMHA to the Division
- A presentation on aging services
- Discussion of Planning Council involvement in the Mental Health System Review in SFY 2013
- Submitted a letter of support for the recommendations of the Dual Diagnosis Developmentally Disabled and Mental Illness Task Force Report
- Submitted a letter of support for the combined 2012-2014 Block Grant Application and Plan

<u>Highlights of Planning Council Activities for SFY 2013:</u>

- Received information on the SFY 2013 approved budget and the impact on the service system
- Participation in the CMHS Mental Health System Review in SFY 2013
- Received an update on the Wellness and Recovery Transformation Action Plan that was implemented from 2008-2010 and where the Division is moving based on the plan
- Information on the Crisis Intervention Team (CIT) program, which is an innovative international model of police based crisis intervention training with community mental health care and advocacy partnerships.
- Provided input on the draft SMI definition that is being created by the Division for future implementation
- Received information on the State Family Support Plan services sponsored by NAMI-NJ
- Provided feedback to the Division on additional Mental Health Block Grant funding that was received for SFY 2013
- Received updates from State staff and Planning Council members on the Behavioral Health Waiver Steering Committee on the State's Medicaid Comprehensive Waiver application to CMS
- Reviewed the 2012 substance abuse and mental health behavioral health reports using BGAS prior to their submission

- Received information on the behavioral health disaster response to Super Storm Sandy in NJ
- Received information on county planning from the Mental Health Administrators Association and the County Drug and Alcohol Directors Association
- Presentation on the value of mental health services
- Updates regarding the Olmstead Initiative in New Jersey
- Overview from the Children's System of Care on youth behavioral health services and the transition of adolescents with substance use disorders into its system
- Received a presentation on the SFY 2014 proposed budget and its impact
- Provided feedback on a potential "'Lost to Contact" DMHAS policy
- Received information on the final report on the closure of Hagedorn State Psychiatric Hospital
- Received information on the PATH Grant
- Overview of provider performance reports
- Update on Medicaid expansion and the impact on behavioral health services

Subcommittee Activities:
A number of subcommittees met during SFY 2012 and SFY 2013 as of this writing. The subcommittees include:

Advocacy Subcommittee – This subcommittee was newly created during the Spring of 2012, and is charged to look at broader issues for where the Planning Council could advocate. The subcommittee met on 4/11/12, 5/9/12, 6/13/12, 9/12/12, 11/14/12, 12/12/12, 1/9/13, 3/13/13, 4/10/13, 5/8/13 and 6/12/13.

Block Grant Subcommittee - The subcommittee reviewed and assisted with the development of the FFY 2012 combined Mental Health and Substance Abuse Prevention and Treatment Block Grant Application and Plan, as well as monitored the Mental Health Implementation Report and Substance Abuse Prevention and Treatment Implementation Report. The subcommittee met on 7/13/11, 8/17/11 and 11/9/11, 10/10/12, 11/14/12, 2/13/13, 3/13/13, 4/10/13, 5/8/13 and 6/12/13.

Membership Subcommittee - This subcommittee is focusing their efforts in the following areas:
- Reviewing Planning Council member attendance records
- Removing absent Planning Council members according to the bylaws
- Replacing retired/resigned representatives of the Planning Council
- Recruiting and recommending replacements to fill consumer/family/provider Planning Council vacancies
- Updating a new member orientation guide

The subcommittee met on 9/14/11, 1/11/12, 3/14/12, 5/9/12, 9/12/12, 10/10/12, 11/14/12, 12/12/12, 2/13/13, 3/13/13, 4/10/13, 5/8/13 and 6/12/13.

Nominating Subcommittee - This subcommittee was time limited and oversaw the nomination and election of Planning Council officers. The group conducted its business via email and telephone from March through June 2013 as elections were held in July 2013.

Olmstead Advisory Committee - This Committee meets regularly to monitor the implementation of The Home to Recovery CEPP Plan and Olmstead Settlement Agreement. The subcommittee met on 8/17/11, 10/12/11, 1/11/12, 3/14/12, 6/13/12, 10/10/12, and 2/13/13.

Identified Strengths of the State's SSA, SMHA and Children's System of Care (CSOC)

- Statewide basis for services
- Positive working relationship between Medicaid and SSA, SMHA and CSOC
- Youth development council
- Consumer operated services
- Free standing consumer operated care at the State hospitals
- Program regional analysts
- Multiple outlets to provide input to State
- Access to many services for children and adults compared to other states
- Commitment of funding for mental health and Olmstead services
- Commitment to integrated affordable community-based flexible supports for housing
- Collaboration with State universities for evidence-based practices
- Wellness and Recovery Transformation Plan as a framework for transition
- Psychiatric rehabilitation efforts
- Family volunteer hospital monitoring program
- Involvement of families and consumers
- Positive efforts regarding veterans
- Seamless and integrated response to natural disaster
- Intensive Family Support Services
- Increased integration of physical health and behavioral health services
- Tobacco services and consumer run education program

Identified Areas for Improvement of the State's SSA, SMHA and Children's System of Care (CSOC)

- Continued increase of integration on physical health and behavioral health services
- Importance of serving homeless who are mentally ill
- Need for innovative housing models like public/private partnerships for funding and service delivery
- Training of front-line staff in recovery and wellness principles
- Comprehensive plan for workforce development
- More peers in field
- Increase in payment rates
- Attention to transportation needs, especially in the South
- Lack of services and consumer support groups in the South
- Lack of services for individuals who identify as LGBTQ
- Waiting lists for services
- Financial literacy training for consumers
- Obstacles to services for individuals who are involved in juvenile justice system and ex-offenders
- Declining support for legal services for individuals and their families

- Insufficient supports for psychosocial services

Review of the Combined Block Grant Application for New Jersey

The Planning Council has met on a monthly basis throughout the past year and has remained focused on the integration of addictions and mental health. The Planning Council has had the opportunity to review the application and provide input regarding the Joint Block Grant Application. With the use of the BGAS Citizen's log in, the Planning Council members have had the opportunity to review and comment on the Joint Block Grant Application prior to submission. The letter of endorsement is attached.

State of New Jersey
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MENTAL HEALTH AND ADDICTION SERVICES
222 SOUTH WARREN STREET
PO BOX 700
TRENTON, NJ 08625-0700

CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

JENNIFER VELEZ
Commissioner

LYNN A. KOVICH
Assistant Commissioner

August 19, 2013

Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road
Room 7-1091
Rockville, MD 20857

RE: New Jersey' Combined Community Mental Health and Substance Abuse Prevention and Treatment Block Grant for 2014-2015

Dear SAMHSA Grants Management:

On behalf of the New Jersey Mental Health Planning Council (herein referred to as the Planning Council), I am pleased to submit this letter of endorsement for the combined Community Mental Health and Substance Abuse Prevention and Treatment Block Grant application for 2014-2015 submitted by the New Jersey Division of Mental Health and Addiction Services (DMHAS). The Planning Council meets monthly, and in addition to regular presentations of interest to members about services and programs throughout the State, the Planning Council has focused much time on the review of the application components.

The Planning Council has had the opportunity to provide input regarding the Combined Block Grant Application. The Planning Council received monthly presentations at our Block Grant Subcommittee meetings, as well as at the general membership meetings on the content being developed and the tables being completed. At each meeting, comments and feedback were presented by members to State staff for review and incorporation as applicable. In addition, by using the WebBGAS Citizen's log in, Planning Council members have had the opportunity to review the Combined Block Grant Application prior to the State's submission.

The Planning Council will continue to evaluate and monitor the implementation of the Block Grant funding and make recommendations as needed. The Planning Council meetings are

"Open Public Meetings" and as a result the public at large has also had the opportunity to comment on this submission either in person or on BGAS. In addition, the Planning Council will continue to work over the next year to add to its membership consumers, family members and providers of addiction and co-occurring services in an effort to move closer towards a more behavioral health focused council.

Sincerely,

Phillip Lubitz, Chair
New Jersey Mental Health Planning Council

cc: Jacob Bucher, Vice Chair, New Jersey Mental Health Planning Council
Lynn Kovich, DMHAS
Donna Migliorino, DMHAS
Dona Sinton, DMHAS
Elizabeth Manley, Children's System of Care
Geri Dietrich, Children's System of Care

IV: Narrative Plan

Behavioral Health Advisory Council Members

Start Year: 2014

End Year: 2015

Name	Type of Membership	Agency or Organization Represented	Address, Phone, and Fax	Email (if available)
Jacob Bucher	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Collaborative Support Programs of NJ, Inc.		
Jesus Castro	Parents of children with SED			
Winifred Chain	Family Members of Individuals in Recovery (to include family members of adults with SMI)			
Joseph Delany	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Lisa Negron	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Karen Vogel-Romance	Providers	Jersey Shore University Medical Center		
Annette Wright	Providers	COMHCO		
Damyanti Aurora	Providers	NJ Coalition of Residential Providers		
Donna Best	State Employees	New Jersey Department of Education		
Bruce Blumenthal	State Employees	NJ Housing Mortgage and Finance Agency		
Karen Carroll	State Employees	NJ Department of Labor, OVR		
Patricia Dana	State Employees	Medicaid		
Mary Ditri	Providers	NJ Hospital Association		
Eileen Doremus	State Employees	Mercer County Office on Aging		
Maryanne Evanko	Parents of children with SED			
Angel Gambone	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Independent Survivors		
Alice Garcia	State Employees	NJ Juvenile Justice Commission		
Marilyn Goldstein	Family Members of Individuals in Recovery (to include family members of adults with SMI)			
Joseph Gutstein	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			

Renee Ingram	State Employees	Division of Family Development
Michael Ippoliti	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	
Barbara Johnston	Providers	Mental Health Association in New Jersey
J. Michael Jones	Family Members of Individuals in Recovery (to include family members of adults with SMI)	
Linda Kornacki-Kuhns	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	
Gail Levinson	Providers	Supportive Housing Assoc/Alternatives
Philip Lubitz	Family Members of Individuals in Recovery (to include family members of adults with SMI)	National Alliance on Mental Illness of NJ (NAMI)
Christopher Lucca	State Employees	New Jersey Department of Corrections
John Maher	Providers	New Jersey Association of Clinical Case Management
Patricia Matthews	State Employees	Division of Aging
Tracy Maksell	State Employees	NJ Association of County Mental Health Admin.
Linda Meyer	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)	
Hazeline Pilgrim	Parents of children with SED	
Thomas Pyle	Family Members of Individuals in Recovery (to include family members of adults with SMI)	
Jim Romer	Providers	Kimball Medical Center
Regina Sessoms	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Self Help Center, Brighter Day
Robin Weiss	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Consumer Provider Association of NJ
Debra Wentz	Providers	New Jersey Association of Mental Health and Addictions Agencies, Inc.
Marie Verna	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	
Lynn Kovich	State Employees	
Helen Williams	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Collaborative Support Programs of NJ

Footnotes:

IV: Narrative Plan

Behavioral Health Council Composition by Member Type

Start Year: 2014

End Year: 2015

Type of Membership	Number	Percentage
Total Membership	41	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	13	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	5	
Parents of children with SED*	3	
Vacancies (Individuals and Family Members)	0	
Others (Not State employees or providers)	0	
Total Individuals in Recovery, Family Members & Others	21	51.22%
State Employees	11	
Providers	9	
Federally Recognized Tribe Representatives	0	
Vacancies	0	
Total State Employees & Providers	20	48.78%
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Persons in recovery from or providing treatment for or advocating for substance abuse services	3	

* States are encouraged to select these representatives from state Family/Consumer organizations.

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?

The Planning Council was involved in developing the plan and reviewing the priorities. The entire Planning Council was advised of the revisions to the previous application that were unveiled during the Block Grant conference. State staff developed responses to the various sections of the application and the Planning Council was provided presentations monthly from December 2012 through August 2013 at the general meetings on the content being created, as well as in the multiple Block Grant subcommittee meetings that were held. In addition, all Planning Council members were made aware of the BGAS website and encouraged to use the citizen login feature to review the application as it was currently drafted.

Footnotes:

IV: Narrative Plan

X. Enrollment and Provider Business Practices, Including Billing Systems

Narrative Question:

Each state is asked to set-aside three percent each of their SABG and MHBG allocations to support mental and substance use service providers in improving their capacity to bill public and private insurance and to support enrollment into health insurance for eligible individuals served in the public mental and substance use disorder service system. The state should indicate how it intends to utilize the three percent to impact enrollment and business practices taking into account the identified needs, including:

- Outreach and enrollment support for individuals in need of behavioral health services.
- Business plan redesign responsive to the changing market under the Affordable Care Act and MHPAEA.
- Development, redesign and/or implementation of practice management and accounts receivable systems that address billing, collection, risk management and compliance.
- Third-party contract negotiation.
- Coordination of benefits among multiple funding sources.
- Adoption of health information technology that meets meaningful use standards.

Footnotes:

X. Enrollment and Provider Business Practices, Including Billing Systems

New Jersey has elected to implement a federally facilitated Health Insurance Marketplace. DMAHS (New Jersey Medicaid) will be implementing an Assistors Training and a Certified Assistors program across the state. DMHAS is currently working with DMAHS as they market and implement the Assistor and Certified Assistor trainings. We anticipate that the SABG funds will be used in two areas; to expand or enhance the Assistor training for behavioral health providers and to support the behavioral health provider capacity to enroll consumers at the point of service and during outreach.

The DMHAS has made training opportunities available to the substance abuse and mental health provider community to provide them with the information and tools necessary to prepare for the changes resulting from the Patient Protection Affordable Care Act, Medicaid expansion, and contract reform associated with the procurement of an ASO/MBHO which will manage all state and federally funded mental health and substance use services in NJ. Specifically, New Jersey applied to the "BHbusiness: Mastering Essential Business Operations" training initiative funded by SAMHSA. Through this initiative, New Jersey was able to enroll 62 provider organizations to engage in "Strategic Business Planning." This training supported providers in "learning about the impact of the ACA, identifying their market niche and completing an initial strategic business plan for positioning themselves in the marketplace." Upon completion of this training the DMHAS will issue a RFP to procure training in the areas of third-party billing, third party contract negotiations, coordination of benefits among multiple funding sources, and adoption of health information technology that meets meaningful use standards. The DMHAS anticipates that this RFP will be issued by the second quarter of FFY 2014.

IV: Narrative Plan

Y. Comment on the State BG Plan

Narrative Question:

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. 300x-51) requires that, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the State BG 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 the Secretary of HHS.

Footnotes:

Y. Comment on State BG Plan

New Jersey Mental Health Planning Council

The 2014-2015 Community Mental Health and Substance Abuse Prevention and Treatment Joint Block Grant Application was reviewed in sections from December 2013 through August 2013 at the monthly New Jersey Mental Health Planning Council Meetings. The Planning Council is comprised of members who are representative of a comprehensive cross section of mental health consumers, addiction consumers, State staff, and mental health and substance abuse advocates and provider agencies, as well as various State Departments and Divisions. Notice of the meetings are sent to the Newark Star Ledger, Asbury Park Press, The Times (Trenton), Bergen Record, The Press (Pleasantville), and The Courier-Post (Cherry Hill). A Block Grant Subcommittee within the New Jersey Mental Health Planning Council reviewed and commented on the Plan as it was developed and reported its findings, comments and recommendations to Planning Council members at the general meetings. Members had the opportunity to review and comment on the Plan. Members were also provided the Block Grant Application System (BGAS) information for the Citizen's log in to be able to view the application and submit comments to DMHAS at DMHAS@state.nj.us or via mail to DMHAS, 222 South Warren Street, PO Box 700, Trenton, NJ, 08625-0700

Public Notices

A public notice regarding the availability of the Community Mental Health and Substance Abuse Prevention and Treatment Application was published on the New Jersey Department of Human Services website on February 20, 2013 to facilitate public access and comment. It was also sent out to the DMHAS providers' email list serve.

On March 12 and 13, 2013, DMHAS published a Notice of Solicitation of Comment simultaneously in the Newark Star Ledger, Asbury Park Press, The Times (Trenton), Bergen Record, The Press (Pleasantville), and The Courier-Post (Cherry Hill, which specified that DMHAS is making available to the public the draft Community Mental Health and Substance Abuse Prevention and Treatment Plan Block Grant Application. The notice specified the procedure for acquiring the BGAS website address and Citizen Log in information to be able to view the application. Comments can be submitted to DMHAS at DMHAS@dhs.state.nj.us or via mail to DMHAS, 222 South Warren Street, PO Box 700, Trenton, NJ, 08625-0700.

Public Viewing

DMHAS utilized the public viewing function of the BGAS. Those requesting to view and comment on the draft Community Mental Health and Substance Abuse Prevention and Treatment Application were given the website address, username, and password to view the Plan as it is drafted and posted online.

DMHAS provided the BGAS citizen log in information to the Mental Health Planning Council, as described earlier.

DMHAS provided the BGAS citizen log in information to the SSA's Professional Advisory Committee (PAC), which is comprised of members who are representative of a comprehensive cross section of addictions providers.

DMHAS also provided the BGAS citizen log in information to the State Board of Human Services, which oversees State institutions and agencies of the DHS and conducts long-range planning and policy studies. It serves as an advisory and consultative body to the Commissioner of Human Services on matters of public policy.

The completed Joint Block Grant Application is electronically submitted through SAMHSA's BGAS website and will be posted on the DMHAS website which is accessible to the public after it is submitted. Comments received by DMHAS about this submission will be compiled and used to guide the future planning efforts.