New Jersey

UNIFORM APPLICATION
FY 2020/2021 Block Grant Application

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

OMB - Approved 04/19/2019 - Expires 04/30/2022
(generated on 11/19/2020 11.05.21 AM)

Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

and

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

State Information

State Information

Plan Year

Start Year 2020

End Year 2021

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 and Prevention

Mailing Address 120 South Stockton Street, 3rd Floor PO Box 362

City Trenton

Zip Code 08625-0362

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

First Name Valerie

Last Name Mielke

Agency Name Division of Mental Health and Addiction Services

Mailing Address 5 Commerce Way PO Box 362

City Hamilton

Zip Code 08691-0362

Telephone (609) 438-4352

Fax (609) 341-2302

Email Address Valerie.Mielke@dhs.nj.gov

State CMHS DUNS Number

Number 806418257

Expiration Date

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

Agency Name New Jersey Division of Mental Health and Addiction Services

Organizational Unit Office of Olmstead, Compliance, Planning and Evaluation

Mailing Address 120 South Stockton Street PO Box 362

City Trenton

Zip Code 08625-0362

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

First Name Valerie

Last Name Mielke

Agency Name New Jersey Division of Mental Health and Addiction Services

Mailing Address	5 Commerce Way PO Box 362
City	Hamilton Township
Zip Code	08691-0362
Telephone	(609) 438-4352
Fax	609-341-2302
Email Address	Valerie.Mielke@dhs.nj.gov

III. Third Party Administrator of Mental Health Services

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

First Name	
Last Name	
Agency Name	
Mailing Address	
City	
Zip Code	
Telephone	
Fax	
Email Address	

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

From	
To	

V. Date Submitted

Submission Date	8/30/2019 1:43:32 PM
Revision Date	11/19/2020 11:03:47 AM

VI. Contact Person Responsible for Application Submission

First Name	Valerie
Last Name	Mielke
Telephone	(609) 438-4352
Fax	(609) 341-2302
Email Address	Valerie.Mielke@dhs.nj.gov

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Footnotes:

Substance Abuse Block Grant Planner – Suzanne Borys, Ed.D., Phone 609-984-4050, Suzanne.Borys@dhs.nj.gov

National Prevention Network Representative – Donald Hallcom, Ph.D., Phone 609-984-4049, Donald.Hallcom@dhs.nj.gov

Mental Health Planner - Donna Migliorino, Phone 609-777-0669, Donna.Migliorino@dhs.nj.gov

Children's Mental Health Planner – Geri Dietrich, Phone 609-888-7191, Geri.Dietrich@dcf.nj.gov

State Information

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

Fiscal Year 2020

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

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ASSURANCES - 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.
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 Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions

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

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

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

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

2. Certification Regarding Drug-Free Workplace Requirements

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

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

3. Certifications Regarding Lobbying

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

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

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

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

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

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

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

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

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

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

HHS Assurances of Compliance (HHS 690)

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

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

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

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

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

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

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

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

State: _____

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

Signature of CEO or Designee[1]: _____

Title: Assistant Commissioner

Date Signed: _____

mm/dd/yyyy

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

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

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

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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.
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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.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

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

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

2. Certification Regarding Drug-Free Workplace Requirements

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

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

3. Certifications Regarding Lobbying

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

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

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

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

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

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

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

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

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

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

HHS Assurances of Compliance (HHS 690)

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

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

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

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

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

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

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

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

State: New Jersey

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

Signature of CEO or Designee[1]: Valerie Mielke

Title: Assistant Commissioner

Date Signed: July 24, 2019

mm/dd/yyyy

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

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

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

PHILIP D. MURPHY
Governor

December 19, 2018

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

Dear Dr. McCance-Katz:

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

Sincerely,

Philip D. Murphy
Governor

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

State of New Jersey
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MENTAL HEALTH AND ADDICTION SERVICES
PO BOX 362
5 COMMERCE WAY
HAMILTON, NJ 08691

PHILIP D. MURPHY
Governor

SHEILA Y. OLIVER
Lt. Governor

CAROLE JOHNSON
Commissioner

VALERIE L. MIELKE, MSW
Assistant Commissioner

November 18, 2019

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

Dear Dr. McCance-Katz:

I certify that the New Jersey Department of Human Services, Division of Mental Health and Addiction Services and all sub-recipients will comply with the following Notice of Award (NoA) language:

Grant funds may not be used, directly or indirectly, to purchase, prescribe, or provide marijuana or treatment using marijuana. Treatment in this context includes the treatment of opioid use disorder. Grant funds also cannot be provided to any individual who or organization that provides or permits marijuana use for the purposes of treating substance use or mental disorders. See, e.g., 45 C.F.R. § 75.300(a) (requiring HHS to "ensure that Federal funding is expended . . . in full accordance with U.S. statutory . . . requirements."); 21 U.S.C. §§ 812(c)(10) and 841 (prohibiting the possession, manufacture, sale, purchase or distribution of marijuana). This prohibition does not apply to those providing such treatment in the context of clinical research permitted by the DEA and under an FDA-approved investigational new drug application where the article being evaluated is marijuana or a constituent thereof that is otherwise a banned controlled substance under federal law.

Sincerely,

Valerie L. Mielke, MSW
Assistant Commissioner

C: Deepa Avula, SAMHSA

State Information

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

Fiscal Year 2020

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

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1911	Formula Grants to States	**42 USC § 300x**
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	**42 USC § 300x-1**
Section 1913	Certain Agreements	**42 USC § 300x-2**
Section 1914	State Mental Health Planning Council	**42 USC § 300x-3**
Section 1915	Additional Provisions	**42 USC § 300x-4**
Section 1916	Restrictions on Use of Payments	**42 USC § 300x-5**
Section 1917	Application for Grant	**42 USC § 300x-6**
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	**42 USC § 300x-51**
Section 1942	Requirement of Reports and Audits by States	**42 USC § 300x-52**
Section 1943	Additional Requirements	**42 USC § 300x-53**
Section 1946	Prohibition Regarding Receipt of Funds	**42 USC § 300x-56**
Section 1947	Nondiscrimination	**42 USC § 300x-57**
Section 1953	Continuation of Certain Programs	**42 USC § 300x-63**
Section 1955	Services Provided by Nongovernmental Organizations	**42 USC § 300x-65**
Section 1956	Services for Individuals with Co-Occurring Disorders	**42 USC § 300x-66**

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 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.
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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.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

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

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

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

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

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

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

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

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

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

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

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

HHS Assurances of Compliance (HHS 690)

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

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

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

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

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

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

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

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

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

Signature of CEO or Designee[1]: _____

Title: Assistant Commissioner Date Signed: _____

mm/dd/yyyy

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

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

State Information

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

Fiscal Year 2020

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

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1911	Formula Grants to States	42 USC § 300x
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	42 USC § 300x-1
Section 1913	Certain Agreements	42 USC § 300x-2
Section 1914	State Mental Health Planning Council	42 USC § 300x-3
Section 1915	Additional Provisions	42 USC § 300x-4
Section 1916	Restrictions on Use of Payments	42 USC § 300x-5
Section 1917	Application for Grant	42 USC § 300x-6
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53
Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 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.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

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

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

2. Certification Regarding Drug-Free Workplace Requirements

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

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

3. Certifications Regarding Lobbying

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

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

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

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
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The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

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

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

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
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5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

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

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

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

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

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

Signature of CEO or Designee[1]: Valerie L Mielke

Title: Assistant Commissioner

Date Signed: 07/24/19

mm/dd/yyyy

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

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

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

PHILIP D. MURPHY
Governor

December 19, 2018

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

Dear Dr. McCance-Katz:

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

Sincerely,

Philip D. Murphy
Governor

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

State of New Jersey
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MENTAL HEALTH AND ADDICTION SERVICES
PO BOX 362
5 COMMERCE WAY
HAMILTON, NJ 08691

PHILIP D. MURPHY
Governor

SHEILA Y. OLIVER
Lt. Governor

CAROLE JOHNSON
Commissioner

VALERIE L. MIELKE, MSW
Assistant Commissioner

November 18, 2019

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

Dear Dr. McCance-Katz:

I certify that the New Jersey Department of Human Services, Division of Mental Health and Addiction Services and all sub-recipients will comply with the following Notice of Award (NoA) language:

Grant funds may not be used, directly or indirectly, to purchase, prescribe, or provide marijuana or treatment using marijuana. Treatment in this context includes the treatment of opioid use disorder. Grant funds also cannot be provided to any individual who or organization that provides or permits marijuana use for the purposes of treating substance use or mental disorders. See, e.g., 45 C.F.R. § 75.300(a) (requiring HHS to "ensure that Federal funding is expended . . . in full accordance with U.S. statutory . . . requirements."); 21 U.S.C. §§ 812(c)(10) and 841 (prohibiting the possession, manufacture, sale, purchase or distribution of marijuana). This prohibition does not apply to those providing such treatment in the context of clinical research permitted by the DEA and under an FDA-approved investigational new drug application where the article being evaluated is marijuana or a constituent thereof that is otherwise a banned controlled substance under federal law.

Sincerely,

Valerie L. Mielke, MSW
Assistant Commissioner

C: Deepa Avula, SAMHSA

State Information

Disclosure of Lobbying Activities

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

Standard Form LLL (click here)

Name

Title

Organization

Signature: Date:

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

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

Planning Steps

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

Narrative Question:

Provide an overview of the state's M/SUD prevention, early identification, treatment, and recovery support systems, including the statutory criteria that must be addressed in the state's Application. Describe how the public M/SUD system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic, and sexual and gender minorities, as well as American Indian/Alaskan Native populations in the states.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

The Single State Authority on Substance Abuse (SSA)

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

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

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

The Department of Human Services (DHS) serves more than 2.1 million of New Jersey's most vulnerable citizens, or about one of every five New Jersey residents. DHS serves individuals and families with low incomes, people with mental illnesses and/or substance abuse issues, developmental disabilities, late-onset disabilities, the blind, visually impaired, deaf, hard of hearing, or deaf-blind, and aging individuals. In addition, the Department serves parents needing child care services, child support and/or healthcare for their children, as well as families facing catastrophic medical expenses for their children. DHS has the following Divisions: 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 the Division of Mental Health and Addiction Services (DMHAS). These divisions provide many support systems for the families of children served by the Department of Children and Families (DCF). The DHS also operates the Commission for the Blind and Visually Impaired.

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

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

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

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

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

In 2017, the State provided funding to open substance use disorder residential beds to treat 18 and 19 year olds as the system at the time did not allow treatment for this age as children. The expansion through DCF allowed their licensed residential facilities to treat 18 and 19 year olds and expand residential capacity by an additional 200 beds.

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

On June 21, 2018, Governor Philip Murphy issued a reorganization plan to return the Division of Mental Health and Addiction Services to the Department of Human Services. The purpose of the plan is to ensure that the State is delivering behavioral health services in the most efficient, effective manner possible to patients by connecting behavioral health services with

critical wrap-around services administered by DHS that support the treatment, recovery, and long-term well-being of individuals struggling with substance use and mental health issues. DHS also houses the State Medicaid Agency which plays a significant role as the primary payor for mental health and substance use treatment in the State, as it is the insurance provider for approximately 1.7 million NJ residents. The reorganization plan was effective September 29, 2018. DOH continues to operate the State psychiatric hospitals and licensing of mental health and addiction services programs and facilities.

Overview of the Delivery of Substance Use Disorder (SUD) Services

DMHAS is the Single State Authority (SSA) for substance abuse in New Jersey. Between the Substance Abuse Prevention and Treatment (SAPT) Block Grant and other federal and state resources. The SSA provides services across the continuum of care, which includes prevention, early intervention, treatment and recovery support. In FFY 2018 and 2019, the SSA funds: a) 19 community-based prevention coalitions for the provision of prevention programs with a focus on environmental strategies, b) over 30 community-based prevention providers that offer a variety of evidence-based curricula for children, adolescents, older adults, and families, c) two state institutions of higher education that provide early intervention services (Rutgers University and The College of New Jersey), e) four intensive supported housing programs including the recent contract awards of three regional pilot recovery-based housing residences and case management and supportive services for consumers with an opioid use disorder (OUD) who are homeless or at risk of homelessness, f) 24-hour Addictions Hotline services, g) two non-profit corporations for the operation of recovery support centers, Recovery Center at Eva's Village and Living Proof Recovery Center, h) three smaller Community Peer Recovery Centers, i) 21 Opioid Overdose Recovery Programs, j) 21 Support Teams for Addiction Recovery (9 recently awarded), k) 19 Older Adult Education Programs (9 recently awarded), l) three Family Support Centers, m) a Telephone Recovery Support program, n) an addictions workforce training and development initiative, o) 21 county governments for the provision of services throughout the continuum of care, p) funding through a Request for Letter of Intent (RLI) for all county jails to incorporate or enhance Medication Assisted Treatment (MAT) as well as case management services for inmates with an Opioid Use Disorder (OUD) at the jail, q) 16 trainings to support approximately 1,000 physicians, APNs and Physician Assistants to attain a buprenorphine waiver, and r) the recent request for proposals (RFP) award of 11 hospitals for the Opioid Reduction Options (ORO) in the Emergency Department (ED) that aims to reduce the use of opioids in EDs and the subsequent prescribing of opioids at ED discharge.

Within its treatment continuum levels of care range from detoxification, outpatient, intensive outpatient, residential (short-term, long-term, halfway house), partial hospitalization and opioid maintenance. As of June 2018, there were 242 licensed providers, 344 licensed Outpatient sites and 73 licensed Residential sites which provide substance use disorder services. DMHAS utilizes the American Society of Addiction Medicine (ASAM) principles in client placement.

The SSA is also responsible for: 1) the Statewide Intoxicated Driving Program (N.J.S.A. 39:4-50), which processes the conviction records of drivers convicted of driving under the influence and schedules these drivers for detention, evaluation, education, and treatment referral by the county-based intoxicated driver resource centers and makes funding available to address the treatment

needs of indigent individuals convicted of a Driving Under the Influence (DUI) who meet diagnostic criteria for treatment through the Driving Under the Influence Initiative (DUII), 2) the development of treatment services for people involved in the criminal justice system, 3) the Co-Occurring Network to serve individuals with co-occurring mental illness and substance abuse disorders, 4) the special substance abuse treatment needs of people who are deaf, hard of hearing or disabled; women who are pregnant or have dependent children; minorities; and middle-aged or senior citizens, and 5) promoting and training on evidence based programs such as Medication Assisted Treatment, co-occurring services, motivational interviewing and "The ASAM Criteria Treatment Criteria for Addictive, Substance-Related and Co-Occurring Conditions, American Society for Addiction Medicine Third Edition, 2013."

In Calendar Year (CY) 2018, there were 89,629 substance abuse treatment admissions and 87,483 discharges reported to the SSA through its New Jersey Substance Abuse Monitoring System (NJSAMS). Of these admissions, 55,783 were unduplicated. In CY 2018, there were 22,393 fee-for-service (FFS) admissions. For primary drug at admission, 50% reported heroin and other opiates and 28% reported alcohol. Data from NJSAMS for Calendar Year 2018 indicate that only 15% of methadone is planned and 7% of buprenorphine in treatment for clients admitted to treatment, yet heroin and other opiates are the primary drugs of admission for 50% of clients entering New Jersey's addiction treatment system. Most admissions were to outpatient care (27%), followed by intensive outpatient care (26%). Regarding age, 1% were under 18 years old, 5% were 18-21 years old, 26% were 22-29 years old, 58% were 30 to 54 years old and 10% were over 55 years old. For race/ethnicity, 60% were white, 23% were black and 16% were of Hispanic origin. Clients who did not have insurance at admission decreased (25%). Those who had Medicaid was 64%.

The SSA's primary population served are the indigent in need of substance use disorder treatment. Priority is given to special target groups: persons who inject drugs (PWID), pregnant women and women with dependent children, and individuals with/or at risk of HIV or TB. Other special target groups include individuals with: co-occurring mental illness; homeless; deaf, hard of hearing or disabled; criminal justice; older adults; gay, lesbian bisexual, transgendered and questioning (GLBTQ); military, and intoxicated drivers.

Description of the Organization of the Public Behavioral Health System at the State and Local Levels for the Delivery of SUD Services

State Government

The SSA strives to promote the prevention and treatment of substance abuse, support the recovery of individuals affected by the chronic disease of addiction, and promote the use of evidence-based practices. The SSA is responsible for regulating, monitoring, planning and funding substance abuse prevention, early intervention, treatment and recovery support services in New Jersey. In addition, the SSA assists with training the addiction 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.

County Government

In New Jersey, county governments also play an important part in the overall functioning of the public behavioral health system. Since 1983, a portion of the proceeds of the state's alcoholic beverages tax has been dedicated to the production and implementation of county comprehensive plans in all 21 counties. The plans correlate county resources to the needs of individuals with alcohol and drug use disorders. Originally, the scope of these plans was limited to the needs of individuals with an alcohol use disorder. In 1989, both the scope of the county plans and corresponding financial resources for which the counties were made responsible expanded to include the needs of individuals with drug use disorder. Additionally, in the same year, a governor's advisory council was established to coordinate the actions of all departments and divisions of state government with regard to substance abuse and to oversee locally-driven prevention efforts by municipal alliances.

Presently, the SSA oversees county alcohol and drug comprehensive planning in collaboration with counties that has gradually elevated quality assurance standards of county planning for the entire continuum of care, from prevention to early intervention, treatment and recovery support services. The SSA does this by issuing: a) guidelines for plan content, format and planning process, b) compendia of secondary source data, c) reports of survey findings, and d) technical assistance tailored to the needs of county behavioral health planners. The SSA works collaboratively with the 21 County Alcoholism and Drug Abuse Directors. A representative of their association is a member of the Behavioral Health Planning Council.

The SSA's current county planning activities focus on the current 2016-2019 four-year period from 2016 to 2019 and the upcoming 2020-2023 planning cycle. As New Jersey continues to implement its Medicaid Waiver (1115) establishing a managed behavioral health care organization, counties will provide the state with a critically-important monitoring and feedback function "on the ground," as well as develop investment proposals for early intervention and recovery support services that remain the least well developed segments of the continuum of care. Additionally, the county plans will direct greater attention than ever before to the problems of citizens dually afflicted with both substance use and mental health disorders. Thus, the county Mental Health Administrators were invited to participate in the community-based planning certificate program DMHAS sponsored in 2013 and the comprehensive planning process with the hope that, over time, both the substance abuse and mental health planning processes and products will integrate under a single county comprehensive, behavioral health plan.

Roles of Other State Agencies with Respect to the Delivery of SUD Services/ Interdivisional and Interdepartmental Collaboration

Department of Human Services, Division of Medical Assistance and Health Services (DMAHS). NJ FamilyCare's Comprehensive Demonstration ("The Waiver") was approved on October 31, 2017 and includes an Opioid Use Disorder (OUD)/Substance Use Disorder (SUD) continuum providing authority for the New Jersey Department of Human Services' Division of Medical

Assistance and Health Services, to serve individuals with a substance use disorder or opioid use disorder in a full continuum of care. The continuum matches beneficiaries with the most appropriate services to meet their need, and provides an efficient use of resources grounded in evidence-based practice. This includes services provided in residential treatment settings that qualify as an Institute for Mental Disease (IMD) consistent with key benchmarks from nationally recognized, SUD-specific program standards. Beneficiaries will have access to high quality, evidence based, OUD and SUD treatment services ranging from acute withdrawal management, ongoing chronic care in cost effective settings, and care for comorbid physical and mental health conditions.

Specifically, New Jersey was granted waiver authority to:

- Claim expenditures for services provided in an IMD for a statewide average length of stay of 30 days.
- Add a new level of care to the continuum for long term residential treatment, ASAM 3.5;
- Develop peer recovery support specialist and case management programs that will engage, support and link individuals with an SUD in the appropriate levels of care; and
- Move to a managed delivery system that integrates physical and behavioral health care.

As part of the waiver requirements New Jersey is expected to report data as part of the SUD Monitoring Protocol and track progress toward waiver goals.

The SSA, in collaboration with NJ FamilyCare, has established and is expanding mental health and SUD service providers who are able to enroll consumers needing treatment services in 24 -72 hours through presumptive eligibility (PE). PE allows a certified provider to enter information directly in the FamilyCare enrollment application that is then checked, and a temporary Medicaid number assigned. The application goes through verification, and if successful, a permanent Medicaid number is assigned. At the time of this writing, 1,086 agency staff have been trained and certified with 197 provider sites certified to take a PE application.

Division of Medical Assistance and Health Services and Department of Children and Families. DMHAS was selected to be one of the eight Certified Community Behavioral Health Clinic (CCBHC) demonstration states. This project is a collaboration between the Department of Human Services' Division of Medical Assistance and Health Services (DMAHS) and DMHAS and the Department of Children and Families (DCF). This demonstration is part of a wider effort to integrate behavioral health with physical health care, increase consistent use of evidence-based practices, and improve access to high quality care for people with mental and substance use disorders. Populations to be served are adults with serious mental illness, children with serious emotional disturbance, and those with long term and serious substance use disorders, as well as others with mental illness and substance use disorders. There are seven behavioral health providers licensed to provide treatment to adults and children who have a mental illness (including serious emotional disturbance) and/or substance use disorder participating as CCBHCs. The Federal Demonstration was extended to September 13, 2019 and the state partners are currently evaluating plans for sustaining some or all of the program in the state. A recent announcement is the House voted to pass the "Empowering Beneficiaries, Ensuring Access, and Strengthening Accountability Act of 2019 (H.R. 3253),"

which would extend funding for certain Medicaid programs. Under the provision, funding for the eight-state Certified Community Behavioral Health Clinic (CCBHC) demonstration program would be extended for another two and a half years until December 21, 2021.

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

DMHAS provides funding via a Memorandum of Understanding between the SSA and DCF to supplement DCF contracts for women with children under supervision of the Division of Child Protection and Permanency (DCP&P). This specialty funding is for the Substance Abuse Initiative for Substance Abusing Women (SISAW) Initiative. SISAW includes residential (18 beds) and intensive outpatient treatment slots (43) for women and children who reside in three catchment areas; Asbury Park, Jersey City and Newark and are also eligible for Work First.

DCF provides funding for one of seven Maternal Wrap Around Programs (M-WRAP) statewide. The overall goal with the M-WRAP is to alleviate barriers to services for pregnant opioid dependent women through comprehensive care coordination implemented within the five major timeframes when intervention in the life of the substance exposed infants (SEI) can reduce potential harm of prenatal substance exposure: pre-pregnancy, prenatal, birth, neonatal and early childhood. Care coordination also addresses screening, early intervention, assessment, treatment and recovery supports.

DCF also provides funding for one of 21 OORP programs. The Opioid Overdose Recovery Program (OORP) responds to individuals reversed from opioid overdoses and treated at hospital emergency departments as a result of the reversal. OORP utilizes Recovery Specialists and Patient Navigators to engage individuals reversed from an opioid overdose to provide non-clinical assistance, recovery supports and appropriate referrals for assessment and substance use disorder treatment.

DMHAS is also developing a Memorandum of Agreement with DCF to provide services for the recent Partnership for Success grant that DMHAS was awarded.

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 is transferred to the SSA to implement and manage the statewide network of treatment services in coordination with the AOC and participating Superior Court vicinages. Enhanced services will be maintained as funding permits, including: medication, psychiatric/psychological evaluations, medication monitoring, physical exams, transportation, counselor appearances, partial care, co-occurring integrated

services, methadone, and methadone intensive outpatient services. Since January 2018, Medicaid has been introduced to begin paying for ambulatory SUD treatment for eligible Drug Court participants. In July of 2018, short term residential was added and in October of 2018, long term residential.

New Jersey State Parole Board and Department of Corrections. A Memorandum of Agreement (MOA) will be maintained between the New Jersey State Parole Board (NJSPB) and the SSA to purchase, within a fee-for-service (FFS) network, community-based substance use disorder treatment for NJSPB parolees under the Mutual Agreement Program (MAP). Since October 1, 2017, Medicaid has been introduced to begin paying for ambulatory treatment for eligible parolees. In July of 2018, short term residential was added and in October of 2018, long term residential.

Department of Corrections. DMHAS is working with the Department of Corrections in providing Intensive Recovery Treatment Supports (IRTS) post-release to a cohort of eligible offenders (n=200) that receive MAT prior to release from prison, and to another cohort of non-MAT eligible offenders (n=400) both pre- and post-release into the community. IRTS links eligible offenders to recovery services necessary to support wellness and successful community re-integration. It helps offenders address issues such as: health/wellness, treatment adherence, employment, housing, and opportunities and skills to enhance the individual's ability to participate in meaningful life activities. There are three IRTS teams providing services for up to six months prior to release and up to 12 months post release.

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.

State Police. In 2014, the Regional Operations Intelligence Center operated by the New Jersey State Police developed the Drug Monitoring Initiative (DMI), to address the epidemic of the pervasive use of heroin, opiates, and the violent crimes and burglaries that are directly correlated to this nationwide crisis. The DMI is a cutting-edge program with a robust multi-state drug intelligence capability that collects and analyzes law enforcement and healthcare data in order to help law enforcement and public healthcare experts develop strategies to combat drug activity in their jurisdictions. Some highlights of the initiative are:

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

DMHAS and the DMI continue to be active and committed partners in substance abuse prevention throughout New Jersey. Representatives from the DMI participate in activities of the State

Epidemiological Outcomes Workgroup (SEOW) and DMHAS and the DMI frequently share data and other resources.

Department of Health. Starting in late 2018, the Rutgers Biomedical and Health Sciences Vice Chancellor for Research and Research Training convened a working group for faculty and key outside experts with research, clinical or public health and government program expertise in opioid use and addiction. Staff from DMHAS participate as leaders in the areas of prevention, early intervention, treatment, and recovery support. The goal of the group is to stimulate inter-disciplinary collaboration and partnership with state agencies that will position both Rutgers and New Jersey as leaders in this critical area. The meeting agendas include introductory talks on the opioid addiction epidemic, networking sessions and breakout groups based on partnering interests and funding opportunities. Dr. Brent Ruben, executive Director of the Center for Organizational Leadership in the Rutgers School of Communication and Information is the facilitator of this event. In 2018, two counties in New Jersey-developed Overdose Fatality Review Teams to conduct confidential reviews of resident drug and alcohol overdose deaths to identify opportunities to improve member agency and system-level operations in a way that will prevent future similar deaths. Representatives from DMHAS participate on the teams.

DMHAS is collaborating with DOH on its Opioid Reduction Options (ORO) project. While DMHAS has issued awards to 11 hospitals and will manage the program, the DOH has developed a learning collaborative in which awardees will be required to participate.

DMHAS also participates in bi-weekly calls with the Commissioner of Health and key staff to discuss the state's efforts in addressing the opioid crisis.

Department of Health and Division of Medical Assistance and Health Services. DMHAS participates in a multi-department SUD Health Information Technology (HIT) Plan Workgroup that has been formed. To promote interoperability between behavioral health and physical health providers caring for SUD/OUD individuals, the State of New Jersey is making available a total of $5.3 million in funding for a milestone-based SUD provider incentive program. The program is being administered by the Department of Health.

Description of Regional, County and Local Entities that Provide SUD Services

In New Jersey, the administration and organization of the substance use disorder (SUD) system is centralized, rather than county or locally based. A broad array of SUD services are offered in the community and the SSA awards funding to 178 SUD treatment agencies that provide a continuum of treatment. It provides funding to 32 SUD prevention agencies. It also provides awards to the 21 County Governments.

County Government. The SSA collaborates with the 21 counties of New Jersey in a joint state and county comprehensive behavioral health planning process intended to: 1) coordinate system development and service delivery at state and local levels, and 2) unify community-based planning for prevention and treatment. Chapter 51 of the Laws of 1989, C.26:2BB-12 et seq, amended Chapter 531 of the Laws of 1983 that had established the "Alcohol, Education, Rehabilitation and Enforcement Fund" (AEREF) and the county comprehensive planning requirement for

participation in the AEREF program. The amended statute established 1) the Governor's Advisory Council on Alcoholism and Drug Abuse, GCADA, and 2) the county Local Advisory Committee on Alcoholism and Drug Abuse, LACADA, known under the 1983 Act simply as the citizen advisory committee. The AEREF is a non-lapsing, revolving trust fund into which $11 million are deposited annually from a tax on the sale of alcoholic beverages. Approximately $9 million from the AEREF plus an additional $6.9 million in supplemental funds from the state treasury are distributed per statutory formula to the counties each year, for a total of $16.1 million for CY 2019.

Participation requires each county to develop a community-based, comprehensive plan to provide "community services to meet the needs of intoxicated person and alcoholics," and "relate existing services to the needs of alcoholic and drug addicts" across the full continuum of care, including prevention, early intervention, treatment and recovery support. DMHAS quality assurance standards require county plans be based on a scientific planning process that uses quantitative data, outcomes-related service-provider profiles, and community participation to both assess county needs and optimize county service investments. Additionally, counties must match 25% of their respective annual AEREF allocation with a contribution of county revenues and dedicate approximately 11% of their allotment to the implementation of federally-validated prevention education programs. An additional $20,000 is awarded to each county to support its planning operations. The Office of Planning, Research, Evaluation and Prevention is responsible for overseeing the AEREF county comprehensive planning program.

Governor's Council on Alcoholism and Drug Abuse. The SSA works collaboratively with the Governor's Council on Alcoholism and Drug Abuse (GCADA) on various addiction prevention related projects, including participation on the Prevention Unification Planning Process. The Unification Planning process is designed to provide guidance in the identification of prevention priorities and goals.

Through the Municipal Alliance Program, the GCADA unites New Jersey's communities in a coordinated and comprehensive grass roots prevention effort. Municipal Alliances are local planning and coordinating bodies established in all 21 counties to assess needs, set priorities, develop plans and implement programs that form the foundation of New Jersey's substance abuse prevention activities. New Jersey's Municipal Alliances provide over 3,800 prevention programs statewide. GCADA's Municipal Alliance Program provides 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.

DMHAS, in collaboration with GCADA and the New Jersey Prevention Network is currently engaged in the planning process – recently renamed "Prevention Collaborative". In the current Prevention Collaborative, the SSA, in collaboration with GCADA: 1) helps counties identify and implement a greater number of evidence-based prevention programs, 2) supports counties in the use of environmental approaches to prevention planning at the county and municipal levels, and 3) encourages counties to develop and operationalize community-based and culturally appropriate recovery support systems of care. The plan will also provide direction in the development of future prevention funding opportunities made available by the SSA.

Local Advisory Committee on Alcoholism and Drug Abuse. The SSA works collaboratively with the county Local Advisory Committee on Alcoholism and Drug Abuse (LACADAs) that "assist the governing body in development of the annual county comprehensive plan" required for participation in the Alcohol, Education, Rehabilitation and Enforcement" fund of 1983 and 1989.

The LACADAs are also required to establish a County Alliance Steering Subcommittee (CASS), which is the county-level planning body for each county's Municipal Alliances (MAs) that 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."

Overview of the State's SUD Prevention, Early Identification, Treatment, and Recovery Support Systems

Primary Prevention (Criterion 2)

The SSA develops and supports community-based prevention education and early intervention services using a three-tiered approach to the promotion of healthy life choices:

1. Universal: where media messages and written information are provided statewide to all citizens;
2. Selective: where programs of information and skill development are provided to groups of individuals at some risk; and
3. Indicated: where programs of information, skill development and behavioral change are promoted to identify individuals most at risk.

Employing the five-step Strategic Prevention Framework (SPF) developed by SAMHSA's Center for Substance Abuse Prevention (CSAP) as well as DMHAS' Addiction Prevention Strategic Planning, the SSA plans prevention and early intervention services in the state, awards funding to providers through RFPs and funds 19 county-based prevention coalitions as well as more than 60 community-based programs that offer a variety of evidence-based curricula for children, adolescents, older adults, and families 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. All DMHAS-funded coalitions and programs focus their efforts on addressing the prevention priorities identified in the Prevention Strategic Plan:

- Reduce underage drinking
- Reduce the use of illegal substances – with a special focus on the use of opioids among young adults 18-25 years of age
- Reduce prescription medication misuse across the lifespan
- Reduce the use of new and emerging drugs of abuse

DMHAS funds over 60 curriculum-based prevention programs in community settings throughout the State. DMHAS-funded providers develop an annual work plan for each program they are delivering and submit a quarterly report on the number of individuals and families served with basic socio-demographic information using the Prevention Outcomes Management System (POMS), which is the DMHAS' online prevention data reporting system. Examples of curriculum-based programs include: Strengthening Families, LifeSkills, I Can Problem Solve, and Lions Quest.

While traditional prevention has tended to focus on individual strategies, aimed at convincing individuals to choose not to use alcohol or other drugs, environmental strategies are prevention strategies that focus on changing conditions in the environment. These strategies are an essential part of any comprehensive prevention plan, because there are a number of conditions in the legal, physical, social, and economic environment that may make it easier for youth to use substances. Examples of such environmental conditions include inconsistent enforcement of the laws, easy access to alcohol or other drugs, aggressive alcohol advertising and media messages that link drug use with being "cool," and a social environment that encourages alcohol or other drug use as a rite of passage. Since 2012, when DMHAS established its system of regional prevention coalitions, increasing emphasis has been placed on the use of environmental strategies in order to effect significant, measurable change at the community level.

Additionally, as a result of Partnerships for Success (PFS) funding from CSAP that was awarded in 2013 and 2018, regional coalitions utilize resources to address tobacco prevention. Coalitions also use PFS funds for services to older adults and returning veterans, when warranted.

Services to Families of Military Veterans. Working with the New Jersey National Guard Family Program and its eight Family Assistance Centers based at armories around the state, the SSA funds the New Jersey Prevention Network to provide programs to serve returning military personnel and their families through two evidence-based programs, Coping with Work and Family Stress and the Strengthening Families Program. Both programs are designed to enhance protective factors to support military members and their families in making responsible parenting and individual choices in regards to drug and alcohol use.

Services to Gay, Lesbian, Bisexual, Transgendered and Questioning Youth. According to a study by University of Pittsburgh researchers published in the April 2008 issue of *Addiction,* the likelihood of substance use by gay, lesbian bisexual, transgendered and questioning (GLBTQ) youth are on average 190 percent higher than for heterosexual youth. The SSA funds the North Jersey Community Research Initiative to continue and expand their existing programs for high-risk GLBTQ youth of color by adapting a prevention model developed by the Centers for Disease Control and Prevention, early intervention services, social marketing, and structured recreational activities. A CSAP-sponsored evaluation of the program determined that the program was effective in reducing rates of substance use among participants and that participants were highly satisfied with the services that were provided.

Strategic Prevention Enhancement. In 2011, New Jersey received a State Prevention Enhancement (SPE) grant from CSAP. New Jersey's State Prevention Enhancement (SPE) Project served six high-need counties: Bergen, Camden, Hudson, Essex, Middlesex, and Monmouth. The SPE grant

provided intensive training and technical assistance on the effective use of the Strategic Prevention Framework (SPF) to agencies and local government in these high-need communities to enable them to identify or collect data regarding substance abuse and its consequences in their communities and develop a local approach to addressing the consequences.

Partnership for Success. In October 2013, DMHAS received a five-year Strategic Prevention Framework - Partnerships for Success (SPF-PFS) cooperative agreement from CSAP. The goals of New Jersey's SPF-PFS initiative were threefold: 1) to strengthen and enhance the work of DMHAS-funded prevention coalitions; 2) to further develop the prevention data infrastructure and information systems capacity at the state level; and 3) in collaboration with state partners and community stakeholders, to continue work in developing a unified statewide prevention planning and service delivery system. Specifically, New Jersey's SPF-PFS sought to 1) reduce underage drinking among persons aged 12 to 20; and 2) reduce prescription drug misuse and abuse among persons aged 12 to 25. As additional components of its PFS programming, New Jersey also focuses on unhealthy drinking patterns and prescription drug abuse among adults age sixty and older; and serves military families with prevention education, addressing military community risk levels, striving to mitigate the risk factors, and enhancing the protective factors to support military members and their families in making responsible parenting and individual choices in regards to drug and alcohol use.

DMHAS was awarded a second PFS grant in 2018. In this project, DHMAS prevention coalitions will provide training on the basics of substance abuse prevention, and use of the SPF, to the Children's Inter-Agency Coordinating Councils (CIACC) in each county. The CIACC provides a forum where the system of services for children with special social and emotional needs can be developed, reviewed, revised and/or redirected through a collaborative decision-making process with the New Jersey Department of Children and Families to promote optimal services provided in the least restrictive, but most appropriate setting possible.

DMHAS will utilize current SPF-PFS funds for various prevention infrastructure developments and enhancements, some of which are:

- Updating New Jersey's Epidemiological Profile

  The first New Jersey Epidemiological Profile of Substance Abuse was published in May 2008. It included a comprehensive array of substance abuse-related components and indicators and is organized around indicators for mortality, morbidity, crime, consumption and other factors. The updated Profile will include more indicators related to mental health in order to also support mental health prevention efforts and also will address one of the most prominent data gaps – substance use and mental health data for older adults.

- Updating the Prevention Outcomes Management System (POMS)

  Support is being requested to modify the existing DMHAS prevention information data collection system known as POMS. An outcomes-module will be designed, and the existing curriculum-based module will be re-designed to make it more user friendly.

- Update of the Statewide Prevention Inventory

An inventory of all existing substance abuse prevention interventions in NJ was produced under NJ's SPE grant. The goal of this task was to provide information on existing prevention efforts and their focus so that service gaps could be identified, and duplication avoided in ongoing strategic planning efforts.

Prevent Drug Overdose. In September 2016, DMHAS was awarded a Prevent Prescription Drug/Opioid Overdose-Related Deaths (PDO) grant for $1 million over five years. Called the Opioid Overdose Prevention Network (OOPN) initiative, DMHAS receives real-time, statewide information about drug overdoses from the state's police fusion center that uses cutting edge data collection and transmission technology. This capability allows DMHAS to almost immediately alert front-line practitioners and to make data-driven decisions about where to deploy prevention interventions, which includes community education and distribution of naloxone.

Our project implemented an Early Warning and Rapid Response System (EWRRS) that allows an extensive network of practitioners and community workers in a variety of healthcare settings (e.g., FQHCs, EDs, hospitals) who will be informed when their communities are affected. The alerts will also mobilize opioid overdose prevention practitioners who can provide emergency response training and distribute naloxone to at-risk individuals and their families, as well as disseminate information about addiction treatment services to the local communities that are affected.

Strategic Prevention Framework for Prescription Drugs. In September 2016, NJ was awarded a Strategic Prevention Framework for Prescription Drugs (SPF Rx) grant for $371,616 per year for five years. The SPF Rx provides an opportunity for states that have completed a Strategic Prevention Framework State Incentive Grant (SPF SIG) to target the priority issue of prescription drug misuse. Called NJAssessRX, the grant expands interagency sharing of the state's prescription drug monitoring program, data and gives DMHAS the capability to use data analytics to identify prescribers, prescriber groups and patients at high risk for inappropriate prescribing and nonmedical use of opioid drugs. Informed by the data, DMHAS and its prevention partners strategically target communities and populations needing services, education or other interventions.

The target population is youth (ages 12-17) and adults (18 years of age and older) who are being prescribed opioid pain medications, controlled drugs, or HGH, and are at risk for their nonmedical use. A major component of New Jersey's SPF Rx project focuses on young athletes. A TOP toolkit entitled "Tackling Opioids through Prevention for Athletes" was developed. Literature suggests that when young athletes are prescribed opioid pain relievers for sports-related injuries, there is a risk of addiction and medication misuse. The 19 county coalitions that were established by DMHAS provide education regarding this issue to coaches, parents, prescribers, and young athletes.

DMHAS conducts epidemiological analysis on NJPMP data and employs geographic information systems (GIS) to identify communities and issues that require targeted interventions and public health initiatives. One of the goals of this project is to build capacity to strategically utilize the PMP to inform our prevention strategies. DMHAS purchased the SAS® Analytics software for Prescription Drug Monitoring data. This product allows us to identify suspicious or problematic patterns and helps us develop targeted prevention strategies. We can use the SAS® Analytics tool

for anomaly detection and predictive modeling. This helps us achieve our goal to identify drug misuse trends and develop appropriate prevention strategies. Reports will identify those populations, practice settings and geographic areas, with the highest rates of nonmedical use of opioids and opioid prescriptions.

The reports developed from DMHAS data analysis will be shared with other state agencies and with DMHAS' Prevention Coalitions to inform planning in local communities, which might, for example, target locales for naloxone distribution to prevent drug overdoses. These reports will also be the basis for a public awareness campaign and for training of providers and the health care community on addictions and the risks of opioid prescribing.

State Targeted Response to the Opioid Crisis. In May 2017, SAMHSA awarded New Jersey $12,995,621 annually for two years for its State Targeted Response to the Opioid Crisis project. As one component of this project, DMHAS awarded funding for prevention services programs to older adults in five counties. Awardees designed and implemented a comprehensive educational program specifically focused on providing older adults with practical information regarding non-pharmacological approaches to dealing with acute and chronic pain. The goal of the project is to reduce the overuse, misuse and abuse of prescription opioid medications within this population.

State Opioid Response. In September 2018. SAMHSA awarded New Jersey $21,566,035 annually for two years. In March 2019, NJ received an additional $11,257,470 in SOR supplemental grant funds. In 2019, with State Opioid Response (SOR) grant funds, DMHAS is expanding educational programs for older adults in all 21 NJ counties. These community based educational programs will focus on providing older adults with practical information regarding non-pharmacological approaches to dealing with acute and chronic pain.

Suicide Prevention. DMHAS Suicide Prevention Committee with input from a statewide NJ Adult Suicide Prevention Advisory Council has developed and implemented an Adult Suicide Prevention Plan in accordance with and guided by the 2012 National Strategy for Suicide Prevention: Goals and Objectives for Action, published by the U.S. Department of Health and Human Service Office of the Surgeon General and National Action Alliance for Suicide Prevention. In addition, the Suicide Prevention Committee used the New Jersey Youth Suicide Prevention Plan and other States' suicide prevention plans as references. The NJ Adult Suicide Prevention Plan contains strategies and actions in addition to crisis responses for specific concerns of adult New Jersey citizens; addressing current NJ needs and activities and linking up-to-date science for prevention with practical application in the field. The plan and the action steps go beyond organizations and agencies and stress the importance of everyone's contribution to keeping all individuals in the state safe, in addition to conveying hope and recovery. Although NJ's rate of suicide has been the lowest or second lowest in the nation, DMHAS believes that every suicide is unacceptable and can potentially be prevented, especially for people under care. The plan recognizes several at-risk populations, such as individuals with mental health and substance abuse, a suicidal and/or trauma history, who are part of the LGBTQ community, or have severe medical conditions/chronic pain, etc., as well as high risk periods, such as transitions of care, especially discharges from EDs and inpatient psychiatric units, and includes programs, policies, and approaches to address these at-risk populations and problems.

Since 2015, DMHAS has initiated and collaboratively developed a Proclamation, signed by the Governor proclaiming September as Suicide Prevention Month (2015) or Week (2016 - 2018). DMHAS funds the NJ Suicide Prevention Hopeline that responds to more than 2,000 callers in distress per month with referral options when indicated.

Stigma Reduction. The many New Jersey residents with a substance use disorder, as well as those who are in recovery from this disease, routinely encounter stigma and discrimination. Existing policies, laws, practices and misplaced perceptions undermine acceptance of addiction as a treatable disease and health condition and restrict access to appropriate health care, employment, housing, and public benefits. NCADD- New Jersey provides extensive education and public information to help reduce the incidence of stigma related to alcoholism or drug addiction.

One mission of the Governor's Council on Alcoholism and Drug Abuse (GCADA) is to reduce stigma related to substance use disorder as a top priority. Through outreach and education, the Council sends a message that addiction stigma must no longer be tolerated. In 2014, GCADA unveiled the Addiction Doesn't Discriminate campaign, which is dedicated to increasing public awareness of substance abuse issues. The awareness campaign represents a partnership between GCADA and the New Jersey Office of the Attorney General, including its Division of Consumer Affairs, Division of Criminal Justice, Office of the Insurance Fraud Prosecutor, and Division of State Police; the New Jersey DHS and its DMHAS; the U.S. Attorney's Office, District of New Jersey; the New Jersey Department of Education; and the Partnership for a Drug-Free New Jersey. The campaign is still in operation.

Drug Free Communities Support Program. New Jersey is home to 29 Drug Free Communities Support Program (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, Department of Children and Families, the Juvenile Justice Commission, Department of Health, the Division of Highway Safety, and law enforcement agencies.

Policy Academy. In 2014, New Jersey was 1 of 10 states selected by SAMHSA to participate in the Prescription Drug Abuse Policy Academy. The goal of the Academy was to develop and strengthen state strategic plans to address prescription drug abuse. Representatives from DMHAS, along with partners from: the NJ Attorney General's Office, Department of Health, Department of Children and Families, the prevention/treatment provider community, as well as a family member who lost her son to an overdose participated in the academy.

New Jersey's approach to the problem of Prescription Drug Abuse emphasizes that drug overdose deaths are preventable. We chose to focus our efforts on three components that have proven to be essential aspects of an effective approach to combating the issue:

A. Public Awareness involves: 1. Utilizing existing or developing new social marketing and public information campaigns that target the General Public and provides information to address existing obstacles such as stigma and beliefs such as prescription drug abuse only happens in "bad" families, or that, if a physician prescribes a medication, there are no risks involved and misperceptions and, 2. Utilizing existing or developing new social marketing

and public information campaigns that target Youth and Young Adults (12-25 year olds) and provides information to address obstacles and misperceptions.

B. Collaboration and Coalition Action: according to Community Anti-Drug Coalitions of America (CADCA), coalitions are by their very nature in the business of strategic social interaction. The central mission of any coalition is to develop a collective understanding across the region of the social issue at hand as well as to envision new ways of living that will yield better outcomes. The work being done by the DMHAS-funded regional coalitions, Municipal Alliances, and Drug-Free Community coalitions around this issue is invaluable and should be coordinated and further enhanced.
C. Surveillance and Ongoing Evaluation of Our Efforts involve 1. Monitoring events and trends related to prescription drug abuse to identify geographic "hot-spots" and/or particular populations at risk and, 2. Evaluating policies and programs that have been implemented to address prescription drug abuse.

The Policy Academy provided an opportunity to refine and enhance the strategies listed above. Additionally, DMHAS developed the Opioid Overdose Recovery Program (OORP) as a result of its participation in the Policy Academy and the information presented there. The intent of the Opioid Overdose Recovery Program (OORP) is to respond to individuals who have been reversed from opioid overdoses (by police, emergency responders, or friends/family) and are subsequently treated at hospital emergency departments as a result of the reversal.

Opioid Overdose Prevention Program. As a result of the Opioid Antidote and Overdose Prevention Act passed in May 2013, DMHAS issued contracts to licensed, contracted opioid treatment programs to provide community education and training, to include the distribution of naloxone kits to individuals who attend and complete training. Contracts were awarded to four opioid treatment programs located in, or adjacent to, five counties which had the highest rates of opiate overdose death reported for the period of January 1, 2013 - June 30, 2014. Efforts to educate and dispense naloxone are focused on individuals who are high risk for opioid overdose and include individuals admitted to opioid treatment programs and other substance abuse treatment programs, as well as those individuals engaged with local syringe access programs. Another priority is educating, training and distributing naloxone to family members, friends and loved ones who are in contact with individuals at risk for an opiate overdose.

Since those contracts expired, an RFP was issued in July 2015 to continue this initiative on a statewide basis, known as the Opioid Overdose Prevention Program (OOPP). The RFP established three programs commencing in the fall of 2015 in the following regions.

North:	Bergen, Essex, Hudson, Morris, Passaic, Sussex and Warren Counties
Central:	Hunterdon, Mercer, Middlesex, Monmouth, Somerset, and Union Counties
South:	Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester, Ocean and Salem Counties

The program provides education to individuals at risk for an opioid overdose, their families, friends and loved ones to recognize an opiate overdose and includes the distribution of naloxone kits and information on how to access treatment, including Medication Assisted Treatment, which is the best practice for someone living with an opioid use disorder.

Request for Letters of Interest (RLI) were issued in June 2017 by DMHAS for contracted OOPPs operating regionally across the State of New Jersey to partner with DMHAS in its State Targeted Opioid Response Initiative (STORI) funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) State Targeted Response to the Opioid Crisis (STR) grant. DMHAS made three awards in the amount of $75,000 each**.** DMHAS is educating and distributing naloxone kits to a larger spectrum of specialized groups including, but not limited to, school nurses and other personnel at statewide school districts, medical and clinical staff at jails and prisons, and medical and clinical staff working for residential substance use disorder treatment programs.

Opioid Overdose Prevention Network. In September 2016, DMHAS was awarded a grant from SAMHSA for $1 million annually for five years to implement the Opioid Overdose Prevention Network (OOPN) initiative. DMHAS has partnered with Rutgers University, Robert Wood Johnson Medical School, for the development and implementation of a comprehensive prescription drug/opioid overdose prevention program for this project which includes Naloxone training and distribution. The project plans to reach 3,000 individuals through training and distribute a minimum of 2,500 naloxone kits annually. The initiative will reach individuals in communities identified through Prevention Pathways, as well as reach out to those programs serving individuals who have specialized needs, including: agencies and organizations working with justice-involved populations and offender re-entry programs; healthcare professionals; pharmacists; syringe access programs; community health centers; individuals who underwent an overdose reversal and women's substance use disorder providers.

Opioid Overdose Recovery Program. The Opioid Overdose Recovery Program (OORP) responds to individuals reversed from opioid overdoses and treated at hospital emergency departments as a result of the reversal. OORP utilizes Recovery Specialists and Patient Navigators to engage individuals reversed from an opioid overdose to provide non-clinical assistance, recovery supports and appropriate referrals for assessment and substance use disorder treatment. The Recovery Specialists and Patient Navigators maintain follow-up with these individuals for a minimum of 8 weeks after the initial contact. OORP includes linking individuals to appropriate and culturally-specific services and provides support and resources throughout the process. OORP providers are required to have protocols and procedures in place for priority populations that include pregnant women and parents who have custody of their children and are at risk of child welfare involvement. For pregnant women, OORP provider policies must indicate how they will collaborate with the hospital social worker and/or hospital staff to ensure coordination and access of MAT services. This program was initially implemented in five counties as of January 2015 and is now currently operational in all 21 counties in New Jersey, utilizing state, SABG, STR and SOR funds. A key goal of OORP is to prevent relapse and future overdose.

DMHAS was able to provide Governor's Initiative funding to 17 OORPs. The funds enable them to serve individuals who did not experience an overdose, but who present in the emergency department with issues attributable to opioid use disorder. These individuals are also able to receive OORP services as described above.

Opioid Reduction Options in Emergency Departments. Funded through SAMHSA's State Opioid Response to Grants and Governor Murphy's initiative to address the opioid epidemic in New

Jersey, DMHAS issued an RFP to increase awareness and focus on non-opioid pain management strategies, reduce the use of opioids in Emergency Departments (EDs) and the subsequent prescribing of opioids at ED discharge. Funding is available for FFY 2019 and may be available for FFY 2020; total funding is $1,790,000. According to a 2015 study of opioid prescribing in a cross section of U.S. ED's, 17% of discharged patients received an opioid prescription; DMHAS seeks a reduction in opioid prescriptions written in New Jersey's EDs at discharge to 12% or lower.

Though there are numerous pain management programs, most deal with chronic pain, not acute pain, the type of pain that ED physicians treat. In its effort to help stem the over-prescribing of opioids, DMHAS developed an Opioid Reduction Options (ORO) Plan that is geared to assisting health facilities in minimizing the use of opioids as the first line of treatment in New Jersey EDs where clinically indicated. The ORO program promotes the CERTA concept: channels, enzymes, receptors, targeted, analgesia. The CERTA concept optimizes the following medication classes in place of opioids: Cox-1, 2, 3 inhibitors, *N*-methyl-D-aspartate ("NMDA") receptor antagonists, sodium channel blockers, nitrous oxide, inflammatory cytokine inhibitors and *gamma*-Aminobutyric acid ("GABA") agonists/modulators. Specific agents include NSAIDs and acetaminophen, ketamine, lidocaine, nitrous oxide, corticosteroids, benzodiazepines and gabapentin.

Three tiers will be established which have different levels of expectation: Gold, Silver, and Bronze. Hospitals can apply for one of the tiers and will be required to participate in a Learning Community tailored to the tier. On July 3, 2019, DMHAS granted ORO awards to 11 hospitals, 10 Gold and 1 Silver.

Early Identification/Intervention

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

Early Intervention Services. ASAM level .5 services are offered in the SSA's continuum of care. In CY there were 430 individuals admitted for Early Intervention services. This service is most commonly delivered to clients referred from DMHAS' Driving Under the Influence (DUI) program.

NJ Connect for Recovery Call Line. The NJ Connect for Recovery Call Line was established by the Mental Health Association of New Jersey to support two distinct groups across the state: those concerned with their own opiate use; and, those who are experiencing distress related to the opiate use of a friend or family member. This service is a safe, confidential, nonjudgmental forum that New Jerseyans may call to connect, grow and transform through a unique combination of supportive counseling from Certified Alcohol and Drug Counselors and Peer Specialists. The NJ Connect for Recovery Call Line has expanded weekday hours to increase access to guidance for people coping with opiate addiction and their family members. The current hours of operation are: Weekdays from 8:00 a.m. to 10:00 p.m., Weekends from 1:00 p.m. to 9:00 p.m. and Holidays from 3:00 p.m. to 10:00 p.m. This service also includes insurance consultations for individuals with third party insurance who are trying to determine what benefits their insurance includes for treatment for substance use disorders. In addition to the telephone line, the service also provides

training for various groups that include family members using the CRAFT model, so that families can be empowered to support each other cope with their loved ones' Substance Use issues.

Interim Services. Interim Services have been a requirement of provider contracts, but a new initiative allows DMHAS to pay for these services through a fee-for-service (FFS) mechanism. The Interim Services initiative provides funding to agencies to support individuals awaiting admission to treatment following an SUD assessment. Interim Services are an engagement level of service intended to link individuals to services they may not be able to access due to lack of provider capacity. This service is designed to be provided by agencies contracted for any licensed ASAM level of care. Interim services will be made available to any individual eligible for treatment within the public system who cannot be admitted for the assessed level of care within 72 hours. Prior to this initiative agencies enrolled in the Block Grant initiatives were required to provide this service. Once launched in October 2019, funding for Interim Services will be open to all contracted FFS providers.

ReachNJ Hotline. In February of 2017, the Governor announced ReachNJ, the Addiction Helpline. The Reach NJ was continued through 2018 and was updated in 2019. In February 2019 the ReachNJ contract was transferred to Rutgers UBHC and updated to a Hotline in which callers reach a live person within 30 seconds, 24 hours a day, seven days a week. ReachNJ now provides the same level of service to callers as the Interim Managing Entity (IME). These services include: screening, coordinated referrals, and care coordination. Reach NJ is available to all NJ residents including those with private insurance, those in need of financial assistance, children and young adults. Through this process, ReachNJ facilitates referrals to the agency most appropriate to meet the caller's needs.

College Campuses. This initiative awarded funds in November 2014 for five years to Rutgers University and The College of New Jersey 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 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.

Capital agreements are in process with The College of New Jersey, Montclair State University, and Ramapo College of New Jersey to develop and designate recovery housing for students and/or enhance existing recovery communities on campus. Proposed capital improvements include: the re-purposing of a student recreation facility into a health and wellness center, creating a recovery lounge, renovating a single family dwelling into recovery housing, and upgrading an existing residential building with new kitchen and lounge areas for students in recovery.

Internet Gambling. In 2014, the New Jersey Legislature enacted legislation directing that $250,000 be collected from each casino located in Atlantic City or their internet gaming affiliate(s) that were issued a permit to conduct internet gaming. The purpose of the legislation is to increase/enhance the scope of disordered gambling treatment services in New Jersey.

Utilizing monies appropriated through this legislation, in early 2018, DMHAS awarded funding (by means of a competitive RFP process) to the Council on Compulsive Gambling of New Jersey to expand outpatient and short-term residential treatment services for Gambling Disorder. The Council's responsibilities include overseeing the provision of treatment, monitoring all aspects of service delivery, credentialing service providers, processing service authorizations and claims, and reporting to DMHAS.

With the funds described above, DMHAS developed a Memorandum of Agreement with the Rutgers University Center for Gambling Studies (CGS). The CGS conducted a needs assessment of agencies who serve as our state-approved field sites for students pursuing their LCADC license. Supervisors were contacted in person and/or by phone and email and asked a series of questions to gauge their: 1) knowledge of gambling problems and gambling treatment and screening needs; 2) willingness to participate in a pilot project to develop a gambling SBIRT; and 3) interest in attending a 30-hour gambling training either in person or online.

CGS also reviewed all the existing literature on SBIRT protocols for substance use as well as a gambling SBIRT that was designed in Maryland. Based on their review, CGS designed a small pilot study to test the GAM-SBIRT, including validated screening instruments and feedback from participants.

Sports Betting. With the introduction of legalized sports betting in 2018, DMHAS now receives $50,000 as a portion of the licensing fee each gaming establishment is required to pay. These funds are also directed to the further development or enhancement of prevention programs or treatment services for gambling disorder.

Compulsive Gambling. This contract provides statewide assessment, treatment, prevention, and helpline services through the Council on Compulsive Gambling of New Jersey. The Council offers counseling by certified treatment providers; a helpline (1-800-GAMBLER) that provides information on problem gambling and connects callers to treatment programs and Gamblers Anonymous/Gam-Anon meetings; ongoing public awareness activities; and educational materials for compulsive gamblers, families, and others affected by gambling problems. The Council also conducts outreach to at-risk populations such as older adults, adolescents, criminal offenders, and alcohol/drug dependent persons. Advanced professional training workshops and program development assistance are offered throughout the year. The Council's annual statewide conference focuses on promising approaches to assessment, prevention and treatment of compulsive gambling.

Conduct Disorder. DMHAS is currently collaborating with the University Behavioral Health Care (UBHC) at Rutgers University as UBHC implements a substance abuse prevention study/intervention for children age 8-11 who display behaviors consistent with or meet diagnostic criteria for one of the diagnoses included in the definition of Conduct Disorders. Conduct Disorder is a childhood psychological disorder in which a child demonstrates a persistent pattern of behavior, which violates the basic rights of others or disregards major societal norms or rules. Conduct disorders in youth are a significant predictor of the development of substance use disorders in adolescence and adulthood. DMHAS recognizes the need to identify, create and

deliver innovative, quality outpatient services to those children at increased risk for the development of substance use disorders with the hope that these interventions will forestall or prevent their development. The project includes an intensive clinical component in combination with the 14-week Strengthening Families Program. The study will continue through the fall of 2020.

Treatment

Interim Managing Entity. DMHAS partnered with DMAHS and Rutgers University Behavioral Healthcare (UBHC) to implement an Interim Managing Entity (IME) to allow a single point of entry into substance use disorder treatment throughout the state. Launched in July 1, 2015, the IME has coordinated the addiction services for individuals, insuring that it is delivered at the appropriate level for the applicable time required. Clients can either call the IME directly to be screened and receive a warm handoff to a provider, or they can go to/call a provider directly to be screened and continue services. If callers to the IME are amenable, the IME completes a full screen, both clinical and fiscal, and uses this information to make a referral to an SUD treatment agency with the funding and capacity to meet the caller's needs. The IME holds Affiliation Agreements with all of SUD treatment providers who receive state funding, federal funding and/or Medicaid. These agreements allow for coordination between the provider and the IME to increase caller engagement in care. This has allowed NJ to manage its resources across the continuum of care. The IME care coordination center's phone number is publicized as the addiction services hotline. This year, the state has renamed the IME in a new media campaign and so this will be publicized as ReachNJ.

The IME also provides provider training, care coordination to callers and utilization management (UM) activities. UM activities assure that individuals are provided with the correct level of care for their needs.

Between the 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 The ASAM Criteria standards.

Residential. New Jersey's system of care for residential treatment services is comprised of five levels:

1) Level 3.7 WM Medically Monitored Inpatient Withdrawal Management
2) Short-term residential treatment which approximates Medically Monitored Intensive Inpatient Services Level 3.7,
3) Long-term residential treatment which approximates Clinically Managed High-Intensity Residential Services Level 3.5, and
4) Halfway house services which approximates Clinically Managed Low Intensity Residential Services Level 3.1.

Medication Assisted Treatment, including Methadone, Buprenorphine and Naltrexone are available at most residential facilities either through an affiliation with an Opioid Treatment Program or provided by the residential provider directly.

Specified providers offer specialized programs for women, women with dependent children, children and adolescents, which are consistent with the level of care classification but include services appropriate to these populations. Enhanced co-occurring services are also available. Services provided at each level of care will meet or exceed current New Jersey licensure standards.

Outpatient. New Jersey's level of care for outpatient treatment services is comprised of six levels:

1) Early intervention Level .5,
2) Outpatient Level 1.0,
3) Intensive outpatient (IOP) Level 2.1,
4) Partial care Level 2.5,
5) Level 2-WM Ambulatory Withdrawal Management with Extended On-Site Monitoring, and
6) Medication Assisted treatment delivered in an Opioid Treatment Program (OTP). Services are offered on site as well as at some mobile medication sites.

Services provided at each level of care will meet or exceed current New Jersey licensure standards.

The following is a brief description of the various substance abuse treatment initiatives funded through SAPT and state funds.

SAPT Women's Set-Aside (PWWDC Criterion 3). The SSA provides funding through the women's set aside federal block grant to a statewide network of licensed substance abuse treatment providers in all modalities of care: outpatient, methadone outpatient, short-term and long-term residential for substance abuse treatment to pregnant women and parenting women. The women's programs are designed to meet the specific needs of women such as gender specific substance abuse treatment and other therapeutic interventions for their children. Gender responsive treatment is trauma informed and trauma specific, strengths-based and relational. Gender specific treatment includes gender specific therapies with family focused services, such as individual and group sessions, child care, transportation, services for children, parenting, linkages and recovery supports. As per contract language, providers are required to develop Plans of Safe Care. If a woman is pregnant, the Plan shall be developed prior to the birth event whenever possible and in collaboration with treatment providers, health care providers, early childhood service providers and other members of the multidisciplinary team as appropriate. Plans of Safe Care will address the needs of the mother, infant and family to ensure coordination of, access to, and engagement in services.

Integrated Opioid Treatment Services and Substance Exposed Infants (IOT-SEI). In December 2017 the Department of Health (DOH) awarded funding through a Request for Applications (RFA) for the expansion of integrated opioid treatment services and substance exposed infants (IOT-SEI). DMHAS manages the IOT-SEI Initiative which provides an array of services for opioid dependent pregnant women, their infants and family ranging from substance use disorder treatment, prenatal and postpartum medical/obstetric services, care coordination, recovery-based living arrangements, wraparound services such as intensive case management and recovery supports. The overall goal is intended to improve outcomes for pregnant women with opioid use disorder, their infant and

families. This initiative promotes maternal health, improve birth outcomes and reduce the risks and adverse consequences of prenatal substance exposure. Five agencies across the State are participating in this initiative.

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 makes available, based upon clinical need, a complete continuum of care for Drug Court offenders sentenced in New Jersey Superior Court. Drug Court participation has been voluntary. Fifteen vicinages 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. Since 2012, Drug Court has expanded the criteria for participation; legal eligibility now includes second degree burglary and robbery and also mandatory sentencing to Drug Court. As with the State Parole Board, Drug Court agreed to begin using Medicaid to pay for treatment services beginning in January of 2017 for ambulatory services and residential services starting July of 2018. As the result of legislation allowing for the use of medication assisted treatment (MAT), Drug Court has had a six-fold increase in the number of participants using some form of MAT. This trend is expected to continue.

The success of NJ's statewide Drug Court program has diverted a sizable number of non-violent, low security offenders whose crime resulted from their addiction have been diverted from the prison system. Recently, the Department of Corrections (DOC) has shifted its in-prison focus to medium security offenders in need of SUD treatment. This changed significantly in April of 2017 when Mid-State Correctional facility, a shuttered 656-bed medium-security prison, became the state's first fully-dedicated, licensed drug treatment center for male and Edna Mahan for female inmates. In collaboration with the DHS and DMHAS, both facilities were licensed to provide the ASAM levels of care for short-term and long-term residential services as well as intensive outpatient and outpatient levels of care. Access to treatment begins at the inmate's entry into the prison system versus nearer to release as it was in the past. Inmates will be able to receive multiple episodes of treatment throughout their stay in prison so cases of relapse can be addressed for a more sustainable recovery. Currently DOC operates 656 beds at Mid-State and 65 beds at Edna Mahan. An MOU with Rutgers UBHC signed in November of 2016 enables inmates from all DOC facilities being released to either parole or the community to request the full array of ASAM SUD treatment services through the Interim Managing Entity.

Mutual Agreement Program. The SSA oversees the Mutual Agreement Program (MAP), a Parolee Substance Use Treatment Project implemented through Memoranda of Agreements between the SSA and the New Jersey State Parole Board (NJSPB). This funding is a combination of direct appropriations from DMHAS and funds transferred from NJSPB. These funds support a similar FFS network which offers the full continuum of care including long term and short term residential care, halfway house, partial care, detoxification, outpatient and intensive outpatient treatment, co-occurring services, psychotropic medication reimbursement, and MAT. With the advent of Medicaid reimbursement for treatment services and medication, the use of MAT for parolees has expanded.

South Jersey Initiative. This state funded fee-for-service initiative targets young adults (ages 18-24) from eight counties (Ocean, Atlantic, Burlington, Camden, Gloucester, Cape May, Salem and Cumberland). It provides a continuum of care that includes methadone maintenance, detoxification, residential, halfway house, and outpatient treatment services.

Driving Under the Influence Initiative. New Jersey set aside $7.5 million in state funds beginning in November 2005 to support the substance use disorder treatment needs for financially indigent residents of New Jersey who have been convicted of intoxicated driving and related offenses including driving under the influence (DUI). Convicted DUI Offenders who are financially indigent (less than 350% of the FPL) can receive all appropriate levels of care for the length of substance use disorder treatment documented by medical necessity. The intent is to ensure NJ residents in need of substance use disorder treatment receive the necessary interventions, and to reduce the incidence of recidivism and ultimately creating safer roads and waterways. There are over 200 licensed sites in the Driving Under the Influence Initiative (DUII) network providing all levels of substance use disorder treatment services.

The New Jersey Statewide Initiative. The New Jersey Statewide Initiative (NJSI) began on July 1, 2016 when providers with slot-based contracts transitioned to fee-for-service (FFS). Initially NJSI included only ambulatory services – intensive outpatient (IOP ASAM level 2.1) and outpatient (OP level 1) levels of care, and only two of the eight providers that converted to FFS were funded by Block Grant dollars for outpatient substance abuse treatment services (ASAM level 1). In February 2016, residential substance abuse treatment services were also added, including Halfway House (HWH level 3.1), Long-term residential treatment (LTR level 3.5), and Short-term residential (STR level 3.7). LTR and STR services are Block Grant funded. Services also include Assessment and Enhancements such as a psychiatric evaluation and medication monitoring, urine drug screens, as well as an enhancement for Buprenorphine and Vivitrol, and recovery supports.

The Substance Abuse Prevention and Treatment Initiative. As of July 1, 2016, the contracted methadone outpatient, intensive outpatient and residential services reimbursed by SAPT Block Grant funds transitioned to Fee-for-Service. On April 11, 2017 IWM was added.

Vivitrol Enhancement Network. Approval to provide Vivitrol (injectable naltrexone) and related enhancement services in both residential and ambulatory settings through DMHAS Fee-for-Service (FFS) Network is predicated on agency submission and DMHAS' approval of an application to the Vivitrol Network as well as approval of policies and procedures required by the Department of Health, Certificate of Need and Licensing (CN&L). Those agencies contracted to provide Vivitrol must agree that the prescription and administration of the medication will be conducted by the appropriate medical personnel (Medical Director, Nurse Practitioner, Physician Assistant, or Registered Nurse) and that all counseling services will be provided in accordance with DOH and DCA regulation.

Agencies will ensure, and comply with, consumer choice and consent for this course of treatment. Staff shall provide the appropriate education regarding this medication and also discuss the options available for individuals with either an alcohol or opioid use disorder. A consumer information packet that is specific to injectable naltrexone pharmacology and developed by agency medical

personnel shall be provided to the consumer by their counselor and verbally reviewed with the consumer at each level of care. The information packet shall include the benefits and the risks of the medication.

State Targeted Opioid Response Initiative. New Jersey was awarded a State Targeted Response to the Opioid Crisis (Opioid STR) grant on May 1, 2017. The State Targeted Opioid Response Initiative (STORI) was a new initiative added to the DMHAS FFS Network and opened July 3, 2017.

FFS Network initiated an open enrollment process for new and existing providers to participate in the STORI. STORI includes the following substance use disorder treatment for individuals with OUD: assessment, Intensive Outpatient and Outpatient, Opioid Intensive Outpatient and Outpatient (which includes methadone), buprenorphine and Vivitrol enhancements, withdrawal management (ambulatory and residential) and short term residential.

The STORI was implemented in phases. Phase 1 was opened to all Opioid Treatment Programs (OTPs), Residential Withdrawal Management, and Short Term Residential providers. Case management services are included. Phase 2 was opened on August 7, 2017 to all providers who re-enrolled in the Vivitrol Network. New providers were asked to join the Vivitrol network; for those who joined, they were eligible to join the STORI treatment initiative.

As of April 30, 2019, 2,652 clients received either STR, WM, OP or IOP services. New Jersey was granted a no-cost extension for this grant so services for this initiative will continue until March 2020.

SOR Grant. SAMHSA, Center for Substance Abuse Treatment released the State Opioid Response (SOR) grant funding opportunity for states and territories in June 2018. New Jersey was awarded funding in October 2018. The goals of the SOR are to address the opioid crisis by: (1) increasing access to MAT, (2) using the three FDA-approved medications for the treatment of opioid use disorders, (3) reducing unmet treatment needs, and (4) reducing opioid overdose related deaths through the provision of prevention, treatment, and recovery activities for OUD.

DMHAS plans to expand its strategy to develop infrastructure support with SOR funds to provide buprenorphine in both ambulatory substance use disorder (SUD) treatment programs, as well as other programs, such as licensed mental health programs by funding an additional eight agencies, as well as a low-threshold buprenorphine induction program at two Harm Reduction Centers (HRCs). DMHAS also plans to fund Interim Services for individuals on waiting lists for outpatient and residential programs to provide immediate access to MAT to prevent relapse.

DMHAS will partner with both Rutgers University and Rowan University to ensure funding is available to support individuals at clinics who are indigent, so they can be inducted and/or maintained on MAT. Services for these individuals are planned to include other ancillary services such as care coordination and peer services.

In addition, DMHAS will assist all State county correctional facilities establish MAT programs or enhance existing MAT services for inmates with an OUD as well as provide care management

services. Funding is being made available to promote clinical stability and effective recovery processes for inmates prior to release from incarceration.

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 was renamed the Behavioral Health Planning Council in 2014 and 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 funds two Addiction Recovery Centers, and 63 units of supportive housing and case management and supportive housing services for 10 women and their children. DMHAS awarded three providers start-up funding for three small-scale Recovery Centers to provide peer-to-peer recovery support services to prevent recurrent of substance use and promote sustained recovery. Recently, DMHAS awarded contracts to provide housing subsidies, case management and supportive services to up to 200 individuals with an OUD who are homeless or at risk of homelessness in five counties: Atlantic, Burlington, Camden, Mercer and Monmouth. Contracts were also awarded to pilot three recovery-based housing residences (a minimum of five individuals in each residence), one in each region (North, Central and South), for consumers with an OUD who are homeless or at risk of homelessness and are in or recently discharged from treatment.

Citizen's Advisory Council. The Citizen's Advisory Council (CAC) is composed of consumer and citizen members representing the voices of New Jersey residents at risk for, struggling with, or otherwise affected by the chronic disease of addiction. The CAC supports education, prevention, intervention, treatment, and recovery from alcohol, drug, and other addictive disorders and the elimination of associated stigma. The Council provides input and guidance to DMHAS in furthering its mission, linking the Division with consumers and advocating for the needs and interests of individuals, families, and communities. The CAC believes:

- In the rights of all citizens to access and receive quality prevention, treatment, recovery and support services without stigma;

- In quality, holistic, comprehensive, affordable, client centered treatment services within a continuum of care that recognizes the need for life-long management;
- In encouraging informed consumer choice, and that our collective voices are integral to DMHAS in fulfilling its mission.

Self-Help Groups. Support for involvement of recovering persons in self-help groups such as Alcoholics Anonymous and Narcotics Anonymous is also routinely provided as part of recovery planning, beginning in treatment and continuing upon discharge.

Bringing Recovery Supports to Scale – Technical Assistance Center Strategy. In recent years, New Jersey has greatly expanded, particularly for substance abuse treatment consumers, opportunities to provide peer-delivered services. Accordingly, the number of peers providing these services has also increased. Most of the positions held by peers, however, are part-time or casual in nature. There is a widely-acknowledged understanding, supported by scientific evidence, that peer-delivered services complement and enhance behavioral health care by creating the emotional, social and practical assistance necessary that enables the client/patient to manage their illness and stay healthy. Despite the evidence of effectiveness, however, the settings in which peers are currently employed in New Jersey are limited. And, beyond training and certification activities, there is often no "formal" path by which a peer can enter and serve in this field of work.

Peer–delivered services can have a transforming effect on larger systems of care and on our society by enhancing long-term recovery outcomes and elevating public and professional perceptions of hope for recovery. In addition, employment as a peer specialist brings financial benefits not only for the individual, but collectively to society as far too many people with behavioral health disorders are discouraged from working when employment can be a form of financial stability, source of identity, and a positive contributor to recovery.

In May 2017, was New Jersey was one of 10 states selected to participate in the Bringing Recovery Supports to Scale – Technical Assistance Center Strategy (BRSS TACS) policy academy. With guidance from BRSS TACS seeks to develop a plan by which it can expand the role of peers in behavioral health service delivery, and to develop career guidelines for peers who want to use their experiential knowledge to support the recovery goals of individuals experiencing mental illness or those who suffer from a substance use disorder.

Peer Recovery Support Specialists. Peer-based recovery support is defined as a process of giving and receiving nonprofessional, nonclinical assistance to achieve long-term recovery from alcohol and/or drug-related problems. In New Jersey, these supports are provided by certified peer recovery specialists with lived experience who have been successful in the recovery process in order to support others experiencing similar situations. Lived experience is defined as having knowledge of substance use disorders or mental illness gained through direct, personal experience with success in their own recovery process.

DMHAS views peers as an integral and equal partner in our peer initiatives as the recovery support services they provide expand the capacity of formal and informal treatment and recovery pathways. Peers are an essential component of programs that include medication assisted recovery, residential, therapeutic community and outpatient programs, hospital emergency

department deployment, family and recovery centers. Through shared understanding, respect, and mutual empowerment, certified peer recovery specialists strengthen a person's motivation to change, help to initiate the recovery process, and engage individuals in the recovery process to reduce the likelihood of a return to substance use.

Peer support can exist within the context of individual level and/or family levels. New Jersey's recovery support services are designed to span all stages of recovery – from initiation/stabilization through recovery maintenance & the enhancement of quality of life in long-term recovery. mobilize "Recovery Capital": Internal and External resources that can be drawn upon to initiate and sustain recovery (White, 2009). External Recovery Capital includes, but is not limited to, financial assets, health insurance, safe and recovery-conducive shelter, clothing, food, and access to transportation. Internal Recovery Capital includes, but is not limited to, values, knowledge, educational/vocational skills and credentials, self-awareness, self-esteem, self-efficacy, hopefulness/optimism, perception of one's past/present/future, sense of wholeness and healing. Family and/or Social Recovery Capital includes, but is not limited to, intimate relationships, family and kinship relationships (defined here non-traditionally, i.e., family of choice), and social relationships that are supportive of recovery efforts. Recovery specialists encourage families (biological, nuclear or self-chosen) to become willing to participate in their loved one's treatment and recovery. The presence of others in recovery within the family and social network can help access sober outlets for sobriety-based fellowship/leisure, and relational connections to conventional institutions (school, workplace, church, and other mainstream community organizations).

The Division supports the role of peers through several new and existing initiatives. These programs assist individuals with opioid use disorders or those who are at risk of an opioid overdose through supportive services, case management, education, resources, and advocacy for families and individuals. For example, the Opioid Overdose Recovery Program (OORP), which is now in all 21 counties, provides support services to individuals reversed from opioid overdoes treated at hospital emergency departments. Peers working in OORP programs meet with individuals at bedside where they share their stories of hope and recovery. These peers are instrumental in engaging individuals in the emergency department and beyond and letting them know that they are not alone, and that recovery is available to them in whatever pathway they choose. Peers working in the Support Team for Addiction Recovery (STAR) assist participants in connecting to housing, employment, health services, etc.

DMHAS supports the advancement and professionalism of peers by increasing and enhancing its peer workforce. All peers working in DMHAS initiatives attend a 3-day Ethics training, where they learn about themselves, others, cultural diversity, codes of conduct, motivation interviewing, outreach, self-care, wellness, and engagement techniques. In addition, peers attend the 5-day Connecticut Community for Addiction Recovery (CCAR) which leads to peer certification. DMHAS supports two pathways to peer certification. The International Reciprocity and Credentialing Consortium (IC&RC) NJ affiliate, the Addiction Professionals Certification Board, grants the Certified Peer Recovery Specialist (CPRS) and NAADAC, the Association for Addiction Professionals grants the National Certified Peer Recovery Support Specialist (NCPRS). Over 150 peers have receiving training through the Division's Addiction and Training Workforce Development initiative and one-quarter have obtained certification as recovery support specialists.

DMHAS has been working closely with the state's Medicaid Office to develop reimbursement for addiction peers. An individual 15-minute rate has been developed for peers working in SUD treatment agencies and a bundled rate for the OORP program. The rates are in place as of July 1, 2019. New Jersey's Medicaid office distributed a newsletter outlining the reimbursement process for the OORP program as well as providing technical assistance to agencies as they adhere to requirements of this initiative. This is a significant step in helping to provide sustainability for our peer-delivered programs.

Opioid Overdose Recovery Program. A Request for Proposals (RFP) was issued in June 2015 to develop an Opioid Overdose Recovery Program (OORP) to respond to individuals reversed from opioid overdoses and treated at hospital emergency departments as a result of the reversal. This new two-year initiative funded by DMHAS, the Governor's Council on Alcoholism and Drug Abuse (GCADA) and the Department of Children and Families (DCF) funded programs in Atlantic, Camden, Essex, Monmouth and Ocean Counties. The Opioid Overdose Recovery Program utilizes recovery specialists and patient navigators to engage individuals reversed from an opioid overdose to provide non-clinical assistance, recovery supports and appropriate referrals for assessment and substance use disorder treatment. The recovery specialists and patient navigators also maintain follow-up with these individuals. It is expected that, at minimum, recovery specialists will be accessible and on-call from Thursday evenings through Monday mornings in the specific locations where funding is made available. This new initiative commenced in the fall of 2015. Additional OORP RFPs were released in 2016 to implement the OORP in six more counties. New Jersey's STR award has funded OORP RFPs in 2017 to implement the OORP in the 10 remaining counties in the state. As of March 31, 2019, 11,922 individuals have been served by the OORP. While overdose and relapse prevention are key goals, the program is also intended to help individuals move into recovery.

Support Team for Addiction Recovery. Support Teams for Addiction Recovery (STAR) provide case management and recovery support services for individuals with opioid use disorders (OUD). The STAR initiative is comprised of one team, each consisting of a program supervisor, two case managers and two recovery specialists. The team is to maintain a caseload of 40 individuals. STAR case managers work with individuals to assist with issues that often occur concurrently with an OUD, such as homelessness, incarceration, legal issues, employment, education, transportation, need for social services, health care, child welfare involvement, child care, health insurance, documentation, etc. The STAR recovery specialists provide non-clinical assistance and recovery supports services. The overall goal of STAR is to help maintain individuals with an OUD in the Recovery Zone for as long as possible, help to reduce the risk of recurring episodes of opioid related problems, and prevent future overdose. As noted earlier, 10 STAR programs were funded by STR funds, and another 11 by SOR funds.

Maternal Wraparound Program. The Maternal Wraparound Program (M-WRAP) is a program that provides intensive case management and recovery support services for opioid dependent pregnant and postpartum women. Opioid dependent pregnant women are eligible for services through M-WRAP during pregnancy and up to one year after birth event. Intensive case management focuses on developing a single, coordinated care plan for pregnant/postpartum women, their infants and families. Intensive Case Managers work as liaisons to all relevant entities

involved with each woman. Recovery Support Specialists provide non-clinical assistance and recovery supports while maintaining follow-up with the women and their infants.

DMHAS, DCF, and funding through the Governor's Initiative supports seven M-WRAP regions statewide. Target counties were selected based on a high incidence of Neonatal Abstinence Syndrome (NAS) from 2014 data provided by the Division of Medical Assistance and Health Services and the number of unduplicated pregnant women seeking substance use disorder treatment in those counties during 2015 according to data from the New Jersey Substance Abuse Monitoring System.

The overall goal with the M-WRAP is to alleviate barriers to services for pregnant opioid dependent women through comprehensive care coordination implemented within the five major timeframes when intervention in the life of the substance exposed infants (SEI) can reduce potential harm of prenatal substance exposure: pre-pregnancy, prenatal, birth, neonatal and early childhood. Care coordination also addresses screening, early intervention, assessment, treatment and recovery supports.

To ensure that the needs of the mother, infant and family receive coordination, access to and engagement in services, providers are required to develop Plans of Safe Care. The plan shall be developed prior to the birth event whenever possible and in collaboration with treatment providers, health care providers, early childhood service providers and other members of the multidisciplinary team as appropriate. The M-WRAP model is intended to promote maternal health, improve birth outcomes for women, their infants and families, and reduce the risks and adverse consequences of prenatal substance exposure.

Collegiate Recovery. Two public colleges and universities (Rutgers University at New Brunswick and The College of New Jersey) receive funds to support students in recovery. Recovery support and housing agreements are in place with Rutgers University, New Brunswick and Newark campuses and The College of New Jersey. Recovery supports include screening and intervention services for at risk students; recovery housing; self-help, mentoring, peer and academic support; crisis management and relapse prevention; community education; and alcohol-free/alternative programming and community service opportunities. A capital agreement is in process with The College of New Jersey to enhance its existing recovery community on campus.

Family Support Centers. Three regional Family Support Centers were developed to provide peer to peer family support services for at least 50 families in each region whose loved ones suffer from an opioid use disorder (OUD). Each regional center is staffed with Family Support Coordinators with lived experiences trained in the Community Reinforcement Approach and Family Training (CRAFT) model. CRAFT teaches families self-protection along with non-confrontational skills to help empower their loved one to seek treatment; as well as helping each family member develop and work on their own Individualized Wellness Recovery Plan. The overall goal of the FSC Coordinator is to provide compassionate support to empower parents to have a better quality of life, improve their psychological health, reduce levels of stress, feel less isolated, and gain skills needed to cope with their loved ones' OUD.

The Family Support Centers also offers families support, education, resources and advocacy in an environment that is safe and non-stigmatizing. Families who receive FSC services also receive Naloxone Training and Kits to assist their loved ones at risk of opioid overdose.

Telephone Recovery Support. The Telephone Recovery Support (TRS) program is intended for individuals discharged from substance use disorder treatment with an opioid use disorder, as well as those who are trying to maintain recovery from an opioid use disorder. Weekly phone calls are made by trained staff and volunteers who provide support, encouragement and information concerning recovery resources. TRS is a peer-to-peer check-in type service where the staff and volunteers will help provide local recovery supports, including information about local resources such as self-help meetings, food pantries, recovery houses and detox, if needed. Also included in TRS is the incorporation of text messaging and other types of social media in order to appeal to the younger population who rely on cell phones and social media to communicate. Staff help provide information about local recovery supports, including information about local resources such as self-help meetings, food pantries, and recovery-based living, if needed. To date, 618 individuals have been served by TRS.

Prison Intensive Recovery Treatment Support. The Prison Intensive Recovery Treatment Support (PIRTS) program is a collaboration with the NJ Department of Corrections (DOC) providing peer services that expands pre- and post- release recovery support services to individuals within DOC with an opioid use disorder and facilitates continuity of care and treatment that includes comprehensive medical, substance use treatment and social services. Eligible Offenders being released from DOC custody who are receiving FDA approved medication assisted treatment for an OUD and who will continue to receive medication assisted treatment after their release from prison, and those Eligible Offenders, with an OUD, being released from custody who choose not to receive medication assisted treatment while incarcerated are participants in the PIRTS program.

The overall goal of PIRTS is to help individuals with an OUD who are being released from prison access the Recovery Zone. Within the "recovery zone" the client acquires valuable relapse prevention skills from various means, according to what works best, to sustain recovery. Experiences are translated into valuable lessons and integrated into recovery plans that most closely reflect the client's needs, preferences and values. The outcome of sustained recovery is saving lives, families, communities and dollars. The term "recovery zone" refers to a state of sustained recovery characterized by long periods of abstinence, gainful employment, stable housing, and supportive and rewarding social and spiritual connectedness. Interventions that support clients' entrance into and maintenance within the recovery zone improve the quality of life for individuals with opioid use disorders. This program was developed through an MOA with University Behavioral Health Care and in close collaboration with the Department of Corrections (DOC). A key feature of this program is that the provider will begin working with offenders 6 months prior to release.

Recovery Centers. New Jersey has five recovery centers for individuals in recovery from substance use disorders. Recovery centers are places that those in recovery can find help, fellowship, and a safe haven. Peer workers provide mentoring, coaching, care coordination, social and recreation activities, life skills, vocational training, support groups, wellness classes, workshops and assistance in housing, childcare, language and employment.

The SSA opened New Jersey's first Recovery Center at Eva's Village in Paterson in September 2009 and its programs have grown exponentially in the last six years. This peer-driven and peer-operated center, which is open 365 days per year, provides the following services in the large metropolitan area and surrounding communities: referral to treatment, peer support services, housing assistance, employment assistance, and language assistance, and self-help advocacy, childcare assistance, and recreational activities, wellness classes of interest to the community and advocacy activities in support of recovery. Client choice to participate in program activities is paramount. Additionally, the Recovery Center's participants and staff continue to take leadership roles in community oriented recovery activities such as hosting a Recovery Month walk and picnic celebration in the large catchment area of Passaic County as well as organizing transportation for many (four bus loads) of their program participants to attend the largest Recovery celebration in the tri-state area in Philadelphia.

The SSA issued an RFP and subsequently awarded a contract to the Center for Family Services in Camden County in April 2012 to provide New Jersey's second Recovery Center. It opened in December 2012 at a suburban location in Camden County. Staff working seven days a week provide outreach to individuals in recovery as well as to provider treatment programs throughout the state. Like Eva's village before them, Living Proof Recovery Center has a peer advisory board and a full monthly calendar with weekly self-help meetings, anger management, resume-building and financial workshops. There are also sober social activities such as line dancing, wrap sessions and recovery movies on the weekends. Both recovery centers also provide Telephone Recovery Support (TRS) which has been is an evidence-based and data driven method of successful recovery support (White, 209). Both centers have a strong core of volunteers who are helping with day to day operations and recruitment. At present, staff and volunteers at both centers have used CRSP and updated CDA certification for staff and volunteers.

DMHAS has expanded Recovery Centers through the SOR funding. Funding has been issued in 2019 through a Request for Proposals (RFP) to develop Community Peer Recovery Centers (CPRC) where individuals can access peer support, information about substance use disorder treatment, recovery support services, and information about other community resources in a supportive substance free environment. DMHAS has awarded three providers in the amount of $100,000 each which is for start-up small-scale Recovery Centers to provide peer-to-peer recovery support services to prevent recurrent of substance use and promote sustained recovery. Providers are required to provide peer-to-peer recovery support services that are responsive to community needs. All activities and services are led and drive by "peers", individuals who have experienced addiction and recovery, either directly or indirectly as a family member or friend. The overall goal of the CPRC is to provide a safe place for recovering individuals to gather in support of one another and experience recovery-oriented living in a community setting. The CPRC will be a place where those in recovery can have the opportunity to give back to their community thereby fostering senses of empowerment and independence. DMHAS will be issuing another RFP in early Summer, 2019 using SOR funds for expansion of seven additional CPRCs.

Coalition for Addiction Recovery Support. The Coalition for Addiction Recovery Support (CARS) Advisory committee is a diverse group of experienced recovery support practitioners and providers from New Jersey comprised of 75% peers at minimum. It offers the opportunity for

individual members to be part of a statewide voice for recovery. For organizations, it offers the opportunity to contribute to the development and expansion of recovery support services in New Jersey and an opportunity to coordinate the training and cultivation of the per workforce. The organization is currently funded through SAMHA's Building Communities of Recovery (BCOR) grant.

Grassroots Recovery Organizations and Centers. The Recovery Movement that began in the late 1990's with Faces and Voices of Recovery and most recently celebrated in the 2012 movie *The Anonymous People* is well established in New Jersey. In terms of social media, there are numerous NJ Recovery Support pages on Facebook, Instagram and Twitter – ranging from parent to parent support groups sprung from the loss of their own children, to groups advocating for more treatment and recovery options for those suffering from a substance use disorder. At the community level, New Jersey has seen tremendous efforts in advocacy and recovery support. The New Jersey chapter of the National Association on Alcoholism and Drug Dependence (NCADD – NJ) has developed a program of "Recovery Advocates" program with graduates being divided into regional teams across the state. These Advocacy Leaders are trained on how to provide testimony to the New Jersey Assembly as well to develop regional events to educate the community about recovery and reduce stigma regarding addiction.

There are eight grassroots recovery organizations in NJ: Addictions Victorious (Gloucester County), A Change for Nick (Passaic County), CARES- Center for Addiction Recovery, Education and Success (Morris County), CARES (Warren County), City of Angels (Mercer County), CFC Loud and Clear (Monmouth County), Help Not Handcuffs (Monmouth County), Hope Sheds Light Foundation (Ocean County) and Recovery Advocates of America (Mercer County). Some of these organizations run their own peer-developed, peer designed and peer run Recovery Centers independent of DMHAS funding: City of Angels, CARES- The Center for Addiction Recovery, Education and Success in Morris and Warren Counties, CFC Loud and Clear, Recovery Advocates of America and A Change for Nick. All of these centers train their peer recovery staff and volunteers using the CCAR model. The centers are primarily volunteer run and often receive donations from families who lost loved ones to addiction. These organizations are community-based and developed efforts to help individuals access treatment, provide support throughout their treatment experience and provide aftercare/relapse prevention supports and services after discharge. These are peer-designed, non-12 step affiliated groups, although 12 step meetings are often held on site.

Other Recovery Organizations. There are other recovery organizations that provide education, support and advocacy for those with SUD and their families and loved ones. Three grassroots coalitions provide family support: The Silent Epidemic (Gloucester County), Parent to Parent (Burlington County) and Stop the Heroin (Atlantic County). Seven organizations provide advocacy and training: National Council on Alcoholism and Drug Dependence NJ (Mercer County), Mental Health Association of NJ (Union County), Ammon Foundation (Union County), Mainstream Recovery (Monmouth County, New Jersey Prevention Network (Monmouth County), King's Crusade (Burlington County) and New Jersey Recovery Advocates (Bergen County). Five organizations provide recovery residences: Hansen Foundation (Atlantic County), Surfside Structured Sober Living (Atlantic County), Antonia Maria Foundation (Middlesex County), God Winks (Bergen County), and Milestone House (Bergen County).

Recovery High Schools. In the fall of 2014, New Jersey opened its first Recovery High School - the Raymond Lesniak ESH Recovery High School, which is located on the campus of Kean University in Union County. It is open to students throughout NJ. A Recovery High School is exclusively for young people that struggle with substance use disorders. Every member of the staff, faculty and administration in each school is required to attend numerous trainings regarding addiction and recovery. The school provides social, academic and counseling. The initial class enrolled approximately 20 students. The number of students enrolled is increasing annually. In 2018, two additional recovery high schools opened in New Jersey – one in Monmouth County, and the other in Cape May County.

Group Homes for Persons in Recovery (Criterion 7). Funding is provided to Oxford Houses to provide administrative and programmatic oversight of the statewide network of peer-led group recovery homes in New Jersey. The Oxford House model offers recovery-oriented living as a choice in a person's continuum of care. Recovery is an individualized process for individuals with substance use disorders. As of April 2019, New Jersey has approximately 139 Oxford Houses (102 male houses, 30 women houses, and 7 women with children houses); total beds are 1,113 with 827 male and 286 female beds. The Revolving Loan Fund is administered by Oxford House annually to establish new homes, with additional funding from the Administrative Office of the Courts and DMHAS treatment contracts. This funding supports Oxford House outreach staff to establish homes exclusive for the Drug Court population and women with children homes. Federal funding for the State Opioid Response (SOR) allowed for expansion of the Oxford House contract for three full-time Outreach workers to establish 10 new homes per year. In response to the opioid overdose epidemic, and its effects related to Oxford House, DMHAS requires Oxford House outreach staff to conduct annual trainings (overdose specific) for the 14 Oxford House Chapters throughout the state. Trainings are provided at the Oxford House annual state workshop. Each home is required to maintain Naloxone kits on site. Oxford House shall make every effort to accept individuals prescribed Medication Assisted Treatment (MAT) as well as other legitimately prescribed medications. Women and children Oxford Houses shall be responsible for providing lockboxes to each woman for medication storage, and residents in Oxford Houses are responsible for their individual medication lockboxes.

Supportive Housing. The SSA has two existing supportive housing programs modeled on Housing First and incorporated into its MATI. These two contracts combined provide for a total of 63 housing units, 31 units in Camden and 32 units in Atlantic City. Services are provided to individuals with substance abuse disorders who are homeless or at risk of becoming homeless, and are intravenous drug users. Women with children are given top priority. It includes rental subsidies and support services.

The SSA developed a Women's Intensive Supportive Housing (WISH) Program. This program develops permanent supportive housing for pregnant and/or parenting women with a co-existing substance abuse disorder and mental illness who are homeless or at risk of homelessness and being discharged from a licensed long-term residential substance abuse treatment and/or halfway house facility. An RFP was developed and released in January 2015. This RFP calls for the development of a WISH team to provide case management and supportive housing services for 10 women 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. An award was made in May 2015. DMHAS outpatient treatment system will be able to accommodate the substance abuse treatment needs of the project participants. In addition to WISH, DMHAS has provided additional subsidies to DCP&P to develop housing for parents with children in the child welfare system.

DMHAS recently awarded contracts to provide individualized case management and supportive services to up to 200 OUD consumers, on average, up to 8 hours per month, billable in 15 units, based on individual needs. These services will assist individuals in seeking and connecting with behavioral health and or physical healthcare needs. DMHAS will provide 200 rental subsidies, up to the fair market rate (FMR) as defined by the Department of Community Affairs (DCA) for lease based housing. One-time funding will be available to consumers for security deposits, utility start-up costs and furnishings. Contracts were awarded four agencies to serve individuals in five counties: Atlantic, Burlington, Camden, Mercer and Monmouth.

Contracts were recently awarded for pilot three recovery-based housing residences (a minimum of five individuals in each residence), one in each region (North, Central and South), for individuals with an OUD who are homeless or at risk of homelessness and are in or recently discharged from treatment. Individualized case management and recovery-based housing services will be provided for 15 individuals (a minimum of five individuals in each region) who have been identified as needing a safe, healthy, peer-lead, recovery-oriented environment. The housing provided must be licensed as a Class F, Cooperative Sober Living Residence (NJAC § 5:27). Accordingly, individuals will be responsible for providing their own food and taking care of their own laundry. Treatment and counseling may not be provided in the residence; however, non-clinical recovery support services may be provided at the site and the agency may require, at its discretion, drug or alcohol testing of residents. (NJAC § 5:27-2.1).

Services to Special/Target Populations

Pregnant Women and Women with Dependent Children (Criterion 3). In 2014 as a SAMHSA Prescription Drug Abuse Policy Academy State, New Jersey was eligible to apply for a unique technical assistance opportunity through the SAMHSA supported National Center on Substance Abuse and Child Welfare (NCSACW) to address the multi-faceted problems of Substance Exposed Infants (SEI) and Neonatal Abstinence Syndrome (NAS). New Jersey DHS/DMHAS as the lead State agency partnered with DCF and Department of Health (DOH) and submitted a successful application for In-Depth Technical Assistance (IDTA) (no funding attached). The IDTA goal was to develop uniform policies/guidelines that address the entire spectrum of NAS and SEI from pre-pregnancy, prevention, early intervention, assessment and treatment, postpartum and early childhood. The IDTA would also provide assistance to New Jersey to strengthen collaboration and linkages across multiple systems such as addictions treatment, child welfare, and medical communities to improve services for pregnant women with opioid and other substance use disorders and outcomes for their babies. The New Jersey IDTA Core Team included over sixty (60) individuals representing multiple State Departments and Divisions, community stakeholders, treatment providers, and the medical community.

The IDTA established three goals: (1) Increase perinatal SEI screening at multiple intervention points (Health system, SUD/MH system); (2) Leverage existing programs and policy mechanisms to collaboratively increase the rate at which women screening positive on the 4P's Plus get connected for a comprehensive assessment by establishing formal warm-handoffs and other safety net measures; (3) Leverage existing programs and policy mechanisms to collaboratively increase the rate at which women delivering SEIs and their babies and any other eligible children, receive early support services for which they are eligible.

Three workgroups convened: (1) *Data Workgroup* looked at statewide data systems (Medicaid ICD codes and DOH) that capture prenatal screening, linkage to treatment services, follow-up for parenting women, prevalence of NAS and associated costs. During the initiative, the team analyzed 2013 and 2014 Medicaid data to establish prevalence and costs of treatment NAS.

(2) *Prenatal Screening, Early Identification of Infants & Referral to Service Workgroup* focused on how to increase connections to appropriate treatment and supportive services such as Central Intake and Perinatal Cooperatives, by mapping out current screening and referral practices across the state using Pregnancy Risk Assessment (PRA) data; New Jersey implemented the 4Ps+ across the State and embedded the tool within the PRA. The workgroup found high utilization (over 80%) of 4Ps+ within doctors serving pregnant women on Medicaid. The mapping allowed the team to target low utilization areas to increase the prevalence of prenatal screening.

(3) *Labor, Delivery and Engagement (Infants) Workgroup* developed a comprehensive survey with input from the medical community and perinatal cooperatives. The Hospital Birth Survey was disseminated statewide March 2017 to the labor and delivery hospitals. The survey sought to understand how pregnant women with SUD and substance-exposed infants are identified, treated, and triaged with partners at discharge, and if treatment for NAS was explored. The Hospital Birth Survey results is intended to guide Departments in establishing statewide guidelines for best practice; aid in the development of cross system models to ensure families get access to services; establish education needs on issues of SEI/NAS and identify high risk areas.

Throughout the IDTA process the Core team reported to the State Opioid Workgroup. The Opioid Workgroup was comprised of representatives from multiple State departments and their divisions. The Opioid Workgroup engaged the support and commitment of Department-level commissioners in directing the resources and expertise of their particular department to address the issue of opioids and its attendant problems. In order to sustain the work completed in IDTA, the Opioid Workgroup recommended the establishment of a systemic approach to infant substance exposure, prevention and intervention. The Opioid Workgroup developed an interagency workgroup to promote improved outcomes for SEIs and their families. Although, this workgroup is no longer convened, a monthly Opioid Workgroup meeting is convened under the leadership of Governor Murphy's Policy Office, that includes high level leadership representing different state departments including the Department of Human Services (DMHAS and the Division of Medical Assistance and Health Services), Department of Corrections, Department of Law and Public Safety, Department of Labor and Workforce Development, Department of Health and Department of Children and Families.

The IDTA commenced in 2017, however, DMHAS as the IDTA lead state agency requested modified technical assistance from the NCSACW to support New Jersey to interpret the key

findings from the *Birthing Hospital Survey*, and apply these findings to the Project ECHO program design. Robert Wood Johnson and the Nicholson Foundation, in partnership with the three Departments (Health, Human Services, and Children and Families) and other stakeholders began planning to launch Project ECHO (Extension for Community Outcomes) for SEIs. The New Jersey Project ECHO is aimed at Statewide adoption of best practice clinical care and community-based interventions to support SEIs and their parents to support recovery, family formation, and child development through a multidisciplinary case-based learning platform. Project ECHO for SEI and parents focuses on prevention, birth, and the infant's first year of life.

DCF is the lead State agency on Plans of Safe Care for SEI, mothers and their families and has developed protocols for integrating Plans of Safe Care into child protection services and child welfare and child welfare assessments.

Child Welfare/Parents with Dependent Children Programs (PWWDC Criterion 3). July 1, 2015, the treatment contracts for parents with substance use disorders via a Memorandum of Understanding between the SSA and DCF Division of Child Protection & Permanency (DCP&P) transitioned over to DCF.

DCF and DMHAS collaborate on multiple initiatives targeted to pregnant and parenting women with substance use disorders. This partnership focuses on a coordinated multisystem approach to enhance and integrate service delivery that will ultimately improve the outcomes for the women, their infants and families. This cross-system collaboration ensures that services are coordinated, and information is shared appropriately to facilitate better communication, maximize resources and address barriers.

Currently, 12 of New Jersey's 21 counties have monthly DCP&P Child Welfare Substance Use Disorder Consortia meetings which are held at the local DCP&P offices. Child welfare staff, DMHAS, Division of Family Development, Substance Use Disorder Provider Agencies, Work First New Jersey, Substance Abuse Initiative (WFNJ SAI) providers, and Boards of Social Services meet each month and plan on how to better serve families, leading to more effective policies and practices to meet the needs of infants, children and families. The Consortia also addresses ASFA timelines and reunification for children in out of home placement. Through collaboration, multiple agencies working with the same family can improve communication to reduce the gaps in service delivery and improve coordination of services. The Consortia allow for cross systems collaboration with local treatment programs and other community partners who can provide the expertise needed to better serve families in the child welfare system.

Persons Who Inject Drugs Services (Criterion 4). The SSA will continue to require all substance use disorder treatment agencies providing treatment to persons who inject drugs (PWID) to provide outreach activities to encourage PWID clients to seek and undergo treatment. The SSA will continue to incorporate a provision within the requirements section of each contract with the agencies providing treatment to PWID to ensure that these entities: 1) admit all individuals who request and are determined to be in need of treatment for intravenous drug use within 14 days of their request; or 2) make interim services available to the individuals within 48 hours of the request, and should the individual actively remain on the waiting list, admit the clients within 120 days. Each program will be notified that the following information about each client, who cannot be

admitted to treatment within 14 days, shall be documented on the provider's standard waiting list: 1) date of placement on the waiting list; 2) unique client identifying number; 3) categorical priority status for admission; 4) record of provision of interim services by type and date; 5) record of weekly contact between client and entity; and 6) date and reason for removal from the waiting list.

Tuberculosis Services (Criterion 5). In New Jersey, all substance use disorder treatment facilities receiving contracts are required to conduct TB testing as part of the patients' admissions process. A provision of the guidelines require that patients with TB, who were not admitted for treatment because the funded capacity at that facility had been exceeded, would be referred to another treatment provider for services.

HIV Services (Criterion 6). The Division currently funds Early Intervention Services (EIS) and HIV Specialist positions at 14 licensed Opioid Treatment Programs (OTPs) providers statewide at 15 site locations, one of which is in a rural location. Services are available in areas of the state that have 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 Rutgers, Robert Wood Johnson (RWJ) Medical School, Department of Pathology and Laboratory Medicine, that provides administrative services including lab directorship, consultation, lab oversight, authorization, HIV test kits and technical support to ensure rapid HIV testing for clients in several licensed substance abuse treatment facilities statewide. Through the existing MOA, DMHAS also funds for mobile testing services conducted by staff employed by RWJ Medical School. Specific emphasis for mobile services is for residential and ambulatory substance use disorder treatment programs located in areas of the State with the highest incidence of intravenous drug use and HIV infection. The SSA currently expends 5% of its SAPT Block Grant award to support the HIV Early Intervention Services (EIS) at 14 funded providers at 15 site locations. Of these, South Jersey Drug Treatment Center provides access to HIV EIS services to substance use disorder treatment 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 early intervention services allows clients to receive some or all of these services, either provided on-site at the substance use disorder treatment program or at a nearby medical facility in the community or provided at a combination of both settings.

As of FFY 2017, the State of New Jersey was no longer classified as a designated HIV Block Grant State. As a result, the DMHAS will no longer be permitted to utilize funds from its SAPT Block Grant to support the continuance of HIV EIS after FFY 2019. DMHAS will continue to work closely with its providers to develop affiliation agreements with agencies in communities that provide HIV testing and treatment services to ensure integrated care.

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 makes available, based upon clinical need, a complete continuum of care for Drug Court offenders sentenced in New Jersey Superior Court. Fifteen vicinages 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. Drug Court participation had been voluntary. In July 2012 legislation was signed into law that stipulated a two-phase Drug Court expansion: broaden the legal eligibility to include second degree burglary and robbery and require mandatory sentencing to Drug Court. These were both accomplished by the court by July 2017.

In 2016, The Administrative Office of the Courts (AOC) Drug Court received a Federal Grant allowing them to provide temporary recovery-oriented housing to Adult Drug Court participants in New Jersey's 21 counties. In collaboration with the DMHAS (SSA), an RFP was issued which stipulated that the funds from this grant would allow providers to secure and offer temporary recover-based housing to Drug Court participants over a three-year period. Providers would demonstrate a safe and recovery housing environment that will allow for up to 50 beds to be utilized annually serving 150 Drug Court participants in the community during the three years awarded, while maintaining a recovery-oriented lifestyle. The parameters must stay within the maximum scope of four months per Drug Court participant. However, additional months can be utilized if there is a need to continue temporary housing until permanent housing is secured. Individual eligible for this initiative would be participants who are completing or have completed various Levels of Care (LOC) including residential, Outpatient (OP), Intensive Outpatient (IOP), Partial Care (PC) and Halfway House (HWH) and are homeless or at risk of becoming homeless in need of appropriate housing. This grant was awarded because of the barrier that exist for many Drug Court participants who are ready to enter the community. However, they have difficulty securing recovery housing and as a result are forced to stay in county jails, in longer lengths of stay or remain in treatment because housing was not available as an option for them when they were scheduled to be discharged. This barrier has prevented many participants from moving to the next level in their recovery.

Providers awarded this RFP had to utilize Evidence Base Practices (EBP), along with supporting documentation that was reviewed and approved by SAMHSA that acknowledge this is a safe and recovery-based environment. Providers also showed that they follow or will follow the National Association of Recovery Residences (NARR) standards for recovery houses and the NARR code of ethics that governs their recovery-based environments.

Mutual Agreement Program. The SSA oversees the Mutual Agreement Program (MAP), a Parolee Substance Use Treatment Project implemented through Memoranda of Agreements between the SSA and the New Jersey State Parole Board (NJSPB). This funding is a combination of direct appropriations from DMHAS and funds transferred from NJSPB. For the NJSPB, these funds support a similar FFS network which offers the full continuum of care including long term and short term residential care, halfway house, partial care, detoxification, outpatient and intensive outpatient treatment, co-occurring services, psychotropic medication reimbursement, and medication assisted treatment.

Co-Occurring Services. Beginning in SFY 2010, the SSA established a Co-Occurring Services Network (COSN), comprised of 53 substance abuse licensed treatment providers was established to provide treatment to clients with co-occurring disorders on a Fee for Service (FSS) basis. Agencies eligible to join the FFS Initiatives Co-Occurring Network must first meet New

Jersey Department of Health Certificate of Need Licensing Office (CN&L) requirements as a co-occurring provider before applying to the FFS Co-Occurring Network. Currently, there are 127 agencies in the COSN. These agencies represent 240 individually licensed sites with COSN approval. Approval to provide co-occurring services is predicated on agency's submission, and DMHAS' approval of agency's co-occurring policies and procedures as part of the agency's Co-Occurring Services Network Applications.

Those agencies contracted for the South Jersey Initiative (SJI), Driving Under the Influence Initiative (DUII), New Jersey Statewide Initiative (NJSI), Medication Assisted Treatment Initiative (MATI), Substance Abuse Prevention & Treatment Initiatives (SAPTI), State Hospital Access to Rehabilitation and Education (SHARE), and State Targeted Opioid Response Initiative (STORI) FFS Initiatives must also participate in the co-occurring network and have demonstrated readiness to provide integrated care for dually diagnosed clients. The contractee shall be co-occurring capable and provide at a minimum, assessments and treatment, or must be able to screen, refer and provide linkages to a co-occurring capable agency. The contractee shall ensure that clients screened as "at risk" for co-occurring disorders (COD) shall receive a complete mental health assessment. If the screening contractee is not qualified to provide COD services, it is the contractee's responsibility to facilitate a referral for this service and coordinate ongoing care.

Services to Families of Military Veterans. Working with the New Jersey National Guard Family Program and its eight Family Assistance Centers based at armories around the state, the SSA funds the New Jersey Prevention Network to provide programs to serve returning military personnel and their families through two evidence-based programs, Coping with Work and Family Stress and the Strengthening Families Program. Both programs are designed to enhance protective factors to support military members and their families in making responsible parenting and individual choices in regards to drug and alcohol use.

New Jersey is focused on returning Veterans as a priority population by delivering both Block Grant and PFS-funded initiatives. This is another population for which there is limited information. DMHAS has reached out to New Jersey Department of Military and Veteran's Affairs as well as the New Jersey National Guard to solicit their active participation on the SEOW and Advisory Council in light of this priority.

Driving Under the Influence Offenders. New Jersey set aside $7.5 million in state funds beginning in November 2005 to support the substance use disorder treatment needs for financially indigent residents of New Jersey who have been convicted of intoxicated driving and related offenses including driving under the influence (DUI). Convicted DUI Offenders who are financially indigent (less than 350% of the FPL) can receive and all appropriate levels of care for the length of substance use disorder treatment documented by medical necessity. The intent is to ensure NJ residents in need of substance use disorder treatment receive the necessary interventions, and to reduce the incidence of recidivism and ultimately creating safer roads and waterways. There are over 200 licensed sites in the Driving Under the Influence Initiative (DUII) network providing all levels of substance use disorder treatment services.

Older Adults. The SSA recognized that information concerning older adults and substance use is lacking, and this was also identified as a data gap by the SEOW. In order to help close that gap,

the statewide results have yielded some interesting findings that will help drive planning efforts for this population over two years. Based upon results from the New Jersey Older Adult Survey on Drug Use and Health, DMHAS was led to focus on unhealthy drinking patterns and prescription drug abuse among adults age sixty and older. Data from the Older Adult Survey showed, that in terms of illicit drug use, respondents were more likely to use tranquilizers, sedatives, and opiates than older adults who responded to the New Jersey Household Survey. Data also showed a definite pattern of misuse of prescription drugs and alcohol, particularly among male respondents. New Jersey's 19 DMHAS-funded coalitions are addressing issues regarding the misuse of alcohol or prescription drugs among older adults through the use of appropriate environmental programs and strategies.

Nearly one in every four people residing in New Jersey (23.7% of New Jersey's population) is aged 55 or older. Also, compared to national statistics, New Jersey is expected to witness more significant decreases in two population groups: those under the age of 25 and those between the ages of 35-44 years. In addition, the New Jersey population will age more rapidly than the country as a whole. That is, since 2006, New Jersey has experienced a higher percentage point change in the 75 and older age group. Based upon analyses of New Jersey's Older Adult Survey, findings are consistent with those from national surveys as described below.

- 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)
- A 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

According to the National Survey on Drug Use and Health, 2013, rates of lifetime drug use will increase in the next two decades among the baby boom generation, probably because of less stigma among the cohort regarding "illicit" drug use; and because the current cohort of older adults tend to misuse alcohol and prescription medications if they misuse substances at all. As the baby boom generation ages, the cohort's size alone is predicted to double the number of persons needing treatment for substance use disorders. Therefore, DMHAS has identified older adults as a priority population for substance abuse prevention services and provides funding for both the environmental programs and approaches mentioned above as well as evidence-based curricular programs.

In 2017, DMHAS utilized STR funds to develop the Alternative Approaches to Pain Management program for older adults. The programs provide information about managing acute and chronic pain with means other than opioid analgesics: NSAIDs, massage, yoga, nerve blocks, etc. The program is currently in operation in 10 counties and will soon be expanded to all 21.

Deaf and Hard of Hearing. The Alcohol and Drug Abuse Program for the Deaf, Hard of Hearing and Disabled and a Program Advisory Committee were established pursuant to PL 1995, c.318 (NJSA 26:2B-36 to 39) and continue to meet on a quarterly basis to ensure quality substance abuse treatment services are provided to individuals who identify as being Deaf, hard of hearing or disabled in the community. Annualized funding of $350,000 is provided for prevention, education, treatment, intervention, communication accessibility, and advocacy services for the population of

individuals who are deaf, hard of hearing, and/or disabled. Communication accessibility is coordinated to provide sign language interpreters or Computer Assisted Real-Time Translation (CART) for individuals who are identified as deaf or hard of hearing seeking substance abuse treatment at any level of care.

Gay, Lesbian, Bisexual, Transgendered, and Questioning. The SSA provides prevention services to Gay, Lesbian, Bisexual, Transgendered, and Questioning (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.

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 adapting the "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. The SSA has established a guideline of 350% Federal Poverty Level (FPL) for the receipt of state funded substance abuse treatment. Clients are means tested with a web-based tool, known as the DAS Income Eligibility (DASIE) prior to admission into substance abuse treatment to determine whether they qualify for public funding.

Other SABG Criteria (8, 9, 10)

Referrals to Treatment (Criterion 8). DMHAS utilizes the criteria set by the American Society of Addiction Medicine (ASAM) for patient placement. The tool that is utilized for assessment and placement is the Level of Care Index Version 3, which is incorporated in DMHAS administrative data system, NJSAMS. In addition, the DSM- 5 is utilized for diagnosis. The Immediate Needs Profile (INP) is used as a screening tool.

DMHAS Licensed Substance Use Disorder Treatment Providers receiving funding from the Federal Substance Abuse Block Grant Women's Set-Aside are required to conform to current New Jersey Licensure Standards for Intensive Outpatient, Out Patient Psycho/Social, Opioid Treatment, Short Term, Long Term Residential and Halfway House Programs. Contractees must ensure that pregnant women are receiving substance use disorder treatment prenatally through post-partum. Providers are required to complete the following assessments: 1) Addiction Severity Index (ASI); 2) American Society of Addiction Medicine (ASAM) Criteria 2013; 3) Level of Care Indicator (LOCI); 4) Diagnostic and Statistical Manual of Mental Disorders (DSM5); and the New Jersey Substance Abuse Monitoring System (NJSAMS).

Contractees are required to work collaboratively with the community, other stakeholders and state systems to identify potential clients. Providers must ensure that pre-admission service coordination shall be provided to reduce barriers to treatment, enhance motivation, stabilize life situations and facilitate engagement in treatment.

Contractees must ensure that priority admission and interim services to their programs will be given to IV using, pregnant women and parenting women and publicize the fact. If a contractee is at full funded capacity and unable to admit the pregnant woman, they must refer such women to another facility or make interim services available within 48 hours. At a minimum, interim services includes the following: counseling and education about HIV and Tuberculosis (TB), about the risks of needle-sharing, the risks of transmission to sexual partners and infants, and about steps that can be taken to ensure that HIV and TB transmission does not occur, as well as referral for HIV or TB treatment services, if necessary, linkage to Recovery Centers and/or other recovery supports in the community, and referral and/or and referral and/or linkage to community naloxone education programs. For pregnant women, interim services also include counseling on the effects of alcohol and drug use on the fetus, as well as referral for prenatal care.

Medication-Assisted Treatment (MAT) is the standard of care for pregnant women with opioid use disorder (Treatment Improvement Protocol 43, Chapter 13). Contractees are required to ensure that pregnant women are immediately provided with or referred to comprehensive medication assisted treatment and continue this modality of treatment throughout pregnancy. If a woman wishes to continue with this modality of treatment following her delivery, it is expected that the treatment agency coordinate continuance when clinically appropriate. All women will be given timely access to prenatal care either by the program or by referral to appropriate healthcare providers.

Contractees must ensure that program staff is qualified based on professional licensing regulations and be knowledgeable in the area of gender-specific women's substance use disorder modalities and treatment interventions. Programs are required to develop treatment plans that are family centered, provide for family input when clinically indicated, and address specific services and community support for the family. Additionally, program staff must ensure each woman receives continuity of care and is linked with recovery supports after discharge.

Programs are required to provide an array of clinical and supportive services such as transportation, child care, ensure that children will be referred for primary pediatric care (including immunizations) and/or psychological care as needed. Programs are required to provide comprehensive medical services for women including prenatal care and/or referrals and linkages to the local Federally Qualified Health Center (FQHC). Other services include life skills training designed to nurture a range of skills needed for performance of everyday tasks, to attain self-sufficiency and to sustain independent living in the community. Programs are required to assist women with housing supports and assistance by linking them to transitional, permanent and/or supportive housing and to enhance the skills necessary to maintain safe and recovery-based housing. Programs are expected to collaborate and communicate with systems that provide services to pregnant and parenting women as well as referral agencies such as child welfare, maternal health, other social service providers, etc. Programs are required to implement Plans of

Safe Care to address the needs of the mother, infant and family to ensure coordination of, access to, and engagement in services.

Independent Peer Review of Treatment Services (Criterion 9). DMHAS identified three treatment service providers to be reviewed for the FFY 2019 Independent Peer Review (IPR) cycle. The treatment providers selected for review constitute five percent of those receiving FFY 2019 SAPT Block Grant funds and are representative of the population of such entities. A letter was sent informing the agencies that they had been selected for review. The letter also clearly defined the purpose of the IPR. The stated purpose of the IPR is to ensure continuity and quality of care delivered to individuals with substance use disorders, to improve the system of care and ensure that the IPR focus is on education and remediation rather than monitoring and enforcement. The letter indicated that participants could anticipate independent suggestions for service delivery improvement from the IPR Reviewer, and that the review would not be used by any agency for certification, licensing, compliance monitoring, funding related decisions, or for litigation purposes.

Each IPR that was conducted and completed during FFY 2019 was based, in part, on the review of a limited number of discharged patients' records, a survey questionnaire, review of treatment process, and interviews with clinicians. In addition to the records review, the staff's treatment knowledge, skills level, and attitude were analyzed by a questionnaire survey. Agency counselors were asked to present cases for review, of clients who have recently completed the program. The focus of the case review was on implementation of the treatment process. During the FFY 2019 agency selection process, the focus was on standard outpatient treatment. All three reports must be completed by September 30, 2019.

Next year DMHAS' plan is to repeat the process of hiring up to three credentialed substance abuse professionals to conduct three IPRs in the North, South and Central regions of the State by September 30, 2020; one difference, the focus of the review will be on a different modality than long term and short term residential programs which is the chosen modality for the FFY 2019 IPR.

Professional Development (Criterion 10). As part its on-going responsibility to address areas of concern that affect service access, quality, and outcomes, the SSA provided several educational opportunities to enhance the competency of its addiction and behavioral healthcare workforce. Through its Addiction Training and Workforce Development (ATWD) initiative, the SSA has provided scholarships for initial and renewal/recertification alcohol and drug counseling courses for behavioral healthcare professionals, alcohol and drug counselors, peers, and prevention specialists in the State of New Jersey. All training initiatives also assist prospective alcohol and drug counselors with navigating the credentialing process, exam preparation, internship recruitment, and placement.

To prepare clinical staff to achieve certification or licensure, and to comply with the New Jersey Board of Marriage and Family Therapy Examiners' Alcohol and Drug Counselor Committee continuing education requirements, the ATWD contract was renewed with the New Jersey Prevention Network. The principal goal of this initiative was to provide accessible training opportunities statewide for those entering or presently working in the addiction field. The anticipated outcome was to increase the number of credentialed and licensed employees who

provide treatment, prevention, and peer services. The contractee offered alcohol and drug counseling coursework leading to certification and licensure at nine geographically located training sites across New Jersey. Training opportunities were available to individuals and counseling staff in outpatient, residential, and opioid substance abuse, prevention, peer staffed and behavioral healthcare treatment programs. Since its inception in 2006-2007, the ATWD has had over 750 students become credentialed as certified alcohol and drug counselors (CADC) or Licensed Clinical Alcohol and Drug Counselors (LCADC).

In addition, the ATWD contractee provided scholarships for individuals to attend Certified Prevention Specialist (CPS) courses. Participants from prevention agencies, county alliances, and other community agencies were eligible to attend classes. The goal of the scholarship program was to increase prevention knowledge and best practices to the field as well as to increase the number of prevention specific professionals in New Jersey. ATWD also provided training in Motivational Interviewing, clinical supervision, trauma informed care, and cultural competency.

The ATWD contractee held on-going three-day required Ethics training for 85 peer specialists working in DMHAS Initiatives including OORP, STAR, STORI, Family Center and Recovery Center staff. The training focused on peer roles, boundaries, and ethics when working with individuals reversed with Narcan presenting in the emergency room with opioid use disorders. In addition, 82 individuals attended the CCAR – Connecticut Community Addiction Recovery training leading to peer credentialing. To date, over 30 recovery specialists have been awarded certification, and many more are awaiting verification of their applications.

DMHAS held a Peer Recovery Support Summit in collaboration with the New Jersey Prevention Network, in Atlantic City, NJ, on May 19. Over 400 peer specialists attended. The Summit, "Overcoming the Opioid Crisis: Recovery, Hope and Healing," focused on actionable and practical tools that peer recovery specialists can use in their day-to-day functions and responsibilities. Speakers included Cynthia Moreno Tuohy, Executive Director, NAAADAC, Dr. Michael Ganon, D.O., Medication Assistant Treatment Specialist, and David Sheff, author of *Beautiful Boy*.

The SSA continued to build capacity among current credentialed clinical and peer professionals through its Memorandum of Agreement with The Rutgers University, Center for Alcohol Studies (CAS), Education and Training Division. CAS offered highly specialized, one-day professional development seminars throughout the year as well as offering an intensive weeklong summer training program. Both the seminars and weeklong program offered training education hours that can be applied towards recertification or renewal for alcohol and drug counselors and behavioral healthcare professionals working within the addiction and co-occurring treatment fields. Over 500 individuals participated in these training opportunities.

How These Systems Address the Needs of Diverse Racial, Ethnic, Sexual, and Gender Minorities

The population in New Jersey is diverse in its ethnic and cultural makeup, and several counties have significant minority ethnic populations. Staff providing services must be culturally competent, and education must ensure consumer access. Substance use disorder agencies are required to adhere to licensing standards that require culturally competent services. The state has

not announced specific goals in regard to the Patient Protection Affordable Care Act (PPACA), but it has been actively working to promote structures to support the medical home component, and these are required to be culturally competent and meet the needs of a diverse population.

New Jersey's ongoing efforts to fully develop a community-based, client-centered, recovery-oriented, continuum of care that includes prevention, early intervention, treatment and recovery support services are based upon its ongoing needs and capacity assessment activities. These efforts incorporate standards established by state law and federal policies promulgated by SAMHSA. For example, the aforementioned NJ P.L. 1989, Chapter 51 stipulates that the needs of youth, drivers-under-the-influence, women, persons with disabilities, workers, and offenders committing crimes related to substance abuse are given special attention in all county plans. The SSA gathers data from many state administrative databases and reports to provide counties with the data necessary to describe the needs of these particular groups.

All DMHAS-funded prevention service providers (coalitions as well as organizations that provide individual and family curricula) are contractually-required to adhere to the standards listed below. Adherence to these standards is monitored as a component of the annual contract site visit conducted by DMHAS.

1. Promote and support the attitudes, behaviors, knowledge, and skills that are necessary to work respectfully and effectively with clients and each other in a culturally competent work environment.
2. Have a comprehensive management strategy to address culturally and linguistically appropriate prevention services, including strategic goals, policies, procedures, and designated staff responsible for implementation.
3. Develop and implement a strategy to recruit, retain, and promote qualified, diverse and culturally competent prevention staff that are qualified to address the needs of the communities being served.
4. Require and arrange for ongoing training for prevention staff in culturally and linguistically competent service delivery.
5. Provide all clients with limited English proficiency (LEP) access to bilingual prevention staff or interpretation services.
6. Provide a Registries of Interpreters for the Deaf (RID) Certified Interpreter for Deaf or hard of hearing participants when requested as required by the ADA. (American with Disabilities Act).
7. Provide oral and written notices, including translated signage at key points of contact, to clients in their primary language informing them of their right to receive no-cost interpreter services.
8. Translate and make available signage and commonly-used written client educational material and other materials for members of the predominant language groups in service areas.
9. Use a variety of methods to collect and utilize accurate demographic, cultural, epidemiological and clinical outcome data for racial and ethnic groups in the service area, and become informed about the ethnic/cultural needs, resources, and assets of the surrounding community.

Multi-cultural Services Group. The Division of Mental Health and Addiction Services (DMHAS) within the New Jersey Department of Human Services (DHS) has a long standing commitment to culturally and response care and addressing the unique mental health needs of multicultural populations. The DMHAS defines cultural competence as: "… the ability to honor and respect the beliefs, languages, interpersonal styles and behaviors of individuals and families receiving services, as well as staff members who are providing such services. Cultural competence is a dynamic, ongoing developmental process that requires a long term commitment and is achieved over time" (HHS 2003a, p. 12).

The DMHAS Multicultural Services Advisory Committee (MSAC) formed in 1981. Its mission is to address issues of the quality of mental health and addiction services provided; the quantity of services provided; staffing levels, qualifications and training. Additionally, the MSAC devises strategies that are appropriate to the lifestyles, special needs and strengths of New Jersey's diverse minority and cultural groups such as administrative strategies, service delivery system strategies, education strategies and appropriate direct care strategies. MSAC members include representatives from the community and academic arenas as well as division participants.

In Fiscal Year 2012, the DMHAS committed funding and resources to enhance and improve culturally responsive and culturally competent service delivery to consumers via the development of two Regional Mental Health Cultural Competence Training Centers. These Centers provide knowledge, training, technical assistance and serve as a resource regarding multicultural issues in mental health and addiction. More specifically, their major initiatives include:

- Developing and reviewing needs assessments relating to the cultural competency of the DMHAS system of care.
- Providing technical assistance to the DMHAS mental health and addictions agencies in the implementation of an agency cultural competence plan based on the information from both SAMHSA and CSAT TIP 59.
- Providing accredited trainings that match the cultural and linguistic competencies, skills and needs of staff.

In Fiscal Year 2018, the DMHAS committed funding and resources to develop a Multicultural Diversity and Statewide Consultant. This individual provided consultation, technical assistance, training and services as a statewide resource for DMHAS contracted mental health and addiction providers on issues relating to culture, language, and diversity in the DMHAS system of care.

Promoting/Integrating Health and Behavioral Health

Smoking Cessation. DMHAS has focused on a broad plan to reduce smoking rates in individuals with mental illness and or substance use disorders (SUDs). DMHAS contracts with the Robert Wood Johnson School of Medicine, for technical assistance from Dr. Williams, who is a nationally recognized leader in treating tobacco dependence in individuals with mental illness and addiction. Dr. Williams and her colleagues have been working for decades in NJ to enhance tobacco treatment efforts in the behavioral health treatment setting through various policy, education and treatment efforts. DMHAS is also funding CHOICES, which is a consumer-driven program with the goal of increasing awareness of the impact of 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.

In 2017, DMHAS coordinated a State Strategy Session/Leadership Academy for Wellness and Tobacco-free Recovery, which allowed collaborative planning with the Department of Health (DOH), the Department of Children and Families (DCF), and other state and county agencies. Some of the initiatives that increased understanding and awareness about the impact of smoking on those with mental illness and /or SUDs; in addition, a variety of steps were taken to address smoking, which included an increase in Medicaid coverage for smoking cessation. Several committees that were formed made recommendations on workforce training and development, evidence-based and promising practices, and integration of prevention coalition efforts with primary health, all of which are still under consideration. DMHAS is preparing a statewide survey for licensed agencies to determine the educational needs of their staffs and the current level of smoking cessation treatment that they provide.

DMHAS is currently planning a second State Strategy Session/Leadership Academy for Wellness and Tobacco-free Recovery in late July 2019. This will bring together state officials, practitioners, educators, prevention specialists, and peer recovery advocates, who will assist the state with developing an overall strategic plan to address smoking in this population. This is being done in conjunction with the Smoking Cessation Leadership Center at the University of California San Francisco, and the National Behavioral Health Network for Tobacco and Cancer Control. The plan this time is to measure service needs more precisely and to establish how the needs of the population have change since the last summit. The goal is to select a few areas to work on improving and measuring changes in the data at baseline and subsequent years. Further, DMHAS is more closely collaborating with DOH, which has a number of new projects funded by a 1% set aside from tobacco tax. This will fund 11 new quit centers, 5 prevention grants, a collect campus NJ QUITS initiative, and mini grants for colleges to create some free policies.

In addition, smoking cessation services have been incorporated into various DMHAS initiatives to address the opioid epidemic. These initiatives are supported by state and federal funding (known as State Opioid Response or SOR) and are directed at providing medication assisted treatment (MAT) for substance use disorders; use of smoking cessation medications is defined as a form of MAT. In the New Jersey Substance Abuse Monitoring System (NJSAMS), which is a treatment database, smoking cessation medications will be listed as treatments. Some DMHAS initiatives that have promoted MAT in primary care and other medical settings are also including smoking cessation interventions. One of these initiatives is the Certified Community Behavioral Health Clinic (CCBHC), and this routinely provides smoking cessation as one of its required evidence-based practices.

DMHAS has further plans to promote smoking cessation efforts in integrated primary care and behavioral health settings, and this is one of the goals of its July meeting to develop a strategic plan. Another goal is the promotion of practice guidelines that recommend asking about and assessing tobacco use at every health care visit, whether for medical of behavioral health services. Another initiative being considered is the expansion of tobacco-free campuses and smoke free policies in all behavior health care settings, especially in outpatient and residential addiction

services. The latter is especially important because recent evidence suggesting that individuals who quit tobacco have improved outcomes in regard to their use of opioids and other illegal drugs.

DMHAS Medical Director's Integration Office. The SMHA Medical Director's Office has an Integration unit with the goal of promoting integration between behavioral health agencies and primary health care providers. This office is working closely with the state Medicaid Office (Division of Medical Assistance and Health Services, or DMAHS) and DCF. The main goal of the initiative is to increase consumers with mental health and/or substance use disorders (SUDs) access to primary care and improve collaboration between behavioral health agencies and primary health care providers.

Certified Community Behavioral Health Clinics. DMHAS was selected to be one of the eight Certified Community Behavioral Health Clinic (CCBHC) demonstration states. This project is a collaboration between the Department of Human Services' Division of Medical Assistance and Health Services (DMAHS) and DMHAS and the Department of Children and Families (DCF). This demonstration is part of a wider effort to integrate behavioral health with physical health care, increase consistent use of evidence-based practices, and improve access to high quality care for people with mental and substance use disorders. Populations to be served are adults with serious mental illness, children with serious emotional disturbance, and those with long term and serious substance use disorders, as well as others with mental illness and substance use disorders. There are seven behavioral health providers licensed to provide treatment to adults and children who have a mental illness (including serious emotional disturbance) and/or substance use disorder participating as CCBHCs in New Jersey. The Federal Demonstration was extended to September 13, 2019 and the state partners are currently evaluating plans for sustaining some or all of the program in the state. A recent announcement is the House voted to pass the "Empowering Beneficiaries, Ensuring Access, and Strengthening Accountability Act of 2019 (H.R. 3253)," which would extend funding for certain Medicaid programs. Under the provision, funding for the eight-state Certified Community Behavioral Health Clinic (CCBHC) demonstration program would be extended for another two and a half years until December 21, 2021. There was overwhelming bipartisan support of H.R. 3253, passing with a vote of 371-46. The bill must now go to the Senate for a vote before the CCBHC demonstration program expires on June 30, 2019.

Since launching in 2017, CCBHCs have dramatically increased access to comprehensive, community-based mental health and addiction treatment. Members of the House on both sides of the aisle have applauded CCBHCs for being a key solution to combat the opioid epidemic by reducing patient wait times, expanding access to medication-assisted treatment, hiring more staff specializing in addiction treatment and much more.

Office Based Addictions Treatment. The Office Based Addictions Treatment (OBAT) initiative, rolled out in 2019, which is based on the "hub and spoke" approach. In this model, specialty SUD clinics, such as the opioid treatment programs (OTPs) serve as the 'hubs' and treated patients with more complex needs; meanwhile, the 'spokes' were small office based practices and primary care settings in most patients with more routine treatment needs were treated. Office-based practitioners (e.g., family physicians, psychiatrists, medical specialists, advanced practice nurses

and others) prescribe buprenorphine and naltrexone, and they would have to either make referral arrangements or directly provide counselling for the patients.

To assist OBAT practitioners, Medicaid has funded a new position called the navigator, whose role is to arrange social services and supports for patients and to help monitor their progress. The OBAT system of OUD services, also referred to as the MATRx, allows a two-way referral of patients with other Medicaid funded providers. Office-based providers can refer patients needing a higher level of medical and /or addiction services to specialty providers (e.g., substance use treatment agencies, certified community behavioral health clinics, federally qualified Health Care centers, etc.) or to one of two Centers of Excellence (COEs). DMAHS contracted with Rutgers University and Cooper/Rowan Universities to serve as COEs for the OBAT initiative. In addition to providing MAT services, these Centers are available for treatment and consultation referrals of individuals with complex needs. Because many practitioners without extensive experience with buprenorphine need support to maintain a MAT practice, the Centers are also providing MAT training (with the goal of training 1,000 prescribers in calendar year 2019 to receive the DATA 200 waiver whereby enabling them to prescribe MAT) and will be available to provide mentors to these practitioners.

Single MH/SUD License. DMHAS is working with the Department of Health licensing office to comment on regulations that act as barriers to integrating services, with the goal of streamlining the regulations and increasing integration of services. The plan is to develop a single, unified regulation that will remove current barriers and allow integrated services to operate seamlessly.

System Improvements

SUD Promoting Interoperability Program. Health Information Technology (HIT) and Electronic Health Records (EHR) are critical elements in New Jersey's strategy to address the substance use disorder (SUD) and opioid use disorder (OUD) crisis. Due to limitations in federal statute, SUD/OUD providers have generally not been able to participate in the federal Promoting Interoperability Program or meaningful use incentive programs. To promote interoperability between behavioral health and physical health providers caring for SUD/OUD individuals, the State of New Jersey is making available a total of $5.3 million in funding for a milestone-based SUD provider incentive program. Implementing EHR technology allows behavioral health providers to efficiently capture and store data in structured format that, with the proper privacy and security processes in place, can be easily retrieved, shared and transmitted to assist in patient care, monitoring and recovery. Amongst a host of benefits, the behavioral health provider adopting an EHR will have the ability to: (1) gather, analyze and report clinical and operational data; (2) prepare for and demonstrate interoperability to a Health Information Exchange (HIE) and associated use cases; (3) generate electronic prescription and connect to a Prescription Drug Monitoring Database (PDMP) and (4) collect and transmit information to the NJ Substance Abuse Monitoring System (NJSAMS).

In order to make meaningful progress in connecting residents of New Jersey being treated for SUD/OUD, clinical information needs to be portable between SUD clinics, hospitals, and other providers. This will allow all types of providers caring for patients to be armed with the latest

clinical information on a patient, enhancing care quality and appropriateness at all sites and avoiding inappropriate or duplication of care.

All of this requires meaningful investment in the IT infrastructure of SUD clinics, which Governor Murphy intends to provide with these funds. This will not only serve the purpose of modernizing systems; it is intended, specifically, to connect siloed systems of care to each other, to enhance care coordination and quality. In addition, these investments present an opportunity to allow for EHRs in SUD clinics to better align with workflow barriers and needs at the point of care.

This program is administered by the New Jersey Department of Health (DOH) in collaboration with the New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS) and the Division of Mental Health and Addiction Services (DMHAS), collectively referred to "the State". Funding will be made available to participating SUD provider entities on a first-come, first-serve basis through New Jersey Institute of Technology (NJIT) and its New Jersey Innovation Institute (NJII), formerly NJ-HITEC, the designated state entity that manages the New Jersey Health Information Network (NJHIN).

The SUD provider must meet the following criteria to be eligible to participate in the program:

1.1.1 A non-profit or for-profit entity or governmental entity.
1.1.2 A Medicaid provider and have adjudicated claims from Medicaid.
1.1.3 Licensed by the Department of Health's Office of Licensing (OOL) to provide SUD treatment prior to the start of services.
1.1.4 Receiving funding from DMHAS to provide SUD treatment services either through cost-based contract or fee-for-service.
1.1.5 Have at least 50 SUD admissions during CY 2018 which is documented in NJSAMS.

The program anticipates that there will be two categories or tiers of SUD providers that will be able to participate.

1.1.6 Tier 1 providers are SUD providers who currently do not have an EHR and will be implementing a new EHR.
1.1.7 Tier 2 providers are SUD providers who currently have an EHR but will be upgrading to an Office of the National Coordinator for HIT (ONC) Certified EHR Technology (CEHRT).

Incentive payments are disbursed by NJII to participating providers after the achievement of milestones as defined below. The State reserves the right to revise the milestone definitions based on current or future system capabilities and/or overall program milestone achievement progress. Designated personnel from the State will review all supporting document and approve incentive payments. The State will have an option to implement an attestation application to allow participating SUD providers to register and submit attestation information. All milestones are expected to be achieved over a two-year funding period.

1.1.8 Milestone 1 – Participation Agreement / EHR Vendor Contract Agreement
1.1.9 Milestone 2 – EHR Go-live / Upgrade

1.1.10 Milestone 3 – NJHIN/HIE Connectivity
1.1.11 Milestone 4 – PMP Connectivity
1.1.12 Milestone 5 – NJSAMS Connectivity (optional, if supported by EHR vendor)

If all five milestones are achieved, the total amount of incentive payment a Tier 1 participating SUD provider may potentially receive is $42,500, while a Tier 2 participating SUD provider may potentially receive is $30,000.

As of June 21, 2019, 22 SUD providers have signed a participation agreement. The goal is to have 120 providers participate. The New Jersey Association of Mental Health and Addiction Agencies (NJAMHAA) is providing technical assistance and developing learning collaboratives.

Pay for Performance. Incentivizing provider performance or paying for performance (P4P) is an approach being explored to achieve better health and or behavioral health outcomes for clients. However, the literature suggests that few organizations use P4P to improve clinical outcomes directly. As a result of the NJ Governor's Initiatives announced on September 18, 2017, DMHAS will incorporate this model into the Prison Intensive Recovery Treatment Support (PIRTS). The system is the Performance Incentive Payment System (PIPS). It is a new innovative model to incentivize provider performance with the goal of improved outcomes. These incentives are designed to pay for the attainment of meaningful outcomes that will help the client achieve success as they move into recovery from substance use disorder.

Performance-based incentives will be paid as follows:

- **Retention**. If client remains in treatment for 90 days, payment will be $200.
- **Relapse Prevention**. If client remains in the community for 5 months after completion of an episode of care, payment will be $300.
- **Recidivism.** If client remains in the community for 6 months after release from prison, payment will be $300.
- **Overdose Prevention**. If client does not experience an overdose for 6 months after admission to the PIRTS Program, payment will be $500.
- **Stable Housing**. If a client is placed by PIRTS and remains in housing for 6 months payment will be $300.
- **Employment.** If a client is placed by PIRTS in employment and remains for 6 months, payment will be $300.

Eligible Offenders being released from DOC custody who are receiving FDA approved medication assisted treatment for an OUD and who will continue to receive medication assisted treatment after their release from prison, and those Eligible Offenders, with an OUD, being released from custody who choose not to receive medication assisted treatment while incarcerated will be participants in the PIRTS program. The overall goal of PIRTS is to help individuals with an OUD who are being released from prison access the Recovery Zone. Within the "recovery zone" the client acquires valuable relapse prevention skills from various means, according to what works best, to sustain recovery. Experiences are translated into valuable lessons and integrated into recovery plans that most closely reflect the client's needs, preferences and values. The outcome of sustained recovery is saving lives, families, communities and dollars.

This program is being developed through an MOA with a provider and in close collaboration with the Department of Corrections (DOC). A novel feature of this program is that the provider will begin working with offenders six months prior to release.

Financing Strategies. The SSA has explored financing strategies involving payment for an episode of care. Since the SSA has a fee-for-service billing system for many of its treatment initiatives, it has the data available to conduct this analysis. Costs by episode for the different initiatives by the level of care initially entered are analyzed to support fiscal planning. The analysis has indicated the episode costs vary widely across initiatives even though they start at the same level of care. These data have helped inform the SSA in developing benefit management strategies for high cost services such as residential with the goal of ensuring that individuals get the right service at the right time in the right amount (as per SAMHSA's recommendation). Maximizing the appropriate use of services in the most cost-effective manner, allows the SSA to provide more services to clients in need and helps reduce the treatment gap between met and unmet demand.

Quality Reporting. The purpose of the Certified Community Behavioral Health Clinic (CCBHC) is to provide ready access and an expansive scope of services to clients who present with behavioral health concerns and most often present with needs in multiple life domains. The CCBHCs offer services within an integrative, holistic framework, thereby closing a treatment gap that frequently results in inadequate service provision for individuals with co-existing social, physical and behavioral health care needs.

New Jersey selected seven CCBHCs in six counties, including six CCBHCs in five metropolitan counties plus one provider in a rural pocket of Atlantic County. The CCBHCs include: Care Plus in Bergen County; Northwest Essex in Essex County; Catholic Charities and Oaks Integrated Care in Mercer County; Rutgers UBHC in Middlesex County; CPC Behavioral in Monmouth County; and AtlantiCare in Atlantic County.

New Jersey's CCBHCs are expected to: decrease the time from patient's initial outreach to first appointment, increase access to a wide scope of mental health services, meet treatment gaps for individuals with substance use disorders, expand the use of mental health and substance use peer supports, and increase use of evidence-based practices such as Medication Assisted Treatment (MAT). New Jersey's CCBHCs offer 24-hour crisis care, treatment for co-occurring substance use disorder and mental illness, ambulatory and medical withdrawal management, evidence-based outpatient counseling, case management, and family support services.

SAMHSA identified 22 standardized variables based on the above domains of service that will be used to measure the aggregated impact of the CCBHCs, including six measures that may qualify for a quality bonus payment. If a CCBHC reports all six quality bonus payment measures, it will receive a QBP for meeting or exceeding national standards established by the Healthcare Effectiveness Data and Information Set (HEDIS).

Nine of the measures are clinic level which means they are reported by the individual CCBHC clinics. Listed below, they include time to evaluation along with eight preventive care and screening measures for adults and children.

- Time to Evaluation
- Adult and Child Body Mass Index
- Tobacco Use
- Unhealthy Alcohol Use
- Adult and Child Major Depressive Disorder/Suicide Risk Assessment (QBPs)
- Screening for Clinical Depression and Follow-up
- Depression Remission at Twelve Months

Thirteen of the measures are state level measures which are primarily reported using Medicaid claims data. These measures, listed below, include Uniform Reporting System housing status and consumer satisfaction, information about follow up after emergency department visits and hospitalizations, adherence to medications, and alcohol and other drug treatment.

- Housing Status
- Adult and Youth/Family Patient Experience of Care
- Follow-up After Emergency Department Visit
    - Mental Illness
    - Alcohol and Other Drug Dependence
- Plan All-Cause Readmissions Rate
- Diabetes Screening for People with Schizophrenia or Bipolar Disorder Using Antipsychotic Medications
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia (QBP)
- Adult and Child Follow-up After Hospitalization for Mental Illness (QBPs)
- Follow-Up Care for Children Prescribed Attention-Deficit Hyperactivity Disorder Medication
- Antidepressant Medication Management
- Initiation and Engagement of Alcohol and Other Drug Dependence

In addition to the 22 measures required by SAMHSA, New Jersey created seven additional variables that will be used to measure the local impact of the specialized substance use disorder services implemented at the CCBHCs in New Jersey. The New Jersey-created measures are listed below.

Scope of services:

- Unhealthy Drug use-screening and cessation intervention
- Targeted case management
- Peer recovery support while in treatment
- Family support services
- Supported employment services
- Medication-assisted treatment (MAT) for individuals with Opioid Use Disorder (OUD)

Access to services:

- Number/percent of treatment admissions by target group

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

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

Department of Human Services

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

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

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

In 2011, DHS merged its Division of Mental Health Services and the Division of Addiction Services into DMHAS. The merger provided an opportunity to integrate adult mental health, substance 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 and coordination of services, alignment of policies and contracts, and workforce development efforts.

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

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

Mental Health Services

DMHAS is the state mental health authority (SMHA) that oversees the state's public system of adult mental health services. The SMHA works closely with three regionally-based, adult psychiatric hospitals, and one adult forensic hospital. The SMHA contracts with 117 not-for-profit community provider agencies. In addition, the SMHA provides 85% of the cost for individuals with a designated county of residence who are uninsured and a 100% of the cost for individuals who do not have a county of residence and are uninsured for the four county-operated psychiatric facilities (New Bridge Medical Center, Essex County Hospital Center, Meadowview Hospital, and Cornestone Behavioral Health Hospital of Union County) . The state psychiatric hospitals, county hospitals, and community provider agencies all function as part of the continuum of mental health services in New Jersey.

New Jersey's 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 New Jersey Behavioral Health Planning Council (BHPC) of issues and programs that are of significance to their locale and residents. In each county, a System's Review Committee (SRC) is convened monthly in accordance with state regulation (NJAC10:31-5.3(a)). The SRC is comprised of representatives from the acute care community and include staff from: state and county hospitals, short-term care facilities (inpatient units serving individuals on commitment status), voluntary psychiatric inpatient units, the county Mental Health Board, community provider representation (including the county's Program for Assertive Community Treatment and county's Integrated Case Management program), family and consumer organizations, and the SMHA. The SRC is charged with the collection and review of service data as well as monitoring the provision of acute care services statewide. 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 four levels of care in each county: (1) prevention and early intervention; (2) acute care programs and crisis stabilization; (3) intermediate care and rehabilitation; and (4) 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 providers regarding individuals dually diagnosed with a mental illness and developmental disability; Statewide Clinical Outreach Program for the Elderly (S-COPE) which provides consultation and training to nursing facilities and DMHAS residential providers who serve older adults (55 years of age and older) who are at risk of psychiatric hospitalization; and *ACCESS* which provides consultation, residential, outpatient and case management services to individuals who are deaf or hard of hearing and diagnosed with a mental illness. Additional statewide contract services include contracts to provide training and technical assistance to specialized segments of the provider workforce and statewide depositories of behavioral health resource information and self-help information. The SMHA contracts for regional services including: Behavioral Health Cultural Competence Training Centers to provide training and information to providers regarding cultural competence, co-occurring services for individuals with a mental illness and substance use disorder and housing with enhanced supports for individuals with co-occuring medical needs, development disorders, substance use disorders, or criminal justice involvement.

According to its 2018 URS Data Table 3, & 14a, the SMHA served 341,774 unduplicated adult (age 18+ years) consumers SFY 2018. Of the total number of unduplicated adult consumers served in SFY 2018, 322,240 (94.3%) were served in community settings—including county hospitals and Short Term Care Facilities (STCFs); 2,952 (0.86%) were served in State Psychiatric Hospitals, and 16,582 (4.85%) were served in other psychiatric inpatient settings. Of the total number of unduplicated adults (341,774) served in *all* settings by the SMHA in SFY 2018, 132,561 (38.8%) were reported to have SMI.

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

The Five Criteria in State Mental Health Plan

Section 1912(b) of the Public Health Act (42 USC § 300x-2) establishes five criteria that must be addressed in state mental health plans. States must describe these in the planning steps. The criteria are defined below:

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

SMHA funds four levels of service along the mental health continuum of care with Community Mental Health Block Grant, and other federal or state funds. They are: Prevention and Early Intervention Services, Acute Care Services, Intermediate and Rehabilitative Services, and Recovery Support including Consumer Operated Services. In addition, the SMHA operates four State Psychiatric Hospitals and funds four County Psychiatric Hospitals. The SMHA also engages in Olmstead Initiatives.

1. Prevention and Early Intervention Services.

First Episode Psychosis

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

The New Jersey's CSC programs emphasize a team approach with the following components: outreach, low-dosage medications, cognitive and behavioral skills training, Individualized Placement and Support, supported employment and supported education, case management, and family psycho-education. Each CSC team is comprised of six team members of mostly masters' level trained clinicians. They include a team leader, a recovery coach, a supported employment and education specialist, a pharmacotherapist, an outreach and referral specialist; and a peer support specialist. All clinicians are trained to treat clients using Evidence Based Practice methods. Evidence Based Practice methods used to treat clients are recommended by the *Recovery After an Initial Schizophrenia Episode (RAISE) Manuals* and include:

- Individual Placement and Support
- Person-Centered Therapy
- Motivational Interviewing
- Cognitive behavioral therapy (CBT)
- Cognitive remediation

- Peer wellness coaching
- Trauma-informed care
- Individual Resiliency Training (IRT)
- Psychoeduaction
- Supported Education & Employment

New Jersey's CSC services are provided for youth and adults ages 15 to 35 years who have experienced psychotic symptoms for less than 2 years with or without treatment. New Jersey CSC programs cover 21 counties using extensive outreach efforts. As of May 21, 2019, the three CSC programs had over 520 referrals and have treated 266 clients in their programs. New Jersey plans to continue utilizing the 10% set-aside funding in the FY 2020-21 to support these three CSC teams in providing evidence-based services for individual with FEP. With increased demand for FEP services,the CSC programs expanded from serving 35 clients to 70 clients per agency and increased clinical staff from 5.2 FTE to 6.8 FTE levels in FY 2019.

Beside funding the three CSC teams, the SMHA has utilized the 10% set-aside fund to support the hiring of an evaluation specialist, who assists in the development of evaluation tools and data collection instruments. In addition, the evaluation specialist is responsbible for contacting the agencies to ensure that these agencies submit the required data elements on a regular basis. The agencies have been required to submit Quarterly Contract Monitoring Report (QCMR) data and fiscal spending data to the SMHA at the end of each quarter. The data evaluation specialist is also developing a client level CSC database. This database will include client demographic information; admission and discharge data; and clinical and functioning measures of all clients who participated in the CSC programs. The goal of the data collection is to monitor the progress of all clients, to evaluate the CSC programs, and also to address all federal data evaluation and reporting requirements.

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

Since inception in 2017, CSC programs have effectively improved the quality of care for the FEP population in New Jersey. Among the 266 clients served during the past two years, psychiatric hospitalization re-admission rates were reduced from 41.7% to 18%. The psychotropic medication adherence rate was 81.3% compared to a rate of approximately 50% in other ESMI populations that did not receive evidence-based psychotherapies. Since its inception CSC has provided a stable system for FEP individuals to interact in the community through gaining employment, continuing education and has improvement global functioning for those who remain in care for a consistent period. In FY2018, 81.9% of clients who were in a CSC program for 3 months or longer have shown improved functionality.

Moving on Maternal Depression (MOMD) Initiative

In August 2018, New Jersey was one of three states that received an award from the Center for Law and Social Policy (CLASP) through its Moving on Maternal Depression (MOMD) initiative. The 18-month initiative provides technical assistance, which is administered in the form of monthly calls with CLASP and other participating states; site visits with CLASP; and a conference with other states on promising practices toward serving populations with maternal depression. New Jersey's efforts under this initiative come from a collaborative which is co-lead by the Division of Mental Health and Addiction Services (DHS-DMHAS) and the Department of Health (DOH), and includes the Division of Medical Assistance and Health Services (DHS-Medicaid), the Department of Children and Families (DCF), and three maternal health consortia consisting of the Partnership for Maternal Child Health, Central Jersey Family Health Consortia, and South Jersey Perinatal Cooperative. The collaborative, known as the MOMD Core Team, has, as its focus, three individual goals for improving its ability to serve mothers with maternal depression. Each of these goals is the focus of its own subcommittee of core team members, which meets monthly to discuss progress, share insights, and discuss any questions or concerns arising from their efforts. The core team subsequently reports on these meetings to CLASP on monthly calls and receives feedback and consultation where necessary. The three goals comprising New Jersey's MOMD initiative consist of: 1) Enhanced Data Capacity related to examination of maternal depression in New Jersey; 2) Increased Access to Services related to maternal depression; and 3) Reduced Racial, Ethnic, and Socioeconomic Disparities in utilization of maternal depression services.

National Academy for State Health Policy Maternal and Child Health Policy Innovations Program Policy Academy

As a result of a collaborative application between DHS-Medicaid and DMHAS, New Jersey was selected for participation in a policy academy through the Maternal and Child Health Policy Innovation Program (MCH PIP), funded by the federal Maternal and Child Health Bureau, Health Resources and Services Administration (MCHB, HRSA). Through this program, the National Academy for State Health Policy (NASHP) will work with states and other state stakeholders, to support and advance innovative state-level policy initiatives that improve access to quality health care for the maternal child health population. As part of MCH PIP, NASHP is conducting a two-year policy academy for up to eight state teams comprised of representatives from state Medicaid agencies, public health agencies, mental health/substance use agencies, and other state stakeholders (e.g., child welfare agencies, provider groups, Medicaid managed care plans, etc.).

Participating state teams will identify, promote, and advance innovative state-level policy initiatives in order improve access to care for Medicaid-eligible pregnant and parenting women with or at risk of substance use disorder (SUD) and/or mental health conditions through health care delivery system transformation. The Policy Academy will emphasize policy strategies that promote integration of care and systems; align with state initiatives to transform how care is provided and paid for (e.g., Medicaid managed care, accountable care organizations (ACOs),

value-based payment, etc.); and ultimately, improve health outcomes for pregnant and parenting women.

NJ PROMISE Program for Serving Youth and Young Adults at Clinical High Risk for Psychosis (CHR-P)

In Fiscal Year 2019, the Children's System of Care (CSOC) was a recipient of a SAMHSA grant for establishing community programs for outreach and intervention with youth and young adults at clinical high risk for psychosis (CHR-P). DMHAS and CSOC co-lead the project. The project title is NJ PROMISE – Prevention, Resilence, Optimism, Mastery, Insight, Support, and Education. In order to most effectively administer the grant activities, DMHAS and CSOC established a Memorandom of Agreement (MOA) that carves out the details of the responsibilities. The NJ PROMISE program serves youths and young adults not more than 25 years of age who experience the prodromal symptoms of psychosis. This program provides evidence-based interventions to prevent and/or delay the onset of psychosis. NJ PROMISE services are provided through effective outreach, client therapy, and linkages to community supports. DMHAS staff also play the role of the lead evaluator who is responsible for data collection and program evaluation.

DMHAS NJ PROMISE program responsibilities include*:* provider services in accordance with the MOA; program staffing; in-kind contributions; quarterly reports from the providers; client level and aggregate data collection; and program evaluation. Oaks Integrated Care, Rutgers University Behavioral Health Care (UBHC), and Careplus Inc NJ serve as CHR-P service providers. Each team at minimum consists of a prescriber, an outreach coordinator, and a therapist. Each service provider will serve up to 25 clients in Fiscal Year 2019 and 50 clients in each successive fiscal years. This program will focus on community outreach in a prevention-based approach to care in accordance with the "stepped-care" therapy model where clients start with having one evidence-based practice therapy. The EBP service modalities will gradually increase if a client's psychotic symptoms increase. DMHAS data requirements include: QCMR, the adult and children's National Outcome Indicators (NOMs), and client level data. NOMs will be collected at intake and every six months until client discharge to evaluate client well-being during treatment. All other data elements will be collected on a quarterly basis. All data will be submitted by the Childrens' System of Care (CSOC) to SAMHSA through SPARS system for program evaluation.

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

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

Each year the Council presents 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 Ambassador Awards promote respect, understanding and change. Due to the restructuring of the Governor's Council which is still in progress, the Ambassador Awards, did not occur in 2019. However, in the coming months, the Council will reconvene with renewed energy and enthusiasm and plan for their initiatives in Fiscal Year 2020.

The Council posts training videos related to stigma awareness and messages of hope and recovery on its website. The council conducts outreach to schools, the media and other organizations. The Council recognizes the importance of cultural competency in all of its efforts and inclusion of all groups in prevention efforts. Community partnerships focus on collaboration with all groups to insure to ensure that input, information and guidance in regard to messaging, content and approach are accurate and culturally competent.

Suicide Prevention

Compared with the rest of the United States, New Jersey has low rates of deaths by suicide, consistently varying between lowest and second lowest in the nation (CDC, WISQARS). However, suicide rates in NJ are following national trends and have steadily risen over the years. The age adjusted rate for 2017 was 8.36 per 100,000 (compared to 14.0 nationally).

There were 809 deaths by suicide in New Jersey in 2017, making suicide the 2nd leading cause of death among those aged 10-14, 3rd leading cause of death for ages 15-24 and the 4th leading cause of death for ages 25-34, 35-44 and 45-54. The highest increase was seen in age group 45 to 54 years. For every NJ resident who dies by suicide, there are approximately 5.5 inpatient hospitalizations and emergency room treatments for suicide attempts with the cost of care totaling over $194 million in 2017, not to mention the great emotional toll on suicide attempt survivors, their families, friends and co-workers. In 2017 there were 2,392 individuals in need of inpatient hospitalization as a result of suicide attempts and 2,382 visiting the Emergency Department.

The SMHA continues to fund the NJ Suicide Prevention Hopeline, operated by Rutgers University Behavioral Health Care, which is set up to accept calls 24/7 from individuals who are seeking information or assistance for themselves, friends or relatives that may be at risk of suicide. Calls are received from anyone of any age and are answered by a peer, a trained volunteer, or a clinical staff member. If a caller is assessed as being at serious risk of suicide, the caller can be "warm-transferred" to the appropriate local Psychiatric Emergency Service or other entity (i.e. DCF sponsored 2nd Floor Youth Crisis Line) that can provide emergency or other necessary services for that individual. In calendar year 2017 the Hopeline received a total of 26,619 incoming calls. This is an average of 2,218 calls per month. In the year 2018, the Hopeline received a total of 47,254 inbound calls, with a monthly average number of 3938. Due to this enormous increase in call volume, DMHAS added funding for an additional 0.5 FTE position. The NJ Hopeline is an approved National Suicide Prevention Lifeline Crisis Center and provides back up to the Lifeline Crisis Center call system in NJ.

To publicize this valuable, local helpline the SMHA created and distributed posters for display at many gatherings and conferences to providers, agencies and other public places. Given the diverse population of NJ, the SMHA is in the process of making Hopeline brochures and posters available in Spanish.

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

- Veterans and their families can call a crisis helpline at:
  1-866-838-7654 1-866-VETS-NJ 4 U
- Anonymous and confidential resource for youth
  2nd Floor Youth Helpline: 1-888-222-2228
- Peer Recovery Warm Line: 1-877-292-5588
- NJ Mental Health Cares: 1-866-202-HELP (4357)
- Crisis Text Line: Text "Start" to 741-741
- Cop-2-Cop: 1-866-COP-2COP or 1-866-267-2267
- Mom-2-Mom Help line program: 1-877-914-Mom2 or 1-877-914-6662
  (Peer support for Mothers of Special Needs Children and Adults)

In conjunction with the Department of Health that oversees the State Psychiatric hospitals, SMHA developed an administrative bulletin on *Screening, Assessment, Management, and Treatment of Suicidal and Non-Suicidal Self-Directed Violence*. This policy mandates the use of evidence-based screening and assessment tools, as well as the development of a Safety Plan for patients identified as moderate and/or high risk, complemented by active suicide-specific treatment initiatives. SMHA in coordination with Rutgers University Behavioral Health Care, provided training on evidence-based suicide screening and assessment tools to Screening Centers as one component of the involuntary commitment process.

In fiscal year 2018 and 2019 the DHS/DOH Suicide Prevention Committee as well as the NJ Adult Suicide Prevention Advisory Council continued their work of information sharing, collaboration and advising to the governing authority based on identified practice gaps as per survey results. The focus shifted to increasing Community Collaboration and Integration and will be pursued on a regular basis. The membership of the Committee consists mostly of DHS and DOH employees, whereas the Council has a broader membership that includes State Agencies, Professional Organizations, Universities, Support and Advocacy Groups, Consumer Organizations/Agencies and Persons with Lived Experiences. DMHAS also has representation on national suicide prevention initiatives, such as the Community of Practice and the State Coordination Affinity Group.

Community Behavioral Health Programs contracted by the Department of Human Services and/or licensed by the Department of Health are required to report Unusual Incidents regarding individuals they serve. State Psychiatric Hospitals are also required to report Unusual Incident Reporting Management System (UIRMS) data regarding individuals they serve. According to the UIRMS data that DMHAS received, there were 324 suicide attempts and 48 deaths by suicide reported in Fiscal Year 2018. DMHAS requires providers to intensely analyze each of these

events to assess opportunities for improvement in their systems and processes. All reports of the providers are reviewed by the DMHAS Mortality Review Committee for patterns and trends among agencies. Many of DMHAS consumers, who have died by suicide**,** did not have an evidence-based suicide risk screening or assessment completed, consumers were often not appropriately linked to treatment, and oftentimes clear risk factors were overlooked. Members of the Mortality Review Committee review the reports they receive from agencies, make recommendations for improvement, and follow-up on actions taken, if indicated.

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

For 2017 and 2018, the SMHA had requested and received Proclamations from the Governor's Office declaring Suicide Prevention Month and/or a Suicide Prevention Week in September for Suicide Prevention efforts. In order to emphasize coordination and collaboration among the Youth and Adult Suicide Prevention Systems in New Jersey we organized joint Suicide Prevention Conferences.

More than 650 people registered for the 2018 Conference, with close to 500 attending. Attendees included people with lived experience, consumers, medical professionals, social workers and community social service providers, educators, community health providers, hospital-based providers, community agencies, administrators, state representatives, and executive leadership. Of those who attended, over 90% of the 230 post-conference survey respondents rated the conference as good to excellent in each of the survey categories. There has been a steady increase of attendance of these annual conferences over the last four years.

DMHAS submitted a proposal for implementing a state-wide Zero Suicide Model in NJ, following other early adopter states like Wisconsin, Colorado, Texas, Ohio and New York. Funding for this project is included in the 2020 budget and DMHAS already hired a person within the Medical Director's Office who will be tasked with spear-heading the implementation of the state-wide Zero Suicide approach in NJ over the next two years. Such an important initiative for NJ is based in the belief that suicide deaths for individuals under care within health care systems are preventable**.** The Zero Suicide Institute under the Education Development Center (EDC) is recognized as the leading proponent and training entity of this model with the main component being the 2-day Academy. Each Academy trains and consults of up to 80 participants comprised of 16 teams of 4 people. Using the Zero Suicide Framework, participants of the health care system learn how to incorporate best and promising practices into their organizations and processes to improve care and safety for individuals at risk under their care.

2. Acute Care Services. The SMHA funds and regulates a variety of acute mental health care programs for individuals with acute mental health needs and for those experiencing psychiatric crises. They include Designated Screening Centers (DSC), Affiliated Emergency Services (AES), Early Intervention Support Services (EISS), Involuntary Outpatient Commitment (IOC), Intensive Outpatient Treatment and Support Services (IOTSS), and Projects for Assistance in

Transition from Homelessness (outreach to persons who are homeless) and Short Term Care Facility (STCF) beds.

Short Term Care Facilities (STCFs). In order to meet the needs of individuals who require involuntary in-patient psychiatric services, the SMHA currently designates 420 Short Term Care Facility (STCF) beds. The SMHA has allocated $24.6 million in subsidies for STCF beds, half of the cost is paid by the state and the remaining 50% is paid by Medicaid. There are currently 420 STCF beds which are currently online in New Jersey in 24 general community hospitals. These beds serve all 21 New Jersey counties. Most of these agencies are community hospital based and the STCF beds permit the state's residents to access a hospital based level of psychiatric care at the local community level. For SFY years 2017 and 2018, the state's System Review Committee database indicates that occupancy rate for STCF beds was 87.3 % and 88.2% respectively.

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

DMHAS currently contracts for access to 196 beds at three private psychiatric facilities -- Carrier, Hampton, and Northbrook that offer an alternative to state psychiatric hospitalization. Most contracts specify a cost per bed-day of $625. However, a set of the contracted bed-days are reimbursed at a rate of $610. In SFY 2018, the total admissions were 2,154. The total number of bed-days were 48,267. They provided 1,885 diversions from the state hospitals. The actual spending in SFY 2018 was $25,110,210.

Designated Screening Centers (DSC). In FY18, the SMHA continued funding 23 Designated Screening Service (Screening and Screening Outreach) programs across the 21 Counties at a total cost to DMHAS of $52.1 million. The Screening and Screening Outreach Program is designed to provide psychiatric emergency services including screening, assessment, crisis intervention, referral, linkage, and crisis stabilization services, 24 hours per day, 365 days per year, in every geographic area in the state. According to the SMHA's Quarterly Contract Monitoring Report (QCMR) database of information self-reported by the screening programs, there were 91,542 episodes of care to these screening centers during SFY 2018.

Beginning in SFY16, the State received approval for a Medicaid State Plan Amendment that allowed for Psychiatric Emergency Rehabilitation Services. Accordingly, hospital providers bill the Medicaid program at established rates and generate Medicaid revenue to partially offset operating costs.

Affiliated Emergency Services (AES). The SMHA also provides annualized funding to 12 Affiliated Emergency Service (AES) programs, which provide for behavioral health staffing at high volume emergency departments. A mental health provider is responsible for the provision of emergency services to individuals in crisis presenting in hospital emergency departments. Emergency service includes mental health and social services provision or procurement and advocacy. Emergency services offer immediate crisis intervention services and service procurement to relieve the client's distress and to help maintain or recover his or her level of functioning. Emphasis is on stabilization, so that the client can actively participate in needs assessment and service planning. Emergency service is affiliated by written agreement with the geographic area Designated Screening Center. (N.J.A.C.10:31). During SFY 2018, the state's 12 Affiliated Emergency Service Programs delivered 28,954 episodes of crisis care (3 Hudson, 1 Middlesex, 3 Monmouth, 2 Morris, 1 Passaic and 2 Union Counties) and received $3.92 milliion in funding.

Early Intervention Support Services (EISS). In 2008, the SMHA began investing $3.0 million annually in Early Intervention Support Services (EISS) programs in Morris and Atlantic Counties. These urgent care mental health clinics are intended to provide rapid access to short-term, non-hospital based crisis intervention and stabilization services for persons with a mental illness. These early intervention programs are community-based programs aimed at offering individuals mental health service options that can divert undue use of emergency room and in-patient programs. A comprehensive range of pharmacologic, therapeutic, recovery and supportive services are offered in order to divert undue use of emergency room and in-patient programs. Currently, EISS programs are funded for $11.6 million and serve Atlantic, Camden, Essex, Middlesex, Monmouth, Morris, Bergen, Cumberland, Hudson, Mercer Counties and Ocean Counties. During SFY 2018, these programs delivered 13,505 episodes of care, with episodes ranging from one contact with immediate referral to four-six weeks of short term crisis stabilization.

Involuntary Outpatient Commitment (IOC). DMHAS now funds eighteen Involuntary Outpatient Commitment (IOC) programs that serve all twenty one New Jersey Counties. Annualized funding is $6.5 million to support these programs, which have an aggregate statewide service capacity to serve 607 persons. During SFY 2018, a total of 1,203 persons (duplicated count) were served in IOC, with an average active ongoing caseload of 479. IOC programs offer: court ordered out-patient based mental health treatment; assistance with linking with community based mental health services; monitoring of adherence to the court ordered plan; interface with the judiciary including transportation to court hearings and contact with the presiding judge, as needed. Challenges to program development and operations have included; provider recruitment and retention of psychiatrists; operationalization of some aspects of the law, such as managing "unwilling to receive treatment voluntarily" in an outpatient setting and "material non-compliance" with the outpatient treatment plan; matching the law's limits with the right group of persons.

Intensive Outpatient Treatment Support Service (IOTSS). Since 2008, the SMHA has funded 25 IOTSS programs, located in the following counties (1 Atlantic, 3 Bergen, 1 Burlington, 3 Camden, 1 Cape May, 2 Cumberland, 1 Essex, 1 Gloucester,1 Hudson, 1 Hunterdon, 1 Mercer, 2 Middlesex, 1 Morris, 1 Ocean, 1 Passaic, 1 Salem, 1 Somerset, 1 Union and 1 Warren) in order

to create quick access to intensive outpatient services for individuals seeking access to treatment through the acute mental health system. These new programs are designed to create dedicated access for consumers referred from emergency rooms and other acute settings. In SFY2018, 3,962 consumers were served by IOTSS.

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

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

The SMHA contracts with 25 non-profit agencies to operate PATH programs within the state's 21 counties. A small number of PATH programs use PATH funding to directly provide psychiatric assessment and outpatient mental health services. Many PATH providers are Community Mental Health Centers and link their consumers to mental health services in their agency such as, outpatient or partial care programs. All PATH programs link individuals to behavioral health and co-occurring services, entitlements and housing (emergency, transitional and permanent) within their communities. In SFY18 there were 2,417 consumers served by PATH.

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

3. Intermediate and Rehabilitative Services. The SMHA contracts for Intermediate and Rehabilitative services including: Community Support Services; Residential Services; Supported Employment (SE); Supported Education (SEd); Programs for Assertive Community Treatment (PACT); Intensive Family Support Services (IFSS), Illness Management and Recovery (IMR); Justice Involved Services (JIS); Integrated Case Management Services (ICMS); Outpatient

Services (OP); 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 hospitalization, are high service users and who have not been able to benefit from traditional mental health programs. In order to meet the unique needs of this targeted population, PACT teams offer highly individualized services, employ a low staff to consumer ratio, conduct the majority of their contacts in natural community settings (e.g. consumer's residence) and are available to help individuals address psychiatric crises 24 hours a day. Service intensity is flexible and regularly adjusted to consumer needs. Per the evidence-based model, consumers are eligible for PACT for an indeterminate period as clinically needed.

As a long-term program, in which the course of treatment has no pre-determined end point, most New Jersey PACT teams are staffed with eight to ten full-time equivalent direct care staff and can serve between 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. Since state fiscal year 2010, the SMHA has expanded twenty of the 31 teams with additional staffing.

DMHAS anticipates continued targeting of dedicated funding to expand the state's PACT program. 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. During state fiscal year 2017, six New Jersey PACT teams (Bergen, Camden, Middlesex team I, Middlesex team III, Monmouth team I, and Passaic team II) were expanded to serve 25 additional people with access to housing vouchers. The expansion facilitated the discharge of individuals who are in state psychiatric hospitals. According to QCMR data reported by providers, there were 2,733 consumers served by PACT in SFY2018.

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

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

Individuals eligible for services may have challenging behaviors related to frequent untreated mental illness or lengthy hospitalizations and homelessness. This may include a history of non-engagement with services, refusal to leave a hospital setting, active substance use disorder, and lack of financial benefits and other support systems. Some may have co-existing developmental disabilities or medical conditions that remain untreated due to lack of physical health services while homeless, or on-going conditions that need treatment and support.

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

CSS promotes community inclusion, housing stability, wellness, recovery, and resiliency. Illness management, socialization, work readiness and employment, peer support, and other skills that foster increased self-direction and personal responsibility for one's life are also addressed. 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. According to QCMR data reported by providers, there were 4,762 consumers served by CSS in SFY2018.

Residential Services. DMHAS-licensed supervised residential options offering on-site staff support and assistance with activities of daily living according to clients' needs. Housing opportunities include supervised apartments, group homes, and family care homes. Additionally, residences may be targeted to address special needs: MICA, short-term Respite Care, Crisis, and Deaf/Blind, In SFY 2018, the SMHA served 2,600 consumers in residential services.

Supported Employment (SE). The SMHA has been providing the EBP of supported employment since 1988. SE is provided statewide for adults (18 years of age and older) with severe mental illness and/or co-occurring mental illness and substance use disorders are assisted to choose, obtain and keep integrated employment in jobs of their choosing within their skill and credential set. The SMHA provides SE through 20 fee for service (FFS) contracted community mental health provider organizations. In SFY 2018, 1,720 consumers were served by Supported Employment. In that same year there were 32 referrals to SE made for consumers in NJ state non-forensic psychiatric hospitals.

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 SEd through four fee for service contracted community provider organizations who also provide supported employment to fifteen of New Jersey's twenty-one counties. SEd is accomplished through mobile outreach services aimed to assist people with psychiatric disabilities to reach their postsecondary academic goals. Services are individualized and flexible based on student choice and career goals. In SFY18, 879

consumers were served by SEd. In that same year there were 3 referrals to SEd made for consumers in NJ state non-forensic psychiatric hospitals.

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, including medical and dental services; and monitor engagement in services. In SFY 2018, the SMHA served 9,369 with ICMS services[1].

Outpatient Services. Outpatient includes counseling interventions provided by trained clinicians to clients living in the community who require non-immediate care that can be delivered on a scheduled basis. Interventions may include individual, group, and family therapy; medication counseling and maintenance, assessment and testing, outreach services, and referral. In SFY 2018, 120,963 consumers were served by Outpatient Services.

Partial Care. Rehabilitation services are provided within partial care and include engagement strategies that are designed to connect with individuals in order to enter into therapeutic relationships supportive of the individual's recovery. Activities assist a 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. In SFY 2018 , there were 10,111 served in Partial Care services.[2]

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

- Coping skills, adaptive problem solving, and social skills training that teach individuals strategies to self-manage symptoms;
- Psycho-education that provides factual information, recovery practices, including evidence-based models,
- Development of a comprehensive relapse prevention plan that offers skills training and individualized support;
- Medication self-management, behavioral tailoring, simplifying a consumer's medication regimen, and motivational interviewing assist and support 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

[1] DMHAS Evaluation Table 1, July 2019
[2] *ibid*

- Age-appropriate learning activities which are directly tied to the learning of daily living or other community integration competencies such as financial literacy, learning basic computer literacy, and recognition of directions and safety warnings.

Statewide Clinical Outreach Program for the Elderly (S-COPE). In 2011 DMHAS saw a need to develop specialized services to assist screening centers and nursing homes to respond to an increasing number of older adults with behavioral problems. In 2012, the SMHA awarded a contract for the development of a program to provide specialized clinical consultation, assessment, treatment and intervention to older adults who were at risk for presentation to ER for psychiatric hospitalization. Trinitas Regional Medical Center in Elizabeth, New Jersey was the recipient and has been administering this Statewide Clinical Outreach Program for the Elderly (S-COPE), which is fully funded by DMHAS and has been in operation since April 2012.

S-COPE provides crisis intervention and stabilization, consultation, and training for the management of mental health and behavioral issues in older adults (55+) residing in nursing homes and State-funded residential care facilities. S-COPE functions as a multidisciplinary team consisting of a geriatric psychiatrist (consultant), a gero-psychologist, geriatric advanced practice nurse, and master level clinicians. Outcomes are carefully monitored and reported to DMHAS on a monthly basis.

The S-COPE program is available 24 hours/7 day a week to offer face-to-face clinical consultative services. S-COPE staffs also provide training and technical assistance to screeners, administrators, clinical staff, direct care staff and support staff, primarily in nursing facilities to improve staff's ability to assess, provide treatment, manage behavioral disturbances and stabilize crises for this population. The multidisciplinary clinical team advocates for acute care treatment of those older adults who need psychiatric hospitalization and advocates within the facility for management of behavioral disturbance for individuals who would not benefit from inpatient psychiatric stays.

In 2018 there were 921 referrals to S-COPE and 189 were diverted from screening centers. There were 1,532 face to face visits conducted and 2,770 phone consultations. S-COPE continues to provide support in maintaining clients in facilities by closely working with nursing staff. In addition, with S-COPE involvement, at least 12 individuals have been diverted from state hospitals. S-COPE equips staff by sharing best practices and offering trainings. All trainings, assessments, and treatments offered are consistent with promising practices and/or evidence-based practices.

In 2018, there were 177 trainings completed, affecting over 2,300 people. There were 75 trainings completed in northern region, 47 trainings in lower central region, and 55 trainings completed in the southern region. Trainings are open to all professionals including but not limited to Social Workers, Nurses, Psychiatrist, CNAs, and other professionals. The regional trainings and conference offers Continuing Education credits (CEs) for nurses and social workers. Training topics varies based on needs of the facilities and regional areas. Some of the topics delivered in 2018 included: *Understanding the 3D's: Dementia, Delirium, and Depression, Understanding 3A's: Anger, Agitation and Aggression: Strategies for Care*

providers, ABC's of Dementia Care, Behavioral and Psychological Symptoms of Dementia, Promoting Healthy Cognitive Aging, Transitioning to LTC from Psychiatric Hospitals, and Sexuality in Long Term Care.

Trainings are delivered by S-COPE Interdisciplinary team members consisting of Master level clinicians, Advanced Practice Nurse, Psychiatrist, Psychologist, and/or Licensed Clinical Social Workers. Trainings are conducted on-site at facilities, via ECHO on ZOOM platform, and at regional locations (northern region, lower central, and southern). The on-site trainings are facility focused and topics are often suggested by the facility or following S-COPE case assessment. The regional trainings topics are based on identified theme of the area and availability of the space and their request. In 2018, there were 147 on-site trainings offered, 10 Regional Trainings, 19 ECHO sessions, and 1 annual conference.

S-COPE uses a combination of ways to deliver its trainings such case based scenarios, role-plays, videos, and sharing direct information. All trainings are developed by the S-COPE team and trainings topics can be suggested by anyone. In 2018, S-COPE exceeded the training contracted goals and it continues to find innovative ways to deliver evidence based trainings.

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

Family psychoeducation is offered as part of an overall clinical treatment plan for individuals with mental illness to achieve the best possible outcome through the active involvement of family members in treatment and management and to alleviate the suffering of family members by supporting them in their efforts to aid the recovery of their loved ones. Family psychoeducation programs may be either multi-family or single-family focused. Core characteristics of family psychoeducation programs include provision of emotional support, education, resources during periods of crisis and problem solving skills. More specifically, family psychoeducation enhances family functioning by providing the family with a greater knowledge of mental illness, treatment options, the mental health system and skills useful in managing and reducing symptomatic behaviors of the family member with a serious mental illness. Family psychoeducation is offered in each of New Jersey's twenty-one counties via the county IFSS Program. According to QCMR data reported by providers, there were 2,557 consumers served by IFSS in SFY2018.

Services offered include psycho-education presentations, family support groups, single family consultation, respite activities and referral/linkage. Services are delivered in the family home, at the agency or at other sites in the community convenient to individual family members. Engaging minority families has always provided a significant challenge for the IFSS programs.

IFSS programs invest significant effort and energy in attempting to attract minority families. Visits occur on a regular basis to a wide variety of mental health programs.

IFSS staff also establishes contact with local churches and clergy as well as appearing at public meetings and events such as health fairs in their respective counties. Additionally, IFSS programs maintain a positive relationship with the New Jersey Chapter of the National Alliance on Mental Illness (NAMI). 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 (SAMHANJ), Chinese American Mental Health Outreach Program (CAMHOP), and the African American Community Takes New Outreach Worldwide (AACT-NOW!).

Illness Management and Recovery (IMR).

State Psychiatric Hospitals. IMR continues to be consistently offered by Rutgers consultants at all three regional state hospitals as one evidence-based treatment modality that teaches consumers about mental illness and coping strategies with the goal of decreasing symptoms, reducing relapses and future hospitalizations. Priority is given to individualized goals towards recovery. The SMHA, in partnership with the Rutgers School for Health Professions (SHP), has an active State Hospital Psychiatric Rehabilitation Initiative (SHPRI) within the Department of Psychiatric Rehabilitation and Counseling Professions. SHPRI's mission is to improve the quality of care provided at NJ's State Psychiatric Hospitals through consultation, education, program development, and evaluation, using psychiatric rehabilitation goals, values and principles as well as current research. As of 01/01/2018 several IMR groups have been offered to consumers in the three regional state psychiatric hospitals: 7 at Trenton Psychiatric Hospital; 12 at Ancora Psychiatric Hospital; and 3 at Greystone Park Psychiatric Hospital (access to IMR is limited in the state's forensic hospital). These groups have been provided on the hospital units and in the hospitals' centralized treatment malls on average to between 14 and 95 patients. The SMHA decided to require the use of the Using the Illness Management and Recovery Treatment Integrity Scale (IT IS) as a treatment adherence standard for clinical supervision of Illness Management and Recovery program within the state hospitals. As of June 2019, the IT IS scale has only been tested by scoring an audio tape of a random sample of sessions and comparing them to validated outcome indicators. The hospitals are currently using the scored sessions as a form of audit that is fed back to clinicians providing IMR. The clinician then uses this feedback in the process of clinical supervision by identifying areas for improvement within IMR sessions.

Community. DMHAS has incorporated IMR into the foundation of principles and practices central to a recovery-oriented, person-centered system of community mental health services. IMR is incorporated into the partial care systems and it is supported by regulations. Currently, IMR is also incorporated into the community support services programs (CSS), formerly referred to as supportive housing programs. As part of the agencies' contractual agreement with DMHAS, IMR providers track consumers receiving IMR and the type of IMR delivered (group or individual) that they receive. DMHAS, through a contract with Rutgers UBHC-Technical Assistance Center (TAC), provides statewide face-to face and telephone consultations on this evidence-based practice. DMHAS, also through Rutgers UBHC-TAC provides three 2-day IMR

introductory trainings across the state within a given fiscal year and monthly IMR Roundtables (alternating northern, central, and southern locations) to provide consultation for IMR-trained and contracted community providers. In 2015, the DMHAS launched the IMR Regional Train-the-Trainer Training and Consultation Model. Participating agency programs co-create and co-facilitate tailored trainings and consultation meetings in collaboration with UBHC IMR staff. The model's goal is to help a group of agency-based master IMR practitioners develop a collaborative and supportive infrastructure of IMR expertise within their NJ region and at their individual program settings. If these practitioners meet all program model requirements within a 2-year period, they become IMR In-House Master Trainers for their agency. Fidelity measures are optional and done through self-assessment with individual agencies as part of their quality assurance protocol.

The Rutgers UBHC IMR-trained network constitutes IMR-trained CSS Programs and IMR-trained Partial Care/Partial Hospital (PC/PH) programs. In FY 2018, out of a total of 61 IMR-trained CSS Programs in NJ, 26 reported their implementation data. These 26 programs served a total of 487 clients. Data reflecting the number of CSS staff trained in IMR by Rutgers UBHC from July 1, 2017 to June 30, 2018 is 47 CSS staff representing 25 CSS programs.

PC/PH IMR implementation data were received from 56 of 105 IMR-trained PC/PH Programs in NJ in FY 2018. The data showed that 6,051 clients were serviced with IMR. Data reflecting the number of PC/PH staff trained by Rutgers UBHC from July 1, 2017 to June 30, 2018 is 43 PC/PH staff representing 30 PC/PH programs.

In FY 2018, the Rutgers UBHC IMR Regional Train-the-Trainer (T-t-T) pilot Program did not expand to an additional region. Due to staff turnover among the current IMR Regional Train-the-Trainer (T-t-T) Program teams, the Rutgers IMR Program team provided IMR Onboarding training for select agency staff recruited by their agency. Thirteen new IMR practitioners representing eight IMR Regional T-t-T agencies (5 in northern region; 3 in southern region) participated in 2 full-day T-t-T trainings and at least four scheduled regional meetings/workshops throughout the fiscal year. Seven of eight agencies representing the Northern Regional T-t-T cohort continued to provide in-house IMR training at their individual agencies. They also met as a self-facilitating cohort at least 6 times throughout the year. Four of five agencies representing the Southern Regional T-t-T cohort continued to provide in-house IMR training at their individual agencies. They did not meet as a self-facilitating cohort, but continued to participate in monthly scheduled meetings/workshops with the Rutgers UBHC team.

Justice Involved Services (JIS). The SMHA has been funding JIS since 2000. The services work to divert from incarceration individuals whose legal involvement may have resulted from untreated mental illness or co-occurring mental health and substance abuse disorders. It is a short-term case management program designed to help consumers to successfully link to mental health or co-occurring and other services in order to stabilize and enter valued community roles reducing their incidence and length of incarceration. The program provides access to community-based mental health and substance abuse treatment services as well as critical social services. Through case management, clients receive treatment and psychiatric rehabilitation services, housing, employment, medications and health services. The SMHA is involved in very

active collaborations with the Judiciary, Office of the Attorney General, local law enforcement, State Parole Board and Department of Corrections, and funds 15 JIS services and several other criminal justice initiatives. JIS is provided to a diverse mix of consumers, male and female as well as individuals of Caucasian, African American, Hispanic, Asian and Asian Indian backgrounds and from many different countries.

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

Crisis Intervention Team. DMHAS funds a CIT Center of Excellence through the Mental Health Association of Southwest New Jersey. The Center facilitated the development of new county CIT efforts. Presently sixteen of twenty-one counties as well as the NJSP provide training to law enforcement, dispatcher and mental health staff in CIT. These counties offer the training to other counties and municipalities as well as their own. As of May 2019, 276 of 565 municipalities have at least one certified CIT officer. As of February 2019, 4,643 law enforcement and mental health provider staff have been trained.

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

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

The Union County Prosecutor's Office created and piloted this program, with DMHAS funds; however, the funds do not include treatment dollars. In 2014, the Office of the Attorney General (OAG) expanded the program by awarding 2-year grants to Essex and Ocean counties for a prosecutor led mental health diversion program on indictable offenses. The grants had limited treatment dollars. In FY 2016, the OAG awarded three additional Prosecutor Diversion programs: Warren, Hunterdon and Gloucester. The funding was only for two years, with the Prosecutor's Offices continuing as they were able after the funding expired. The SMHA continues to assist with services through local community mental health providers. There were no new grants awarded since 2016.

Atlantic County was awarded funds from the Office of the Attorney for a special Veterans Prosecutor diversion program. In conjunction with division funds, this program targeted Veterans whose charges are related to their behavioral health issues. The program coordinates with the VA Healthcare Systems and the New Jersey Department of Military and Veterans Affairs (DMAVA) to obtain needed services. With the Atlantic Veterans initiative, there are now 7 funded prosecutor diversion programs or one third of the state. Necessary treatment and support services will continue to be a challenge. In 2017, legislation was signed that made the Prosecutor Division program for Veterans statewide, although no appropriation was made. There have been few referrals to this program as reported by the OAG as of 1/1/19.

Municipal Court. DMHAS funds a Municipal Court Liaison (MCL) Program which works directly with the Jersey City Municipal Courts; they have a case manager/municipal court liaison, stationed at the Municipal Court who provides individual consultations to the judges and attorneys, upon request. This often results in diversion to treatment which the liaison facilitates. DMHAS also funds a similar program for Atlantic City. The city of Newark plea court arranges for needed services post plea. Asbury Park has been funding a social worker who provides similar liaison services for many years.

The DMHAS, working with the Administrative Office of the Courts (AOC) continues to expand the availability of the MCL to include two to three municipalities within Passaic, Essex, Ocean, Monmouth, Mercer, Camden, Gloucester and Cumberland counties. The JIS programs will be providing case management services. The effort is ongoing with additional municipalities expected to be included as DMHAS resources are identified.

Re-entry Services. Re-entry services (Forensic Case Management) are referrals from county correctional facilities; programs have between 1 to 2 case managers (typically 2 case managers) who interview and enroll potential candidate while in jail, provide pre-release planning and then successful linkage and coordination to mental health and other social/community services. No psychiatric or treatment services are directly provided by the programs but rather link existing mental health services. Counties include: Atlantic, Bergen, Burlington, Camden, Cumberland, Essex, Gloucester, Hudson, Monmouth, Morris (also included some county funding), Middlesex, Mercer (also included county funding), Passaic, Ocean, and Union. However, as a result of Criminal Justice Reform, the number of inmates in the county jails have been reduce by up to 20%, with upwards of 90% staying no more than 24 – 48 hours. This has resulted in a reduction of referrals to the JIS programs.

PROMISE Parole Program & Parole Collaboration. A collaborative program of the State Parole Board, DMHAS and New Jersey Housing and Mortgage Finance Agency (HMFA) to assist parolees with serious mental illness to transition and integrate into their community and provide mental health and other wrap around services including employment and housing to reduce violations of probation. DMHAS funds a case manager to provide linkage/coordination.

Department of Corrections (DOC) max-out pre-release planning and collaboration is a tri monthly meeting with representatives of DOC, Ann Klein Forensic Center (AKFC) and regional DMHAS representatives who review prisoners with serious mental illness coming up for max

out who may need continued commitment at AKFC or community mental health services as an alternative.

NJ Courts Veterans Assistance Initiative (VAI). VAI program provides services to veteran's / service members who get arrested and need linkage and coordination with services through the local Veterans Service Offices of the New Jersey DMAVA. DMHAS licensed providers provide case management services and also treatment services as needed. The Veterans Assistance Project is a combined effort of the Judiciary, the DMAVA and the New Jersey Department of Human Services, DMHAS. All vicinages in New Jersey have the VAI.

Chief Justice's Interbranch Advisory/Implementation Committee for Mental Health Initiatives. The DMHAS was represented on the Chief Justice's Interbranch Advisory Committee for Mental Health Initiatives which began in 2010. In 2012, the committee presented it's report to the Supreme Court which accepted its recommendations in total which included among other things, the expansion of the Prosecutor Diversion Program, Municipal Court Liaison program and CIT. In December of 2014, the Chief Justice appointed the Interbranch Implementation Committee, the first recommendation of the report, to begin to operationalize the report's recommendations. The committee is co-chaired by the DMHAS Interbranch representative and a Judge from the AOC. The Implementation Committee continues working to operationalize the 17 recommendation of the report. Much has been done in educational activities on mental health of Judges and court staff; knowledge transfer at Superior and Municipal court conferences and enclaves. The Implementation Committee working with the Judiciary public information established a mental health resource page with links to mental health information and resources on the Judiciary webpage, NJ Courts Online.

Criminal Justice Reform. January 1, 2017, the state shifted from a system that relies principally on setting monetary bail as a condition of release to a risk-based system that is more objective and thus fairer to defendants because it is unrelated to their ability to pay monetary bail. The statute also sets deadlines for the timely filing of an indictment and the disposition of criminal charges for incarcerated defendants.

Under criminal justice reform, judges will assess the level of risk each defendant presents and impose conditions of release. Judges will use an objective risk-assessment tool that has been tested and validated with data from thousands of actual cases in New Jersey. With that information, each defendant will be classified as low, moderate, or high risk and may be released on conditions without having to post monetary bail. Defendants who are released pretrial will be monitored by pretrial services staff, similar to those in the federal system and a number of states. The result has been a 20% decrease in the inmate population in the jails. About 90% of those brought to jail on a warrant are released within 24-48 hours.

Legal Services. Legal assistance provided to mental health clients, either through agency referrals or self-referral, by a network of DMHAS-funded legal service agencies. Assistance may include advice and guidance, case coordination, and court representation for issues such as government entitlements, housing, evictions, employment, etc. In SFY2018, 2,634 consumers were served by Legal Services.

4. Recovery Support including Consumer Operated Services. Consumer-operated Services continue to expand the availability of resources, as well as having a strong commitment from the Division of Mental Health and Addiction Services (DMHAS) toward building a recovery-based system-of-care. DMHAS strongly emphasizes the participation of the mental health, addiction and co-occurring consumer population and the families of those consumers into the development of its programs; the planning procedures for those programs; the careful monitoring of such programs; as well as consumer and family inclusion into the evaluation process for nearly all programs provided.

There are currently 33 Community Wellness Centers, Self-help Centers and/or Recovery Centers throughout the 21 counties of the state that are funded by the DMHAS. These centers are consumer-run, community-based, or on the grounds of the State hospitals and strive to provide support services to individuals experiencing mental health and/or substance use issues, with available resources and structure to foster their personal recovery and wellness. The Center members are supported through self-help, socialization, peer support, employment and education opportunities, and recovery-based activities. Some Community Wellness/Self-help Centers/ Recovery Centers are leaders in delivering support services to the members. Many of the Wellness Centers that were originally conceived and set up to provide mental health support to the surrounding communities are seeing considerable changes in their membership structure and most are now serving not only individuals with mental health challenges, but are also providing services to more individuals who are homeless; have co-occurring mental health and substance use disorders; have involvement with the criminal justice system; and individuals from diverse backgrounds whose primary spoken language is not English. An increase in Spanish speaking members has been seen recently. This shift in membership demands, has had an impact on the delivery of services and training needs of peer staff working at the Wellness Centers.

All the Wellness Centers/Self-help Centers continue to have access to the Recovery Library, that provides an opportunity to an array of online supports, group ideas, videos, and interactive exercises that focus on issues relevant to recovery, including addiction issues, wellness issues, parenting, advocacy, relationship building and developing natural supports in ones' community of choice.

In 2019, DMHAS reallocated some of its already existing funding dollars under the auspice of Consumer-Operated Services and created a competitive opportunity for Wellness Centers/Self-help Centers to apply for additional "Wellness Dollars." Through an application process in which the managers had to explain how they would use these particular funds to address the memberships needs surrounding specific dimensions from SAMHSA's Eight Dimensions of Wellness, and how that additional funding would assist to enhance services in dimensions that were important to the members of each Center.

Some Community Wellness/Self-help Centers are leaders in delivering Wellness Recovery Action Plans (WRAP), Peer Outreach, Employment and Recovery support services. Journey to Wellness (JTW) in Ocean County has spearheaded an effort to engage residents of residential health care facilities with a community-wide reintegration effort. JTW offers Nights of

Recovery, Weekend Wellness, and Substance Use Disorder support with many nights reaching 60 participants. Esperanza Self-help center engages in recovery support groups at multiple sites across Union County geared to the needs of the Latino and LGBTQ communities. The Individuals Concerted in Effort (ICE) self-help center in Atlantic County's provides extensive peer-focused case management, their support groups take place throughout the county and they offer boarding home outreach services. Multiple Centers sponsor a trained WRAP facilitator that enable them to offer the Evidence Based Practice level of WRAP to interested members and support Peer Outreach Support Teams (POST) providing peer case management and outreach serving hundreds of consumers each year with WRAP-based recovery services.

Additionally, Community Wellness Centers actively partner with local community providers and resources to engage in outreach activities that seek to enhance the community and wellness center participation. One example is in Bergen County. The Bergen County Community Wellness Center has partnered with Temple University's Community Inclusion Initiative to work with individuals on increasing community participation in areas of life that increase its' quality, along with overall wellness and recovery. In addition, both the Hudson Center and Better Life in Newark, the Bergen center is offering enhanced services for Justice Involved Individuals.

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

The Hudson County Center provides a place for community members to access basic living needs, including food, clothing, housing referrals, financial services, counseling, recreation and socialization activities and self-help groups. The Center provides linkage and referrals to local and state community resources to help individuals obtain identification documents and mainstream entitlements, legal services, primary and acute physical and behavioral health care, literacy training, GED and educational opportunities, and services to reduce poverty. The Center currently supports approximately 90 members in Center sponsored permanent supportive housing and has been working with the Hudson County Department of Corrections, the County Division of Housing and Community Development, and the County Continuum of Care Coordinated Assessment process to house 100 more individuals who are "familiar faces" and homeless from the Hudson County Jail system.

People come to the Hudson Community Wellness Center to be part of its community, for a safe place to meet people, to get help with basic needs; for referrals to community resources, and to participate in a community that accepts and respects each individual's worth and dignity. The Center attracts over 125 individuals per day. The Center is a community, and through the community experiences, isolation and loneliness are reduced. The Center provides individualized support services, assists people in identifying their needs and aspirations and navigating service systems to move towards greater independence. Center membership is voluntary and it does not

require participation in Center activities. However, often members who are moving towards making more positive life choices, come to the Center to give back to other members, which creates a cycle of peer support and mentoring. In addition to the Center's membership, the supportive housing staff provides housing support services, service coordination and outreach and engagement for individuals eligible for federal and state funded Supportive Housing.

The Learning Recovery Community Wellness Center of Wildwood (LRCWC of Wildwood). The newest enhanced Community Wellness Center was developed with the merger of the center and the Wildwood Wellness and Recovery Center (W2R2). The W2R2 functions as an overnight retreat and training site for Community Wellness Center members and other consumers statewide. The LRCWC 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 LRCWC of Wildwood has worked to develop more extensive and culturally sensitive services that meet the needs of their consumer community. The services include traditional Community Wellness Center activities and groups; a community food pantry; a meal connect food rescue/gleaming program; a winter warmth closet, clothing bank and a nutritious meal. The members and staff at the Learning Recovery Center have networked with various providers within the community. Members and staff alike were provided the opportunity to receive training in the use of nasal naloxone to prevent death in the event of opiate overdose to a friend, acquaintance, or family member. Over the course of 3 years, The LRCWC has been instrumental in providing naloxone training to 26 members and staff. Upon receipt of naloxone training, the individual receiving training is eligible to receive their own naloxone administration kit free of charge if desired. The naloxone kit is replaced free of charge if expiration date is reached or kit is used for opiate overdose reversal.

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

Another marketing strategy that these centers have developed is a Welcome to the Community Card. This card will remind consumers that when they are ready and when they get discharged into the community, after a long-term hospitalization, they have friends, family, wellness centers, peer-operated warm lines, agency support, including paid professionals, that they can reach out to for support and assistance in order to avoid re-entering the hospital system. These flyers can help consumers to know who to contact at their local community wellness centers and at the peer respite homes, as well as, other services available to consumers living in a community setting.

The Hospital-based Wellness Centers have been working toward utilizing the Recovery Library by incorporating the materials found at the site for use in support groups and one-on-one purposes. Personal Medicine cards are available to the membership as well as "public logins" that any of members can use when they need to and access the website information. There are many valuable resources in the library that consumers can learn from. The Trenton Psychiatric hospital-based center has also been providing support to the Ann Klein forensic Center (AKFC) since it began operating eight years ago. Originally the staff provided groups to the Transitional

Alternative Programming (TAP) program at Ann Klein. Most recently, groups are offered on the Rehab units at AKFC. Examples of the groups at the forensic site are groups focusing on the materials found in the Recovery Library, WRAP topics, 8 dimensions of Wellness, "Shared Recovery Stories", "Coping in a locked environment", and other topics as requested by engaged group members.

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

Peer Respite Centers. Three peer-run crisis respite programs are operating in New Jersey. The purpose of the peer-run crisis respite is to offer a low-stress, home-like environment to an individual who is experiencing either a crisis or an emotionally distressing episode to take a "time out" of life pressures to re-evaluate what is going on with him/her to understand the source of the difficulty and then to plan on how to move forward in a more deliberate, self-protective way in order to divert this type of situation from recurring. This is done with the help of a peer counselor as well as in group settings with other guests at the respite. Respite has diverted many people in crisis from going into the hospital--saving money of a typical psychiatric stay and providing by all accounts a less traumatizing experience.

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

CSPNJ serves New Jersey residents who are 18 years of age and older and who are in crisis or emotional distress due to mental health and/or substance use issues. Because the program is peer-run, the relationship between staff and guest is a collaborative one as staff comes from the perspective of a fellow traveler. Thus, Respite staff view the guest as the expert on himself or herself. The program offers up to a 10-day stay in a warm, safe and tranquil setting where the guests receive intensive support from peers which includes working through a Wellness Plan that addresses their emotional distress and overall health. The Wellness Plan consists of individuals' self-defined recovery goals which address their current distress and help them to avoid future ones. The Wellness Plan is the primary focus of a guest's stay. Staff and guests meet

daily to work on their Wellness Plan. All guests are eligible for 30 days of follow up services after their respite stay has ended, wherein guests continue to work on their wellness plan goals while transitioning back to their homes.

Referrals to CSPNJ's program come from a variety of settings including family physicians, case managers, therapists, psychiatrists, family members, and friends. However, anyone is able to self-refer to the program as CSPNJ seeks to speak directly to the person seeking services in order to complete an intake. All of the intakes occur directly over the phone and determinations are made during the intake process. Since their opening, both the New Brunswick Respite and the Haledon Respite had nearly 500 combined guest stays and experienced their highest occupancy rate to date in 2016. Moreover, CSPNJ respite staff members are actively involved in their communities. For example, the respite staff members participated in Middlesex County's Mental Health Awareness events, titled "The Power of The Peer" in May 2016 to reduce stigma. Respite staff also participated in a Behavioral Health and Justice Involved Taskforce and took part in multiple counties' Crisis Intervention Training for Law Enforcement which seeks to decriminalize mental health disorders and divert individuals from the criminal justice system. Furthermore, in 2016, CSPNJ respite staff collaborated with consumer groups such as NAMI and family supports such as IFSS. Additionally, CSPNJ respite staff presented at the Spring 2018 conference of the New Jersey Association of Mental Health and Addiction Agencies, Inc. about their program's services.

Legacy Treatment Services operates a Peer Crisis Respite Home in Toms River, NJ. Their mission is to break the cycle of hospitalization in persons experiencing acute mental health symptoms in a residential setting to prevent need for higher level of care. Staff at Crosswinds attempt to link consumers to a variety of community based mental health programs, such as: Wellness Centers, partial care, IOP, re-entry programs, traditional medication management and counseling, and case management support services. To ensure total quality care, consumers are also assisted with linkages to a number of other services such as social services, medical specialists and housing programs such as supportive housing apartments, Oxford Houses, etc. As it stands, roughly 90% of consumers admitted, are experiencing some form of acute mental health issue that is concurrent and often attached to their housing circumstances. Though the intention and design of the program is mental health stability within a residential context and not housing, Crosswinds Peer Respite Center has a relatively high degree of success linking homeless consumers to stable housing upon discharge (85%).

Crosswinds recognizes the insight and understanding peer staff offer is invaluable and looks forward to continuing to pass that experience along to their consumers as they work toward a life of wellness and recovery. Staff at Crosswinds is comprised of a number of peers who operate as those who are mental health consumers and/or co-occurring consumers. Many of the peers hired are done so in conjunction with completing the MHA CORE training that will allow them to become Certified Recovery Support Practitioners. Peers are active in their own recovery and help inform consumers of the variety of services in the mental health community. Specifically to Ocean County, peers are valued to help residents navigate the number of mental health resources based on their personal experience. The peers are trained in WRAPs and can work directly with consumers to develop a WRAP plan of their own. In general, staff utilize the MHANJ as a resource to stay connected with other peer supports in the area. Staff lead supportive groups and

individual wellness services with consumers, under the leadership and guidance of the director and supervisor. Lastly, staff attempt to further assist consumers in a partnership capacity to maintain a focus as they work on maintaining their stability and as they set and achieve goals toward their recovery.

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

Residential Healthcare Facilities/Boarding Homes. Outreach is provided by MHANJ and CSPNJ Wellness and Recovery Centers to individuals residing in Residential Healthcare Facilities and Boarding Homes. In Ocean County, the Journey to Wellness and Brighter Days centers have partnered with Ocean County Human Services, Police, social service agencies, and the NJ Department of Community Affairs to expand access to the services offered and bringing peer recovery services into the homes and transporting clients to community wellness centers. This effort has spawned legislation to create greater community engagement with the facilities. The residents have been assisted in setting up emails so that they can received outside information that they sometimes request. The center staff are helping the boarding home residents with computer skills so that they can find phone numbers, addresses for various agencies in Ocean County. The centers have been doing some groups specifically for the Boarding Homes residents: Budgeting, Independent Living Skills and a few others. Center staff have helped in transporting these residents to and from MVC to obtain identification and to Social Services for Social Security benefits. There have been many outreaches to benefit related program opportunities, shopping opportunities, etc. Residents have been assisted with clothing, small TVs and DVD players. There is much more that has been done in the past year to make the Boarding Home residents lives just a little more hopeful and empowered.

Wellness Recovery Action Plans (WRAP). Several NJ Self-help Centers are committed to providing WRAP as an Evidence Based Practice. For WRAP to be delivered following the Evidence Based Practice, there must be two certified "Facilitators" who has completed a Seminar II, WRAP Facilitator Workshop (37.5 hours) offered through Mental Health Association of NJ (MHANJ) and the Copeland Center. WRAP is designed to be delivered in mutual support groups. WRAP works to encourage an environment of self-determination. These are

accomplished through Seminar I, a WRAP Workshop, which is the prerequisite to seminar II, and focuses on each individual being introduced to WRAP and its' key recovery concepts and other recovery topics in order to encourage each group participant to develop their own WRAP plan. The best practice method is to deliver Seminar I in 8 weeks, with each session being 2 1/2 hours or within three full days.

In 2016, the Mental Health Association conducted the first WRAP Facilitator Training in NJ in ten years, and trained 15 new certified facilitators who are employed by agencies such as: MHANJ, Collaborative Support Programs of NJ (CSPNJ), and Richard Hall Community Mental Health Center. This training helped create the beginning of a NJ WRAP workforce accredited to train consumers and professionals to teach WRAP as an evidence-based practice. The MHANJ's Consumer Connections program offers training for Seminar I WRAP as part of the requirements for the Certified Recovery Support Practitioner (CRSP) certification. Their Consumer Connections training is currently offered 3 times per year. As part of their Community Education, MHANJ also provides WRAP introductions for 75-90 minutes as well as, a slightly more in depth WRAP overview of 4-6 hours. These are accomplished in 15 sessions per year. Overall MHANJ provides a level of WRAP training/education to 500 individuals a year. New Jersey is working to build a WRAP coalition in order to spread the evidence base practice model of WRAP throughout New Jersey.

Certified Psychiatric Rehabilitation Practitioner. Certified Psychiatric Rehabilitation Practitioner (CPRP) is a national credential issued by the United States Psychiatric Rehabilitation Association. It is a test-based certification that fosters the growth of a qualified, ethical, and culturally diverse psychiatric rehabilitation workforce through enforcement of a practitioner code of ethics. Currently there are CPRPs with PhDs to GEDs, occupational therapists to peer specialists, social workers to caseworkers and so many more, all of whom share a commitment to the fundamental principle that recovery from serious mental illness is possible. There are currently eight (8) different pathways to become eligible for the CPRP exam, all include a combination of education, training, and work hours. Individuals with a college degree in psychiatric rehabilitation or a state peer specialist credential are exempt from the training requirements, while most other educational pathways require 45 hours of training that addresses the treatment and/or rehabilitation of individuals with serious and persistent mental illness. Work hour requirements vary depending on education level.

- Basic information on the United States Psychiatric Rehabilitation Association can be found here: https://www.psychrehabassociation.org/
- An overview of the CPRP can be found here: https://www.psychrehabassociation.org/certification/cprp-certification
- A blueprint for eligibility and description of the pathways can be found here: https://www.psychrehabassociation.org/certification/determine-your-exam-eligibility

Certified Recovery Support Practioner. Consumer Connections is the provider of the training component of the CRSP peer certification. The program also provides a wide range of wrap around vocational self-assessments, job readiness, job search, and support once peers are in the workplace. The training consists of 108 hours of interactive classroom instruction in a broad

variety of topics necessary for providing effective peer-delivered services individuals in recovery from mental illness and co-occurring disorders. Each year 75 peers are prepared for the CRSP certification, with an employment rate of over 85%. Consumer Connections has provided training for over 1500 peers since 1997, and continually evolves its services to reflect the needs of the changing peer workforce. Consumer Connections provides graduates with networking opportunities and access to job openings by maintaining strong relationships with mental health agencies throughout the state of NJ. Graduation from Consumer Connections is considered a key to a successful peer employment experience.

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. The service employs two drivers and one dispatcher, all of whom are consumer providers. The service made (1,592) transports during the 2018 calendar year which generated $3,184 during this same period. The service made (416) transports during January 1 through March 30, 2019 which generated $832 during that same period.

Roads to Recovery. This program provides transportation to consumers with co-occurring issues enabling them to attend meetings or groups in the community. Over 18 community groups in 16 geographic areas are accessed each week. This service employs one driver and one dispatcher who are consumer providers, operating four evenings per week. During the 2018 calendar year over (750) transports were made and (143) transports were made from January 1 through March 31, 2019.

Psychiatric Advance Directives (PADs). The Division is transitioned the management and maintenance of PADs to a contracted vendor, U.S. Living Will Registry (USLWR). The online system, which went live June 2019, maintains a confidential and secure internet registry of PADs which provides 24-hour access. User IDs and passwords are generated for consumers who choose to utilize the registry. Certain health care providers will have user agreements with USLWR to allow access of information. A copy of a PAD is available when the health care provider or the consumer can provide the appropriate login information. The PAD, when executed in accordance with NJ regulations (NJAC 10:32) is a legal document irrespective of whether or not it is uploaded in the online registry. Community Wellness Center Members and Managers were trained on creating and updating their Psychiatric Advance Directives. DMHAS worked with consumers in the community on the availability and use of the registry as well as with hospitals and screening facilities. Trainings are in progress for DMHAS service agencies. Wellness centers will be able to contact staff at DMHAS, Mental Health Association of NJ and Disability Rights of NJ, should they find a need for additional support in writing or uploading PAD's. Additional updates and trainings will be ongoing once the registry goes live with the consumer community, service agencies, our hospital system and screening center representatives.

Involuntary Outpatient Commitment (IOC) Services. Peer providers play an integral role in IOC programs and make up a large percentage of the programs' staffing as peer case managers. In this role, peer case managers connect and engage with consumers entering the program and are

vital in overcoming what is often initial resistance on the part of the consumer who is entering an involuntary program. This is achieved by using their life experience and skill set to motivate and empower consumers within the program. They are a vital part of the treatment team and educate consumers on the importance of understanding the importance of what is initially mandated treatment as well as their diagnosis. Peer Case Managers work to ensure consumers are actively engaged in their treatment planning. Peer Case Managers undergo specific training and are certified in WRAP.

Legacy's IOC programs assist consumers in assimilating into the community and provide important linkage to community resources. An individualistic approach is taken to ensure consumers are actively working toward their wellness and recovery in a safe environment outside of the hospital by using creative and motivating methods to engage consumers in service provision. This includes activities designed to improve engagement, socialization and assimilation within the community. Recent events have included collaborations with wellness centers that have included trips to the beach and boardwalk.

CHOICES. Since 2005, the consumer-driven CHOICES team has been providing tobacco education to mental health consumers across the state of New Jersey. The services are delivered by a team of peer providers who do not use tobacco and are highly educated about the consequences of tobacco use and evidence based treatments for tobacco use disorder. The team travels throughout the state to provide onsite tobacco educational presentations and feedback sessions to consumers at outpatient mental health programs, conferences, health fairs, & other events. The team also provides these sessions for Community Wellness Centers, and work collaboratively with center directors to provide engaging activities for consumers who are coming into the centers during the recreational hours.

The goal of the CHOICES Program is to motivate tobacco users to consider quitting and link them to approximate services. The services are highly sought after by community providers and have been presented at statewide events like the annual COMHCO conference for the past 10 years. The CHOICES Program has also participated in the MHANJ Consumer Connections training two to three times per year, to provide tobacco education for mental health consumers in the process of becoming certified peer specialists. This is a vitally important session for the individuals attending this program, as many of them are smokers themselves, and find the information learned inspiring in their own quest to become tobacco free, as well as the work they will be doing with their peers.

CHOICES peer counselors, called Consumer Tobacco Advocates (CTAs) are paid, part-time positions, including a part time Program Director who provides supervision and oversight to the team. CHOICES also creates and disseminates a program newsletter twice yearly which is posted on their website (www.njchoices.org). The CHOICES newsletter is almost entirely made up of contributions from mental health consumers who share their stories. These contributions include personal smoking and quit smoking stories, poetry, artwork, and puzzles. Consumers who have contributed to the newsletter find it extremely validating to see their work in print. Each issue of this newsletter reaches between 3,000-4,000 consumers annually.

The CHOICES program has received national attention and has been presented with awards in Innovative Programming by Mental Health America in 2007, the Silver Achievement Award in 2009 from the American Psychiatric Association, the Community Innovations Award presented by Healthy People 2020 in 2011, as well as the 2016 Excellence in Wellness Award, presented by SAMHSA's Programs to Achieve Wellness. The CHOICES team was also invited to present at the 2018 CDC – Interagency Committee on Smoking and Health, and met with U.S. Surgeon General, Jerome Adams, who was very supportive of the CHOICES message. Additionally, CHOICES was invited to Washington DC in June, 2018 to participate in the stakeholder meeting "Smoke Free at Home" hosted by Mental Health America and the American Lung Association to discuss approaches to addressing the smoking ban instituted at public housing facilities nationwide, which took effect on July 31, 2018. CHOICES has been featured in radio, video, webinars, and print campaigns presented by the Truth Initiative, the National Council for Behavioral Health, the Legacy Foundation, and Mental Health Weekly.

Since 2005, the CHOICES team has completed nearly 1,600 presentations for over 49,000 consumers, and has delivered individual personalized feedback sessions for over 12,000 consumers to help assist them with discovering resources available to them to address their tobacco use.

The Peer Wellness Coach 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 initial wellness coaching program was developed through collaboration between staff at Collaborative Support Programs of New Jersey and faculty in the Rutgers-School of Health Professions. Currently Wellness coaching training and technical support is implemented by Collaborative Support Program of New Jersey.

Parent Advocacy Project: The Consumer Parent Support Network (CPSN). This is the only program in New Jersey that works with Parents diagnosed with a mental illness. Support and advocacy services are offered by Peer Parent Advocates who teach the necessary, skills, resources and coping methods to strengthen the parents' role. Services include case management, referral and linkage, education, evidenced based parenting classes, and Wellness techniques. Parents choose how they will work with the CPSN program and are seen in their homes or any other community setting by Bilingual staff.

Financial Management Accounts. This program provide financial management services to address the issues with budgeting, debt reduction and bill payment to an average of 156 supportive services recipients and community wellness center members across the state. In an effort to provide a more convenient service, a pilot program utilizing ATM cards with money management participants has been implemented with members from the Hudson community wellness center participating in the program and it will be expanded with improvements to other NJ locations across the state.

Social Security Administration (SSA) Representative Payee Service. This program is available to an average of 103 supportive housing recipients and community wellness center members across the state currently receiving the service

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

Savings Incentive Initiatives Accounts. These are offered to an average of 78 supportive housing recipients and community wellness center members across the state who are currently participating in one of the 3 match savings programs offered to acquire a productive asset, such as, car maintenance, apartment security deposit, furniture, household items, clothing for employment, etc.

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

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

The New Jersey Hopeline. The New Jersey Hopeline is a statewide suicide prevention hotline provided in partnership with Rutgers University Behavioral Health Care and the DMHAS. Staffed by clinicians, mental health specialists and peer support specialists 24 hours a day, 7 days a week, the NJ Hopeline provides support, risk assessment and referral for New Jersey residents in crisis via phone, web chat or text messaging. The Hopeline call volume has increased to its' current average of 4,000 incoming calls per month between lifeline calls and Hopeline calls and place roughly 1,100 outgoing calls per month.

The NJ Peer Recovery Warmline. This is a peer operated warm-line that is open 7 days a week providing individuals in recovery an opportunity for one-to-one support from another peer. Designed by MHANJ, the line utilizes a variety of evidence-based practice support and wellness models including Intentional Peer Support (IPS), WRAP and IMR. The line encourages repeat callers and focuses on recovery goals and diversion from emergency clinical services through effective self-care and peer support.

The Coalition of Mental Health Consumer Organizations of New Jersey Incorporated (COMHCO). COMHCO is a statewide membership organization comprised of adult mental health consumer/survivors dedicated to improving the quality of life for themselves and their peers with serious and persistent mental illness through education, empowerment and advocacy. The goal of COMHCO is to provide consumer education on the key issues of self-determination, wellness and recovery and to work toward ending the stigma associated with mental illness. COMHCO is a forum for the presentation and discussion of information that guides mental health consumer/survivors in their quest to achieve empowerment and advocacy for themselves

and their peers. The ideal of personnel development, education, employment and public awareness are central to the values needed for consumer/survivors to become full and responsible members of the larger society. COMHCO General Membership consists of 3,000 NJ consumers. An Annual COMCHO Consumer Conference is held each year. This was the 33rd conference and the theme was "Mental Health Matters! Making Tomorrow Better Today!" The forum was entitled: Internalized Stigma during which 5 peer shared their experiences with stigma within societal groups and our own community. COMHCO looks for ways to create a welcoming environment, that would help to reduce barriers with respect and dignity that all consumer should receive in their communities. At the conference, there were 11 workshops focusing on both the 8 dimensions and stigma. The Conference also offered a Resource room with both peer and professional groups sharing information.

Workshops were selected based on input from the membership and mirror ideas, as well as, suggestions that were raised during the monthly meetings and from past conference evaluations. With an attendance of 230 consumers representing a cross section of state and county hospitals, Community Wellness Centers, Recovery Centers, Support Groups and other consumer organizations throughout the state, the conference offers not only topical workshops but affords the opportunity for inter-county networking, information sharing and gathering, as well a forum to share strategies used for both advocacy and wellness. A highlight of the conference is not only the yearly keynote address, which supports the yearly theme-based on suggestions and the approval of the membership, but the NJ Assistant Commissioner of the Division of Mental Health and Addictions Services annual State of Mental Health in New Jersey presentation. The presentation provides an update to ongoing issues of importance and informs members of new initiatives. This forum reinvigorates members to the value of their partnership in their personal recovery and reinforces the place that NJ Mental health, addiction and co-occurring consumers hold as stakeholders in NJ Wellness and Recovery Programs.

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

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

5. State and County Psychiatric Hospitals

State Hospitals

The Department of Health operates three non-forensic, regionally-based, adult psychiatric hospitals and one adult forensic hospital that serve people with persistent and severe mental illness who are in need of intensive, inpatient care and treatment. Effective August 20, 2018, the Division of Mental Health and Addiction Services (DMHAS) was transferred to the Department of Human Services, while state psychiatric hospitals remained under the supervision of the Department of Health. The SMHA previously operated the state hospitals until this reorganization.

Each regional state hospital has a Community Wellness Center. All of the state hospitals have person-centered treatment planning, shared decision-making, and IMR. 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 adult psychiatric treatment, gero-psychiatry, sub-acute medical care, forensic care, and dual diagnosis (mentally ill and developmentally disabled and mentally ill and substance use disorder) 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.

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

The SMHA supports four 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. They are county operated psychiatric hospitals located in Bergen, Essex, Hudson, and Union counties.

6. Olmstead Initiatives

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

Although the Olmstead Settlement agreement was a result of a lawsuit initiated in 2005, this Settlement 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/dmhas/initiatives/olmstead/olmstead_settlement_agreement.pdf, and called for the following indicators of improved community integration, each with its own individual targets for every year covered by the Settlement Agreement:

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

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

The Division of Mental Health and Addiction Services (DMHAS) is in the process of revising Administrative Bulletin 5:11 in an effort to reduce hospital length of stay. Under this bulletin, consumers in state psychiatric hospitals are assigned to community service providers whom have the option of either accepting the consumer or requesting additional supports from DMHAS. In addition to community providers, state psychiatric hospitals have the option within their discharge planning process of requesting additional supports for the consumer in their potentially new living situations outside the institutions. Such requests and other efforts toward successful discharge are to be documented within the Individual Needs for Discharge Assessment (INDA). Assignments are based on hospital treatment team recommendations as well as consumer choice, and the assigned provider is expected to participate in every treatment

team meeting from the consumer's first to his/her last while in the hospital. The early involvement of community providers in the treatment planning process fosters familiarity between provider and consumer, allowing for immediate planning on the part of the provider to prepare to meet the individualized needs of each consumer upon discharge into their care. This preparation is critical to ensuring that the consumer is provided with necessary community supports and thereby maximizing his/her chances of sustained integration within the community. It is born out of high-level interagency collaboration.

As part of its Home to Recovery II Plan, DMHAS is focusing its efforts on enhancing the community-based resources available to its consumers. One such enhancement is the implementation of Community Support Services (CSS). A rehabilitative service billable by Medicaid, CSS offers education to consumers in the community on navigating daily activities, rather than performing these activities on their behalf. The goal of these services is to nurture independence and self-reliance on the part of the consumer, empowering them to thrive as functional and competent members of a community outside of an institutional setting.

DMHAS has sharpened its focus on consumer employment as another key element to optimal community integration. To that effect, the Division has enhanced its Supported Employment services to include an in-reach pilot within the three regional state hospitals. Implemented in July 2015, this pilot program targets individuals who are ready for discharge and examines their interest in competitive employment outside the hospital. This in-reach is supplemental to the Division's existing Supported Employment services, which are available in each of New Jersey's 21 counties. Supported Employment services include assistance accessing benefits counseling; identification of occupational skills and interests; and the development and implementation of a job search plan based on the consumer's strengths, interests, needs, and abilities. The ultimate goal for consumers receiving Supported Employment services is to obtain meaningful and competitive employment as a means of further ensuring sustained integration within the community. According to the SMHA's Quarterly Contract Monitoring Report (QCMR) database, the number of referrals to Supported Employment resulting from the state hospital in-reach initiative was 36 in SFY 2018 with an acceptance rate of 75%.

Another area of focus for DMHAS' Home to Recovery II Plan is the examination of outcomes geared toward monitoring sustainability of the Division's community integration efforts. These outcomes include the completion of Medicaid applications within 30 days of determining the necessary level of care for consumers in state psychiatric hospitals; an increase in Peer Support Specialists across state psychiatric hospitals; expansion of the Behavioral Health Home initiative integrating primary and behavioral health care for mental health services ; enhanced utilization of Supportive Housing in the form of sustained tenure in CSS placements, expansion of CSS opportunities, and an increase in discharges to CSS as well as in the percentage of consumers served by CSS as compared to state psychiatric hospitals; and finally a decrease in hospitalizations in the form of lower census counts (for CEPP consumers and the total hospital population); fewer admissions to state hospitals; a reduction in length of stay on CEPP status and within the hospital overall; and a decrease in CEPP consumers as a proportion of the total hospital census.

Olmstead developed a pilot program with Centralized Admissions to divert admissions from the state psychiatric hospitals. This pilot began on January 22, 2019. The purpose of the pilot was to keep individuals in the community with the appropriate services. Olmstead worked with Centralized Admission to educate their staff on discharge planning. Each case that was referred to Centralized Admission, for transfer into one of the three state psychiatric hospitals, was assessed and reviewed for readiness for community integration. It was founded that with an appropriate discharge plan individuals did not require further hospitalization. Community individuals were provided the same opportunity of housing as if they were in the state psychiatric hospitals which resulted successful discharge. This pilot continues to assist in managing the total census in each of the three state psychiatric hospitals.

Partnership with Vital Statistics. In October 2014, DMHAS issued Administrative Bulletin 4:27 in response to delays in hospital discharges resulting from missing patient identification documents. With the collaborative efforts between DMHAS and Vital Statistics, and subsequent development of the AB 4:27, a new process was implemented whereby DMHAS staff routinely retrieve birth certificates prepared by Vital Statistics for New Jersey born consumers that were previously unable to produce them for discharge planning. This process has greatly improved the discharge process by helping to remove a significant barrier to discharge, and in SFY2017, 471 birth certificates were obtained by way of this collaboration, alleviating identification as a barrier to discharge for each of those consumers. The number of birth certificates obtained in SFY 2018 and SFY 2019 were 438 and 401 respectively.

Validation of Vacancy Tracking Systems. The Bed Enrollment Data System (BEDS) was developed to help DMHAS manage and track vacancies. The system has replaced the process of cold calls to agencies and the utilization of quickly outdated paper tracking sheets. The Olmstead and Housing Offices within DMHAS are currently collaborating on reconciling the subsidy list maintained by the Housing Office with the vacancies tracked by BEDS. The housing subsidy list is undergoing augmentation to include any fields called for by BEDS not currently included in the subsidy list. This will enable definitive comparison of both tracking systems, as vacancies can be identified across each system by Bed ID and revised or updated as needed in cases of discrepancy. These efforts will serve to improve the validation of data within BEDS, allowing for greater validity and reliability within the Division's main vacancy tracking system.

Enhancements to Community Capacity. From 2010 through 2014, DMHAS was charged with the creation of 695 beds expressly for the community placement of consumers on CEPP status in the regional state hospitals and 370 beds to be created for consumers who are already in the community and at high-risk for hospitalization and/or homelessness. This equates to a total of 1,065 placements to be created over the five-year period covered by the settlement. The SMHA met and exceeded this goal, creating 1,436 new placements. Of these, 941 were set aside for the discharge of CEPP consumers from state hospitals (exceeding the settlement target of 695 by 246 or 35%), and 495 were reserved for consumers at risk of hospitalization (exceeding the target of 370 by 125 or 33.78%). In total, the SMHA exceeded its targets for placement creation by 34.83%, which amounts to 371 placements above its required deliverable. The Division continued creating new placements for these targeted populations, reaching a total of 1,808 new

placements by the end of SFY 2016, with 1,274 reserved for CEPP discharges and 534 set aside for consumers at risk of hospitalization. Two hundred placements will be created in SFY 2020.

Enhancements to the Individual Needs for Discharge Assessment (INDA). The INDA is an extension of the State Hospital Census database and captures each consumer's current needs for a successful discharge, as assessed by the hospital treatment team. Updated every 30 days (or earlier, depending on consumer circumstances), the INDA examines areas of need such as legal issues, finances, challenging behaviors (past and present), housing, medical needs, functional needs, and community needs (e.g. supported employment and aftercare rehabilitation). In keeping with the Division's 2015 updates to its treatment planning process, the INDA was expanded to capture provider involvement, including previous and current provider assignment(s) as well as the assigned providers' plans for addressing the needs identified by the hospital treatment team. As an augmentation to the state hospital census database, the INDA module also provides real-time data reflective of live information on all consumers in non-forensic state psychiatric hospitals. DMHAS has recently implemented INDA-specific canned reports, which provide hospital staff and central office users with immediate access to information contained within the assessment, including but not limited to provider assignments, attendance at treatment team meetings, functional needs of each hospital's census, and consumers refusing to be discharged. This information will be used by the Division and the state hospitals to drive efforts geared toward quality improvement and planning for the allocation of resources and the implementation of new initiatives.

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

Continued Utilization of Hospital Project Teams. Project Team meetings are higher-level meetings that occur immediately after ICRC and are typically chaired by the hospital CEO/DCEO or Medical Director. Policy and systems issues as well as any issue that may involve collaboration with another Division or state Department, are discussed at these meetings and elevated to Olmstead leadership to address. In addition to policy and systems reviews, Project Team meetings also discuss newly-designated CEPP consumers to ensure that a discharge plan is in place. On an as-needed basis, teams also hear brief case presentations in the event that Olmstead resources are needed. Finally, Olmstead staff will also use these meetings to update the hospital leadership on any new administrative bulletins, requests for proposals, updates or changes to the vacancy tracking system, and/or trends identified in the data.

Hospital Diversion Initiative. The Olmstead Office has partnered with Centralized Admissions within the state psychiatric hospitals on a process for redirecting would-be hospitalizations to less restrictive community settings. Regional Olmstead staff assist Centralized Admissions in securing additional supports needed for applicable consumers as a means of addressing their individualized circumstances and needs in the most integrated setting possible within their

required level of care. This collaboration allows for reduced hospital census as well as enhanced community re-integration as mental health consumers otherwise on track for admission to state or county hospitals are able to continue to live independently with additional services or supports.

Bed Enrollment Data System (BEDS). BEDS was developed in the furtherance of deliverables to the Olmstead lawsuit settlement agreement with Disability Rights NJ[3] to facilitate the communication of accurate information between state hospitals and community residential providers regarding bed needs and available housing inventory. Utilization of a web-based system provides real-time access to vacancy information and helps facilitate assignments and avoid outdated spreadsheets. The system also enables planning at both the individual consumer level for placement purposes and system-wide for purposes of enhancements in community resources.

BEDS expedites the assignment process of hospital patients into community-based housing through improved management and tracking of vacancies.The system has replaced the process of cold calls to agencies, and the utilization of quickly outdated paper tracking sheets. Utilization of a web-based system provides real-time access to vacancy information and helps facilitate assignments and avoid outdated spreadsheets. Analysis of the utilization of Supportive Housing vs. supervised settings (e.g. group homes and supervised apartments) allows for assessment of the Division's progress toward community integration. The system also enables planning at both the individual consumer level for placement purposes and system-wide for purposes of enhancements in community resources. At the time of writing, there are over 4,641 community housing options within BEDS, comprised of: group homes, supervised apartments, supportive housing/community support services (assigned to existing DMHAS contracts with provider agencies). DMHAS is planning to include 196 diversion beds to the BEDS system that will enable individuals to stabilize and be discharged to the community avoiding hospitalization.

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

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

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

Prevalence. According to the Federal methodology proposed for estimating the prevalence of SMI, the proportion of adults within the state with a SMI is 5.4% (Federal Register, Volume 64, No. 121, p. 33890)[4]. The lower limit of estimate is 3.7% and the upper limite of estimate is 7.1%.

According to figures released by the United States Census Bureau, the 2018 adult population of New Jersey was 6,948,646. The size of the New Jersey child population was 1,528,702. Using the SAMHSA's SMI prevalence rate among persons 18 and older (5.4%) the estimated number of adults with SMI in New Jersey in 2018 was 375,227. Using the upper SMI limit of 7.1%, the estimated number of adults with SMI in New Jersey in 2018 was 493,354. Accordingly, using the lower SMI limit of 3.7%, the estimated number of SMI adults in New Jersey in 2018 was 257,100.

According to URS Table 2a, a total of 341,808 unduplicated consumers ages 18 and over received services in programs provided or funded by the SMHA in FY 2018. SMHA served 132,561 unduplicated adult consumers with SMI (refer to URS data table 14a) in FY 2018. That was 35.3% of the total estimated SMI adult consumers in New Jersey (i.e. 375,227). The objective of the SMHA is to continually increase the number of adults with SMI that may receive emergency mental health services and non-emergency community mental health services.

Also shown in URS data table 14a, out of the total 132,561 unduplicated adult consumers with SMI served by SMHA in FY 2018, 54,867 (41.4%) were ethnic minorities. SMHA will ensure that ethnic minority population continues to have access to mental health services in New Jersey.

Like most other states, New Jersey has not established a methodology to estimate incidence in the state of SMI among adults.

Criterion 3: Children's Services: **Provides for a system of integrated services in order for children to receive care for their multiple needs. Services that should be integrated into a comprehensive system of care include: social services; educational services, including services provided under IDEA; juvenile justice services; substance abuse services; and health and mental health services.**

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

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

Services to Homeless Populations

DMHAS operates Projects for Assistance in Transition from Homelessness (PATH) program using a combination of federal and state funds. The target population is homeless adults or those

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

at risk of homelessness who have a serious mental illness, including those with co-occurring substance use disorders who are not currently engaged in and are resistant to mental health and other community support services.

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

The SMHA contracts with 25 non-profit agencies to operate PATH programs within the state's 21 counties. A small number of PATH programs use PATH funding to directly provide psychiatric assessment and outpatient mental health services. Many PATH providers are Community Mental Health Centers and link their consumers to mental health in their agency outpatient or partial care programs. All PATH programs link individuals to behavioral health and co-occurring services within their communities.

In SFY 2018, the PATH programs in New Jersey provided outreach to 4,284 individuals and served a total of 2,417 persons. 1,108 program participants were linked to mental health services, 289 to substance use treatment services, 410 to primary health/dental care, 623 to financial services, 467 to temporary housing/shelter, 527 to long term housing and 198 were linked to employment or vocational and educational services. In addition, the SMHA provides funding for At-Risk supportive housing beds for individuals who are at risk for hospitalization and homelessness.

Services provided under the CCBHC initiative are available to all who meet programmatic criteria without regard for race, ethnicity, age, gender identity, sexual orientation, religious affiliation, or place of residence. Policies such as "no wrong door" allows any consumer access to CCBHC services regardless of insurance or pay status, place of residence, or lack of a permanent address. An average of three percent of CCBHC consumers at each CCBHC provider reported being homeless or living in a shelter during Demonstration Year 1. The two CCBHCs located in Trenton--Oaks Integrated and Catholic Charities, served the highest homeless populations at 10 percent and five percent, respectively.

Services to Rural Populations

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

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

New Jersey selected seven CCBHCs in six counties, including six CCBHCs in five metropolitan counties plus AtlantiCare in Hammonton, a rural underserved pocket of Atlantic County. The CCBHCs offer services within an integrative, holistic framework, thereby closing a treatment gap that frequently results in inadequate service provision for individuals with co-existing social, physical and behavioral health care needs. New Jersey's CCBHCs offer 24-hour crisis care, treatment for co-occurring substance use disorder and mental illness, ambulatory and medical withdrawal management, evidence-based outpatient counseling, case management, and family support services. CCBHC populations of focus include individuals with serious mental illness (SMI), those with severe substance use disorders (SUD), children and adolescents with serious emotional disturbance (SED), former or current military personnel experiencing Post Traumatic Stress Disorder (PTSD), and youth and adults with physical health risk factors and/or mental health diagnoses such as anxiety and depressive disorders other than Major Depressive Disorder who are not already covered in the target population. The CCBHC Demonstration Program was extended to September 13, 2019. The state is currently reviewing plans for sustainability.

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

In 2011, DMHAS saw a need to develop specialized services to assist screening centers and nursing homes to respond to an increasing number of older adults with behavioral problems. In 2012, DMHAS awarded a contract for the development of a program to provide specialized clinical consultation, assessment, treatment and intervention to older adults who were at risk for presentation to ERs for psychiatric hospitalization. Trinitas Regional Medical Center in Elizabeth, New Jersey was the recipient and has been administering this Statewide Clinical Outreach Program for the Elderly (S-COPE), which is fully funded by DMHAS and has been in operation since April 2012.

S-COPE provides crisis intervention and stabilization, consultation, and training for the management of mental health and behavioral health issues in older adults (55+) residing in nursing homes and State-funded residential care facilities. S-COPE functions as a multidisciplinary team consisting of a geriatric psychiatrist (consultant), a gero-psychologist, geriatric advanced practice nurse, and masters level clinicians. Outcomes are carefully monitored and reported to DMHAS on a monthly basis.

The S-COPE program is available 24 hours/7 day a week to offer face-to-face clinical consultative services. S-COPE staff also provide training and technical assistance to screeners, administrators, clinical staff, direct care staff and support staff, primarily in nursing facilities to

improve staff's ability to assess, provide treatment, manage behavioral disturbances and stabilize crises for this population. The multidisciplinary clinical team advocates for acute care treatment of older adults who need psychiatric hospitalization and advocates within the facility for management of behavioral issues for individuals who would not benefit from inpatient psychiatric stays.

Prior to S-COPE's inception, individuals with dementia were more likely to be referred to mental health crisis screening centers and emergency rooms, and many were subsequently being admitted to inpatient psychiatric facilities, including state psychiatric hospitals. In 2018, there were 921 referrals to S-COPE and 189 were diverted from screening centers. There were 1,532 face to face visits conducted and 2,770 phone consultations. S-COPE continues to provide support in maintaining clients in facilities by closely working with nursing staff. With S-COPE involvement, at least 12 individuals have been diverted from state hospitals. S-COPE equips staff by sharing best practices and offering trainings. All trainings, assessments, and treatments offered are consistent with promising practices and/or evidence-based practices.

Trainings are delivered by S-COPE Interdisciplinary team members consisting of Master level clinicians, Advanced Practice Nurse, Psychiatrist, Psychologist, and/or Licensed Clinical Social Workers. Trainings are conducted on-site at facilities, via ECHO on ZOOM platform, and at regional locations. In 2018, there were 177 trainings completed, affecting over 2,300 people. There were 75 trainings completed in northern region, 47 trainings in the central region, and 55 trainings completed in the southern region. Trainings are open to all professionals including, but not limited to, Social Workers, Nurses, Psychiatrist, CNAs, and other professionals. In 2018, S-COPE exceeded the training contracted goals and it continues to find innovative ways to deliver evidence based trainings.

S-COPE ensures that the program is culturally and linguistically competent, accessible, and responsive to agencies, consumers and families. The older adult mental health service system in New Jersey does not discriminate with regard to diverse racial, ethnic and sexual /gender minorities.

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

Staffing Resources and Training

The DMHAS is dedicated to community--based mental health services and is advancing community supports for individuals no longer in need of hospital based psychiatric treatment and those at risk of hospitalization. The DMHAS coordinates with community based providers to administer behavioral health services, including prevention and early intervention, screening services, outpatient counseling, partial and day treatment services, case management, residential and supported housing, family support, self—help centers and supported employment. In SFY 2019, State appropriations for mental health community providers were $352 million. A significant source of the increase has been the State's investment in the *Olmstead – Home to*

Recovery Initiative, which has primarily provided funding for supportive housing placements for clients discharged from state hospitals, as well as for clients at risk of hospitalization. Additionally, DMHAS is now over two years into the transition of moving select community based mental health services from cost-reimbursement contracts to fee-for-service contracts, also known as the Mental Health Fee-for-Service Program (MH-FFS Program). This transition, which began January 1, 2017, represented an historic transformation for the New Jersey public mental health system. The State has transitioned providers and clients to Fee for Service reimbursement, and away from fixed cost or overall cost reimbursement contracts. Concurrent with this, reimbursement rates were enhanced for many services and additional state funding (roughly $20 million) was appropriated for this purpose. DMHAS believes that the combination of more attractive Medicaid rates and the transition to a direct Fee for Service reimbursement approach for non-Medicaid services (with enhanced rates), will lead to greater access for clients and a more transparent, accountable and efficient behavioral health service delivery system. As part of its remaining cost reimbursement contract base, DMHAS continues to fund training and technical assistance that many community providers are able to access. The total contracted amount for SFY 2019 was approximately $5.2 million. In addition, State staff are continuously organizing conferences, meetings and webinars that providers attend on many subjects of interest to them in their daily operations. Notably, in SFY 2019, and continuing into SFY 2020, State staff have been holding weekly webinars/information sessions to help providers adjust to the new Fee for Service billing system for non-Medicaid services.

While New Jersey currently has cost-based contracts and Fee for Service arrangements with 117 unduplicated agencies that provide eligible Block Grant services, to facilitate reporting, administration and minimize the audit burden on our providers, SMHA has allocated the available Block Grant funding to a selected group of 26 provider agencies. This group of agencies and the amounts allocated to each have been revised over the years to reflect changes in Block Grant requirements, funding and service levels, changes in the agencies' service programs due to mergers, name changes, and other reasons. In order to ensure that we are in compliance with the requirement to expend such funds only for services to adults with SMI and children with SED, DMHAS first reviews data on consumers served by each of the selected agencies' contracts to identify the percentage of total consumers receiving services who are either adults with SMI or children with SED. Based on these results, we calculate the portion of each agency's total contract ceiling that represents Block Grant eligible costs. The result of this calculation yields a total pool of eligible costs, just for the above noted selected group of agencies, of about $94 million for state fiscal year 2020. Consequently, the Block Grant funding for contracted services is then allocated to each of the agencies in the selected group, based on the relative percentage of their eligible costs to the total eligible costs of all agencies in the group.

APN Program. As licensed independent practitioners, psychiatric Advanced Practice Nurses (APNs) are an important component of NJ mental health service system and serve in a variety of settings in both inpatient and outpatient services. Psychiatric APNs provide almost all of the services that psychiatrists provide (e.g., intake, assessment, etc.), except that they must prescribe medication under a joint protocol (collaborative agreement). While DMHAS had a program that funded psychiatric APN positions in community mental health services in the past, this program ended in 2017 with the state’s conversion from a contract-based to a fee-for-service funding

mechanism for community agencies. DMHAS continues to fund a few of its community agencies that remain under contract, such as in programs providing outreach.

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

Multicultural Services Trainings. Under the DMHAS Multicultural Services Group, the SMHA has funded two Multicultural Training Centers. The overall goals of the training centers are to:

- Develop and review needs assessments relating to the cultural competency of the DMHAS system of care.
- Provide technical assistance to DMHAS agencies in the implementation of a cultural competence plan based on the information from both SAMHSA and CSAT TIP 59.
- Provide accredited trainings that match the cultural and linguistic competencies, skills and needs of staff.
- Design and implement curriculum to provide ongoing training and technical assistance to Wellness Centers, DMHAS agencies, their administrators and staff.
- Develop outcomes to measure the effectiveness of Cultural Connections' training and technical assistance.
- Collaborate with any other cultural competence training entities in the state, especially the Center in the South.
- Use pre and post tests and follow-up survey to examine change following training and technical assistance.

Through contract, each Training Center offers annually two conferences on topics relating to diversity and at least 6 full day accredited trainings provided to DMHAS contract agency staff. Upon approval and release of the format for the DMHAS Cultural Competence Planning Toolkit for contract agencies, the Centers will also each hold annually at least 4 TA sessions for agencies in the catchment area with minimum 30 attendees at each session (total of 240) to assist in plan development and implementation.

Children's Behavioral Health Services

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

In New Jersey, adult and children's mental health systems were separated in 2006 for those programs that served children only. On July 11, 2006, legislation was signed creating the New Jersey DCF, the state's first Cabinet-level department focused solely on child and family well-being. All services provided by the DHS Office of Children Services were transferred to the DCF. On June 29, 2012, Governor Chris Christie signed a bill that further reorganized DCF into

a single point of entry for all families with children, youth and young adults with developmental disabilities and/or substance abuse disorders. This realignment of services is intended to remove barriers to accessibility, provide more complete care through all service offerings, and improve efficiency for those families served by DCF throughout the state. The substance abuse programs that serve children under 18 years were transferred from DHS to CSOC in July 2013 and children in the South Jersey Initiative were transferred in December 2013. CSOC coordinates the state mental health plan for children, youth and young adults; provides support and assistance to child welfare youth who need to access intensive or multiple mental health services; allocates state and federal resources for mental health programs; promulgates standards for services; and is now responsible for the provision of services for children, youth and young adults with developmental disabilities as well as substance use challenges.

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

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

State Government

The SMHA supports adult services in the following capacities: (1) direct service provider; (2) purchaser of services; (3) regulator of standards and services; (4) coordinator for immediate mental health disaster 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. The county Mental Health Administrators were 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.

Each of New Jersey's 21 counties has a mental health board that is staffed by a mental health administrator. The boards advise the SMHA and the Behavioral Health Planning Council of issues and programs that are of significance to their locale and residents. A Mental Health Administrator representative is a member of the Behavioral Health Planning Council.

Additionally, the SMHA meets with the mental health administrators at their bi-monthly Association of County Mental Health Administrators meetings.

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

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

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

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

The DMHAS works with DMAHS and the Division on Aging Services (DoAS) to continue to coordinate the Managed Long Term Services and Supports (MLTSS) services. MLTSS refers to the delivery of long-term services and supports through New Jersey Medicaid's NJ FamilyCare managed care program. MLTSS is designed to expand home and community-based services, promote community inclusion and ensure quality and efficiency. MLTSS uses NJ FamilyCare managed care organizations (also known as MCOs/HMOs/health plans) to coordinate all MLTSS services. MLTSS provides comprehensive services and supports for individuals who meet clinical eligibility, whether at home, in an assisted living facility, in community residential services, or in a nursing home.

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

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

NJ was also a recipient of a CCBHC Demonstration Grant, which includes a variety of services such as screening and referral for physical health needs and Health and Wellness services. Currently, seven CCBHCs are in operation (as of 7/1/17). Medicaid has been a partner throughout, having developed the Prospective Payment System that NJ is utilizing for this project.

DMHAS has explored several models of integration with DMAHS, and continues to evaluate the needs of its population. Together, the two divisions received assistance through CMS State Innovation Model grant that includes integration as one of its priorities, and technical assistance from the National Academy for State Health Policy (NASHP) to assist with developing a more integrated system.

It also recognizes that many barriers to integration currently exist, including the need for agencies to seek licenses from several agencies in order to provide integrated behavioral health and primary care services. As a result, the Department of Human Services, with assistance from a private foundation, has procured the Seton Hall Law School to review Department of Health and Department of Human Services regulations, to identify regulatory barriers and develop and implement strategies to eliminate them.

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 Behavioral Health Planning Council. The SMHA has developed an RFP process to promote the development of community-based supportive housing opportunities and other support services for consumers with co-occurring mental health and developmental disabilities. DDD has also hired full time Transitional Case Managers (TCMs) that are stationed at each respective state hospital. The DDD TCMs have their sole or primary responsibilities at the state hospitals focusing on the state hospital DD/MI population, the DDD referrals, and working with hospital staff to address any discharge barriers that may be present. Joint DDD and State Hospital meetings occur at each hospital on a monthly basis to discuss discharge planning and address any systems issues. In addition, biweekly meetings with DMHAS and DDD Olmstead management occurs to address systems level issues and barriers to community re-integration.

Department of Children and Families. Interdivisional and interdepartmental collaboration between DMHAS and the DCF CSOC is frequent. Executive Staff from each Division have collaborated to make system recommendations for youth with mental illness and/or substance

use challenges and families currently served in the CSOC whose youth are emerging adults. Recommendations were made in the form of policies, procedures and protocols that will ensure a seamless transition of youth and their families to all adult mental health services. In addition, several staff from CSOC attend monthly Behavioral Health Planning Council meetings to better coordinate services.

DMHAS Medical Director's Integration Office. The SMHA Medical Director's Office has an Integration unit with the goal of promoting integration between behavioral health agencies and primary health care providers. This office is working closely with the state Medicaid Office (Division of Medical Assistance and Health Services, or DMAHS) and DCF. The main goal of the initiative is to increase consumers with mental health and/or substance use disorders (SUDs) access to primary care and improve collaboration between behavioral health agencies and primary health care providers.

The behavioral health homes (BHHs) developed by DMHAS are considered the first step of a plan to integrate behavioral health and physical health services. Another integration project that the unit is overseeing is a two–year demonstration grant awarded by SAMHSA for Certified Community Behavioral Health Homes (CCBHCs), which began in July, 2017. The program has been extended to September 13, 2019. New Jersey was also fortunate to have had four agencies in four different counties that were awarded Primary and Behavioral Health Care Integration (PBHCI) grants through SAMHSA. In addition to the health home project, DMHAS and DMAHS have partnered to expand integrated care throughout the adult system.

Finally, the integration unit is also working with the Department of Health licensing office to comment on regulations that act as barriers to integrating services, with the goal of streamlining the regulations and increasing integration of services. The plan is to develop a single, unified regulation that will remove current barriers and allow integrated services to operate seamlessly. The final regulations will be developed in the next fiscal year, before being published for comment and promulgated.

NJ Housing and Department of Community Affairs (DCA). On January 1, 2019, the Supportive Housing Connection (SHC) was transferred to the Department of Community Affairs (DCA), Office of Housing. All direct care staff of the SHC were transferred to DCA, DoH as hourly employees as they were for HMFA. DCA, Office of Housing employed an SHC supervisor and began recruitment for vacant positions within the SHC. The role and function of the SHC remains intact, the changes are in the physical location of SHC and its employees, now housed at the DCA. The MOA between the HMFA and DMHAS, expired December 31, 2018; the new MOA between DCA and DHS/DMHAS, has an effective date of January 1, 2019

The Supportive Housing Connection (SHC), pays housing subsidies for individuals served by applicable DMHAS programs. Under this MOA, the SHC acts as fiscal agent and by agreement follows all DHS policy decisions. The SHC contracts with property managers and owners, completes all necessary apartment inspections makes subsidy payments to property managers and landlords. The SHC recruits landlords, provides training, assists with consumers completing

paperwork and distributes welcome packets to afford a smooth transition for consumers. The SHC assists consumers in referrals for affordable housing units, administers DMHAS housing subsidies, and expands relationships for housing opportunities through developers and or other HMFA housing projects. In the event of disputes between consumers and landlords, the SHC brokers disputes and contract issues. In State Fiscal Year's 2017 through 2020, DMHAS issued supportive housing contracts that are for services only. When individuals require a housing subsidy the SHC processes the subsidy requests and pays awarded subsidy payments directly to the landlord.

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

Lastly, DMHAS has launched a multiagency Suicide Advisory Council to aid in the prevention of suicide within all demographics. This initiative has partnered with a number of state agencies, including the Department of Health.

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

In 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, county hospital or Short Term Care Facility (STCF) for 12 months post discharge from the inpatient setting. Other mental health services include Programs for Assertive Community Treatment (PACT), Outpatient, Acute Partial, Partial Hospital, Supported Employment, Community Support Services (CSS), Coordinated Specialty Care (CSC), Jail Diversion, etc.

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.

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 are provided. At minimum, all agencies provide cultural competency training at initial hiring and at least annually thereafter. A number of agencies take advantage of the trainings offered by the regional Cultural Competency Training Centers and other regional training opportunities. All PATH programs are informed by SMHA staff of any and all cultural awareness trainings being offered through SAMHSA or the Homeless Resource Center.

Multicultural and sensitivity training is mandatory for staff (per DMHAS regulations) upon hire to CSS programs and on an annual basis. This training is provided to ensure that staff are sensitive to age, gender and racial/ethnic differences of clients.

Supported Employment and Supported Education 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.

DMHAS Services to Special/Target Populations

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

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

Services to Co-occurring Populaton. 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). The DMHAS, in partnership with the DMAHS, developed FFS Medicaid and NJ Mental Health state FFS rates that enable clinic agencies to hire a workforce that is able to serve individuals who are dually diagnosed with a mental illness and substance use disorder. Additionally, 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 to 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.

Services to Families of Military Veterans. The SMHA has consistently provided mental health and related support services to members of the armed forces and veterans as part of its regular behavioral health service delivery system. When possible, the service member is connected to the VA healthcare system if eligible, however this is typically on 13%. In SFY 2016, During SFY 2016, SMHA served just under 7,000 individuals who identified themselves as veterans. They were provided with a range of services, the most frequent being emergency services, outpatient, partial care, case management, Justice Involved Services, Supported Employment, and Supported Education. However, the SMHA believes that the actual number served is closer to 14,000 because many active or former service members may not consider themselves veterans in response to provider intake questions as well as based upon discussion with the NJ Healthcare System (VA). The SMHA and SSA had previously participated in the state's now inactive 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. The SMHA also participated in Operation Immersion with the hopes that a similar training effort could be started in New Jersey. The SMHA has established quarterly meetings with the NJ Healthcare System (VA) to enhance collaboration, particularly around acute care services. A SMHA representative has recently reconnected with the NJ Department of Military and Veterans Affairs who was part of the SAMHSA Policy Academy to update and collaborate regarding needed services for NJNG and other military service personnel. Discussion included providing NJNG with Mental Health First Aid training, the result of a SAMHSA grant, and reestablishing a points of contact between the two divisions for referrals to services. A SMHA representative recently provided an overview of the mental health and substance abuse system in New Jersey and how to access services for the Semi-Annual State and County Veteran Service Officers; it was very well received.

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

DMHAS Disaster and Terrorism Branch (DTB) is providing Question, Persuade and Refer (QPR) to the veteran population. One of the team trainers is a combat veteran and regularly meets with veteran groups throughout the state to discuss Mental Health First Aid (MHFA) and QPR training opportunities. A QPR training was provided to a Veterans support group in East Orange in July 2019 with 16 in attendance. Mental Health First Aid training was facilitated for a

Teen Challenge program for at risk youth. The staff for the program were primarily veterans and 25 were trained.

Hudson County Office of Veterans Affairs hosted a QPR Gatekeeper Suicide Prevention Training on May 7, 2019. In this collaborative effort, the Hudson County Mental Health Administrator and the Coordinator of Hudson County Office of Veterans Affairs invited various county agencies as well as Catholic Charities Support Services for Veterans Families (SSVF) to be certified as QPR Gatekeepers. The term "gatekeeper" refers to anyone who may benefit from learning how to use QPR to intervene to stop a suicide. Gatekeepers are people who may be in a position to recognize warning signs of suicide and that someone is considering taking their own life. 22 participants are now able to recognize and response positively to a veteran exhibiting suicide warning signs and behaviors.

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.

Deaf and Hard of Hearing. New Jersey has an array of services throughout the state for individuals who are Deaf and Hard of Hearing and have mental health issues. ACCESS at St. Joseph's Medical Center in Paterson is contracted to provide on-site outpatient services at several outpatient locations throughout the state with Master's level clinicians who are specialists in Deaf Culture and 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/Videophone/TTY). Consultation is also available to inpatient settings, and outpatient programs. ACCESS staff participates in the New Jersey training for Certified Psychiatric Screeners so that they are able to understand, navigate, and explain the state's screening process. Additionally, ACCESS provides onsite clinical consultation and liaison services to New Jersey's Short Term Care Facilities (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 inpatient unit in the main hospital building and an eight bed capacity less restrictive residential cottage to prepare individuals for discharge. All SSIP staff are trained in ASL and Deaf culture. Certified ASL Interpreting staff are available for patient and staff interfaces, particularly clinical contacts.

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

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

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

The Division has had a long standing commitment to issues of cultural and diversity, originally forming a Multi-Cultural Advisory Committee in 1981. Since that time, the role and membership of this group has changed to meet the changing needs of the system. In June 2015, MSG was formed to devise strategies that are appropriate to the lifestyles, special needs, and strengths of New Jersey's diverse minority and cultural groups who receive services in the behavioral health system of care. The MSG will address the needs for ongoing plans within all agencies in the system as we improve quality of care for minority, cultural, linguistic, LGBTQ, deaf and hard of hearing, and aging populations.

MSG membership includes broad representation from providers in the behavioral health treatment community, consumer representatives, LGBTQ, administrators, and academics. This group has begun agency self-assessment process, developing a mechanism to incorporate agency cultural competence plans into contracting, development of a strategic plan, and development of a training curriculum.

CSOC Planning Step 1

The current state-wide Children's System of Care began as a single county-based initiative in 2001. At that time, New Jersey began to implement the elements outlined in the January 2000 New Jersey DHS Concept Paper, *The Children's System of Care Initiative Concept Paper.* The concept paper detailed key elements for system reform to better serve children with emotional and behavioral health care challenges and their families. The reform was ambitious and virtually unprecedented in its scope and commitment to individualized, integrated, culturally competent, and family driven services. The goal was to create an entity to coordinate and expand existing services and to develop new community services state-wide to help youth and their families recognize their strengths and plan services to meet their needs.

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

The goal of DCF's CSOC is to enable the youth to remain at home, in school, and within their community. Therefore, through an organized system of care approach, CSOC is committed to providing services that are:

A. Clinically appropriate and accessible;
B. Individualized, reflecting a continuum of services and/ or supports, both formal and informal, based on the unique strengths of each youth and his or her family/ caregivers;
C. Provided in the least restrictive, most natural setting appropriate to meet the needs of the youth and his or her family/ caregivers;
D. Family-guided, with families engaged as active participants at all levels of planning, organization, and service delivery;
E. Community-based, coordinated, and integrated with the focus of having services, decision-making responsibility, and management resting at the community level;
F. Culturally competent, with agencies, programs, services, and supports that are reflective of and responsive to the cultural, racial, and ethnic differences of the populations they serve;
G. Protective of the rights of youth and their family/caregivers; and
H. Collaborative across child-serving systems, involving; child protection, juvenile justice, and other system partners who are responsible for providing services and supports to the target populations.

The NJ Children's System of Care is founded on the following Core Values and Principles:

- **Family Driven and Youth Guided**– Families are engaged as active participants at all levels of planning, organization, and service delivery.
- **Culturally and Linguistically Competent** – learning and incorporating the youth and family's culture, values, preferences, and interests into the planning process, including the identified language of the family.

- **Community Based** – identifying and utilizing supports that are least restrictive, accessible, and sustainable to maintain and strengthen the family's existing community relationships.

In the years since 2006, the mission of CSOC has expanded. On June 29, 2012 Governor Chris Christie signed a bill that reorganized CSOC into a single point of entry for all families with children, youth and young adults with intellectual/developmental disabilities and substance use challenges. This realignment of services removes barriers to accessibility, provides more 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 Department of Human Services (DHS) began July 1, 2012.

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

Highlights of the New Jersey Children's System of Care:

1. Keeping youth in NJ for treatment
    - In 2007, there were over 300 youth being served in behavioral health residential centers out of state
    - As of today, there is **1** youth in an out of state behavioral health program

2. Reducing the length of stay in residential treatment centers
    - In FY 2003, average length of stay was 407 days
    - In FY 2010, average length of stay was 349 days
    - In FY 2016, average length of stay was 267 days
    - In FY 2018, average length of stay was 256 days
    - A 37% reduction in length of stay in residential treatment has been achieved over the last fifteen years

3. Expanding community-based care management, in-home, and day treatment programs for children
    - In 2000, NJ served approximately 7,000 children, youth and young adults in community-based care management, in-home services and supports and day treatment programs
    - In 2010 NJ served 35,000 children, youth, and young adults in community-based care management, in-home services and supports, and day treatment programs, a 500% increase in a ten-year period
    - In 2018, NJ served approximately 56,000 children, youth and young adults in community-based care management, in-home services and supports, and day treatment programs, a 700% increase in an eighteen-year period

- As of January 2019, 22% of the youth receiving care management are Developmental Disability (DD) eligible
- As of January 2019, 23% of the youth receiving care management are involved with child welfare

4. Reducing the number of juvenile justice commitments:

- The system of care is fully accessible to youth involved with the juvenile justice system and helps keep youth out of detention centers. There has been a significant decrease in the number of detention center admissions resulting in the reduction of the number of county detention centers from seventeen to seven in the past few years (Union County detention center closed in February 2019).
- In 2004 there were approximately 200 youth, statewide, in detention awaiting residential treatment post disposition.[1] Today, it is rare to have even one youth awaiting residential treatment post disposition.
- The average waiting time to be admitted to a residential program is approximately 52 days (an increase from 40 days last year) across all levels of intensity for behavioral health. The waiting time increased this year due to increased demand for two co-occurring residential programs and specialty programs for girls. For youth in detention centers in need of out of home treatment, there are detention alternative beds that can be accessed on an emergent basis.

5. Creating a proactive safety net for youth:

- In 2003 40% of newly enrolled children were under 14 years of age; today that percentage has grown to over 50%
- This change in age distribution among youth served indicates that the system of care is effectively reaching youth at a younger age and thus able to engage youth and families to offer earlier intervention to address the child and family's needs.

6. Reducing the number of children in out of home (OOH) treatment settings:

- In FY 2007, there were almost 4,000 children in behavioral health OOH treatment settings. In the intervening 5 years, the numbers of children in OOH decreased substantially. Between FY 2012 and FY 2018, the number of youth in all OOH placement settings (behavioral health (BH), substance use (SU) and Intellectual and Developmental Disability (IDD) continued to decrease.

Year	**Children in OOH treatment settings**
FY2012	3,178
FY2013	3,100

FY2014	3,213
FY2015	3,114
FY2016	3,662
FY2017	3,430
FY2018	3,090

7. Providing immediate services to youth in crisis:

- Mobile Response maintains youth in crisis in their homes or current living situation, reducing disruptions for youth and their families and providing them with support and access to services during times of behavioral health instability.
- As of December 2018, over 97% of youth receiving Mobile Response services remained in the home or current living situation during the Mobile Response intervention.

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

9. In October 2015, Children's System of Care was awarded a SAMHSA system of care expansion grant, to implement trauma-informed care and provide workforce development to our system partners. The grant, which is called Promising Path to Success, utilizes the evidence-based practices of Six Core Strategies and the Nurtured Heart Approach to reduce restraint and seclusion, while additionally striving toward the goal of limiting out of home treatment to one episode of six to nine months in duration. The grant requires all system partners, including CSOC, to examine institutionalized practices and policies that could be trauma-inducing to achieve better outcomes for youth and families through improved system collaboration, policy creation, and the enhancement of youth and family voice. SAMHSA representatives conducted a project site visit in December 2017. SAMHSA provided New Jersey with an exemplary exit report that recommended having enhanced youth voice within CSOC and the importance of supporting our Children's Inter Agency Coordinated Councils at the local level. In response to the report, the Children's System of Care recruited and hired its first Statewide Youth Ambassador, with lived experience from DCP&P as well as CSOC, in January of 2018. This Youth Ambassador has brought youth voice more prominently at the State Level into policies, program development and operations. Although youth voice was previously represented in the System of Care, having a Youth Ambassador employed by CSOC amplifies youth voice at the State level in a meaningful way and is true to the system of care approach.

Implementation of the Department of Children and Families (DCF) Strategic Plan

In keeping with Governor Murphy's platform of a stronger, fairer NJ, DCF is undergoing a transformation that is guided by best practice, national trends, staff and consumer voice.

Our vision is that all NJ residents are (or become) safe, healthy and connected.

Our values are what we hold to be true of our work for the department. It is the core of our operations and interactions. It is the professional compass that guides us.

- Collaboration is about our willingness and intention to work in teams, **in comfortable and uncomfortable ways**.
- Equity means making sure we do what is needed to support each person we serve to be safe, healthy and connected.
- Evidence means using evidence-based, or promising practices, data and outcomes as our basis for advancing - or ending – certain programs and services.
- Family means all that we do should be in the interest of family and should be determined, as much as possible, by listening to their needs and providing appropriate supports.
- Integrity means that we're honest, reliable and respectful in all that we do.

DCF has also embraced five core approaches or practices that we will embed in all our work.

- Race equity – DCF is committed to integrating policies that advance racial equity in the work that we do.
- Healing Centered Practice – DCF will strengthen practice models, customer service, physical spaces and services that we purchase, so that they promote healing.
- Protective Factors Framework – DCF will structure practice models and purchased services to assess for and to promote the 5 protective factors: parental resilience, social connections, concrete support in times of need, knowledge of parenting and child development, and social and emotional competence for children.
- Family Voice – DCF's new Office of Family Voice will provide us with staff and families with lived experience to ensure that we're attentive to their ideas and input.
- Collaborative Safety – DCF will incorporate safety science into child and family services so that we do not merely respond to adverse events, but learn from them in such a way that we can reliably prevent future adverse events from happening

DCF's strategic focus represents an effort to identify the major areas in need of attention to maintain service excellence while simultaneously achieving significant transformation of the systems

Four (4) major Departmental priorities have been identified:

1. Primary prevention of maltreatment and maltreatment related fatalities. This includes child maltreatment, domestic violence and sexual assault prevention.

2. Preserving kinship connections

3. Staff health and wellness

4. CSOC

   In order to best align the priorities of the CSOC with the DCF vision and values, DCF is forming an external advisory group to collaborate with us to identify the specific goals for innovation and change that will sustain and grow the children's system of care in the years to come. DCF anticipates framing the recommendations of the advisory group within these three priorities:

   - Promote integrated health and behavioral health
   - Build capacity to deliver evidence-based interventions and services
   - Enhance CSOC capacity to ensure equitable access

DCF Children's System of Care Funding

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

Funding Source	Adjusted FY19	Recommended FY20
State	$ 384,428,000	$ 77,578,000
Federal	$ 244,570,000	$ 237,622,000
Total Budget Authority	**$ 628,998,000**	**$ 615,200,000**

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

Currently CSOC serves **over 59,000** youth per year through a complement of needs-driven supports and services within a system of care approach: family driven, youth-guided, strengths-based, individualized care. The primary goals of CSOC are to ensure youth receive quality care in the most appropriate, community-based setting whenever possible to maintain connections to family and communities for sustainable relationships and planning. CSOC also has a continuum of out-of-home treatment settings of varying degrees of intensity of service accessible based on youths' individual needs.

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

2. There is generally one CSOC staff member assigned to manage each of the key services available through CSOC (i.e. CMO, MRSS, IIC/BA, FSO).

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

    - Mental Health Rehabilitation Services Behavioral Assistance (01-04);
    - Mental Health Rehabilitative Services Intensive In-Community (01-06);
    - Reimbursement for Mental Health Rehabilitation Services Children's Mobile Response (01-10);
    - Reimbursement for Mental Health Rehabilitation Services Residential Care Facilities, Children's Group Home, and Community Psychiatric Residences for Youth and Other Programs for Children Licensed/Certified by New Jersey Government Agencies (02-8, 02-09 and 02-14) and;
    - Behavioral Health Homes (16-0002) and;

4. CSOC also receives funding through the NJ FamilyCare Comprehensive Demonstration (1115 Waiver) approved by the Centers for Medicare and Medicaid Services (CMS) in 2017.

5. Services are provided based on medical necessity.

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

Care Management Organization (CMO) - CMOs are county-based, nonprofit organizations that combine face-to-face care management and comprehensive service planning for high and moderate need youth and their families into a single, integrated system of care. Youth are enrolled with a CMO when independent CSOC CSA review of clinical and need based information about the youth meets the threshold of clinical criteria and the youth and family can benefit from services. CMOs facilitate the Child/Family Team (CFT) meetings and implement Individual Service Plans (ISP) for each youth and their family. The CMO provides a single point of accountability for the organization, the delivery of services and the supports needed to maintain stability for each youth.

Child Family Team (CFT) - The CFT/Wraparound is an ongoing coordinated process that includes participation from the youth, the youth's family, the CMO care manager, and any other individual identified by the youth and family to help support the family towards a sustainable plan of care.

Behavioral Health Homes - Each Behavioral Health Home (BHH) is a designated Care Management Organization (CMO) with enhanced care management teams that include medical

expertise and health/wellness education for purposes of providing fully integrated and coordinated care for youth remaining in their home and who have chronic medical conditions. BHH services are a "bridge" that connects prevention, primary care, and specialty care. Medical and wellness staff are integrated into the existing CMO CFT structure responsible for care coordination and comprehensive treatment planning for youth and their families which includes planning for the holistic needs of the youth.

Family Support Organizations (FSOs)

FSOs are operated by 15 agencies under contract with CSOC to: ensure that service plans developed for families are child-centered and family-focused; provide support to families through peer counseling, family training and workshops; advocate for families at the local level with other system partners; and cultivate and empower youth development consistent with the wellness and recovery model.

Mobile Response and Stabilization Services (MRSS)

MRSS provides rapid response to youth and families experiencing family-defined crisis, 24 hours per day, 7 days per week, 365 days per year, that focuses on crisis intervention and stabilization that is intensive, therapeutic and rehabilitative. MRSS approach is engagement focused, strengths based, collaborative with youth and families, culturally sensitive and based on individual needs. The purpose of MRSS is to provide crisis intervention, assessment, and planning services designed to stabilize escalating behaviors and/or emotional challenges, maintain children and youth in their home environment and community, and avoid unnecessary psychiatric hospitalization, out of home care and legal involvement

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

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

IIC services have two components:

- **IIC Bio-Psychosocial and Strengths and Needs Assessments** are conducted and submitted to the CSA for review by licensed behavioral health clinicians within 10 days of request. The assessment describes present challenges, strengths, identified goals, youth and family perspective and recommended intervention strategies. Assessments are provided in a youth's current living situation, including resource homes and detention centers. Assessments provide necessary information for a level of care determination.

- **IIC Treatment Services** are clinical interventions provided by licensed or licensed-supervised master's level clinicians working within the scope of their licensing board in the youth and families' natural environment. Time limited and goal-oriented, these services aim to reduce acute symptomatology, enhance strengths, and transition youth and families to more traditional, i.e. clinic/office-based, services as soon as possible.

BA services are adjunctive to IIC services. They are never stand-alone. BA services are delivered by a license-supervised individual who holds a bachelor's degree at minimum and has 1-year experience working with the population served. The BA is the agent of the IIC plan of care. The BA service provides direct youth and parent training, support, and intervention to maximize the potential of positive and sustainable change.

Evidence-Based Practices

The Children's System of Care is dedicated to providing behavioral health services that are based on the best evidence available and to improving outcomes and the quality of life for children, youth and young adults receiving services through the Division. The following EBPs are available through CSOC: MST, FFT, Wraparound approach, FFT for Foster Care, Six Core Strategies and Nurtured Heart Approach and the ARC GROW Model.

Youth Outpatient programs

Outpatient

Outpatient treatment services provide behavioral health care to youth and families in a licensed community agency. Outpatient services are designed to support, enhance and encourage the emotional development of life skills to preserve or improve individuals' functioning, strengths and resources. Interventions may include individual, group and family therapy; and referral. Interventions are provided on maintenance, assessment and testing; outreach services; and referral. Interventions are provided on a long-term basis when necessary.

Partial Care/Partial Hospitalization

Partial Care/ Partial Hospitalization programs are highly structured, intensive (minimum 2 hours, 3 to 6 times per week) behavioral health services for youth with serious emotional challenges. Multi-disciplinary behavioral health interventions include rehabilitation programming such as activities for daily living, recreation, socialization, and community reintegration. Programs are typically located in, but not necessarily limited to, a community-based mental health or hospital setting (N.J.A.C. 10:37-12). Partial Care services assist in stabilizing youth with acute needs, either following or in lieu of hospitalization or other out of home treatment.

County Interagency Coordinating Council (CIACC)

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

- Evaluating the local county policies and policies to understand and minimize the impact of local barriers to serving youth with behavioral and emotional health needs substance use and/or intellectual and developmental disabilities in their community.
- Identifying local strategies and mechanisms to promote the integration and coordination of county, State, or other resources serving youth with behavioral and emotional health needs, substance use and abuse, and /or intellectual and development disabilities.
- Assessing local systems needs using information received from DCF, the Contracted System Administrator (CSA), any child-serving agency identified by DCF, and other bodies to make recommendations regarding service and resource development priorities.
- Identifying and informing DCF/CSOC regarding gaps and barriers to local service effectiveness.
- Providing input to State, regional, and county entities regarding system performance and service need.

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

Out-of-Home Treatment Services

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

Clinical criteria for the OOH continuum of services is available at http://www.performcarenj.org/provider/clinical-criteria.aspx.

CSOC data have demonstrated a gradual decline in OOH utilization over the past several years, which is attributed to the success of maintaining more youth at home with community supports. Based on the analysis of utilization data, youth with high needs are requiring OOH intervention, whereas youth with low needs are more likely serviced in the community. Due to this decrease in utilization, as well as reduced lengths of stay, several OOH programs closed during FY 2018, resulting in a net loss of **132** beds. The Specialized Residential Treatment Unit (SRTU) provides administrative programmatic oversight of these programs and thus conducted a needs analysis to identify the types of OOH programs where additional capacity is needed.

Children's Crisis Intervention Services

Psychiatric inpatient hospital services, located in community hospitals, provide acute inpatient treatment, stabilization, assessment and short-term intensive treatment. The units are licensed by the Department of Health, following yearly designation by CSOC. The Children's Crisis Intervention Service (CCIS) designation process ensures that CCIS units, established to meet the intent of the 1987 Children's Regional Plan, are following both the intent and spirit of the plan and comply with the Certificate of Need criteria for CCIS units (N.J.A.C. 8:33) and Hospital Licensing Standards (N.J.A.C. 8:43G).

Nine CCIS units are located around the state and provide services to all 21 counties. There are currently 164 beds. They are funded through Medicaid and private insurance. Seven of the nine CCIS' receive additional support through a mental health subsidy ($15, 056 annual per bed) from the Division of Mental Health and Addiction Services.

Substance Use (SU) Treatment

The Children's System of Care offers an array of substance use treatment services for youth and young adult, including four withdrawal management beds, contracted outpatient/intensive outpatient services through 10 providers statewide, partial care services through one provider, short term out of home treatment through one provider with 22 beds, and long term out of home treatment through two providers – one with 36 beds and the other with 64 beds). In addition, residential treatment services for youth with co-occurring substance use needs and significant behavioral health needs can be accessed through the CMO from five providers with a total of 54 beds.

The South Jersey Initiative provides fee for service funding to 11 providers for outpatient and intensive outpatient substance use services for the eight southern counties. One agency, with a capacity of three beds, provides short term out of home treatment.

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

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

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

Supports and Services for Youth with Developmental Disabilities

DD Eligibility

As of January 1, 2013, CSOC assumed responsibility for determining eligibility for developmental disability services for children under age 18. The CMOs and MRSS work with family members to make application for eligibility determinations. DDD continues to determine eligibility for individuals aged 18 and over, and the Children's System of Care provides services to those youth. DDD and CSOC collaborate through an established protocol to provide a seamless transition to adult services. During SFY 2018, **14,422** DD eligible youth were active with CSOC.

Intensive in Community – IIH Clinical/Therapeutic Supports

Intensive in community – Habilitation (IIH) clinical supports are intensive community-based, family-centered services delivered face-to-face as a defined set of interventions by a clinically licensed practitioner. The purpose of IIH services is to improve or stabilize the youth's level of functioning within the home and community to prevent, decrease or eliminate behaviors or conditions that may lead to or that may place the youth at increased clinical risk, or that may impact on the ability of the youth to function in their home, school or community.

Family Support Services for children with intellectual/developmental disabilities

CSOC began to provide funding for family support services in 2013. These services provide a wide range of supports including, but not limited to, respite, assistive technologies, camps, and home and vehicle modifications for uncompensated caregivers of youth with developmental disabilities living at home. Family Support Services are federally mandated and detailed under NJ Statute. Family Support Services FAQ is available at http://www.performcarenj.org/families/faqs.aspx

Juvenile Justice

Reducing the number of Juvenile Justice commitments

The Children's System of Care (CSOC) is fully accessible to youth involved with the juvenile justice system and the services coordinated by care managers help to keep youth out of detention centers. There has been a significant decrease in the number of detention center admissions resulting in the reduction of the number of county detention centers from seventeen to seven in the past few years (Union County detention center closed in February 2019).

Detention Alternative Program/Youth Advocate Program

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

Medicaid

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

Protocol for Court-Ordered Assessment of Children with Emotional and Behavioral Health Needs (14 Day Plan Protocol) between DCF/Children's System of Care and the New Jersey Judiciary, Family Division.

During 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 protocol exists

Biopsychosocial Assessments

The Juvenile Justice Commission requires, in the Manual of Standards, that all youth entering Detention receive the MAYSI (Massachusetts Youth Screening Instrument) within 24-48 hours of admission. CSOC has implemented an easily accessed clinical assessment process for any youth in a county juvenile detention center that may score on the MAYSI regarding possible mental health concerns or need for substance use treatment. This assessment is also utilized to expedite out of home treatment.

CSOC is represented on the New Jersey Council for Juvenile Justice Improvement. Diversion and the Reentry processes are discussed by the Access to Treatment and Racial

Disparities sub-committees of the Council. Formal recommendations are presented to the full Council by the individual sub-committees.

DCF has established cooperative relationships with the Juvenile Justice Commission (JJC). In December 2004, the Department with the JJC signed a Memorandum of Understanding that outlines a distinct process by which youth in the JJC can be referred directly to what is now known as the Children's System of Care for services that will be implemented upon the youth's release from a JJC facility. Representation from both DCP&P and CSOC participate in the JJC and Annie E. Casey Foundation driven JDAI (Juvenile Detention Alternative Initiative) 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.

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/CSOC.

CSOC developed two out of home Detention Alternative Programs (DAP) with a total of 14 beds. The priority population is youth in DCF DCP&P custody awaiting DCF placement once their charges have been disposed. The CSOC liaison also refers youth in detention centers with mental health needs.

The Contracted System Administrator (CSA)

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

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

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

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

- Providing a Call Center with 24-hour/7-day intake and Customer Service capability;
- Providing a web-based application/interface with the CSA's Management Information System (MIS);
- Managing care, which includes utilization management, outlier management (including authorization of services), and care coordination; if youth are involved with a Care Management Organization, the CSA reviews service requests based on the youth's comprehensive plan of care which is developed by the Child Family Team (CFT).
- Coordinating access to services for all youth, including facilitating access to specialized services for youth involved with the Division of Child Protection and Permanency (DCP&P);
- Coordinating Third Party Liability and medical coverages;
- Coordinating a transition to adult services for youth;
- Providing Quality and Outcomes Management, and System Measurement that supports CSOC's goal to promote best practices, and providing assistance to the State to assure compliance with State and federal guidelines;
- Providing training and training materials;
- Providing support for Provider Network Development; and
- Completing annual audit reviews.

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

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

Suicide is the third leading cause of death for New Jersey's youth. CSOC is dedicated to the prevention of youth suicide. New Jersey's primary youth suicide prevention program is the Traumatic Loss Coalitions for Youth funded by CSOC. The Traumatic Loss Coalitions for Youth Program at Rutgers-University Behavioral HealthCare is an interactive, statewide network that offers collaboration and support to professionals working with school-age youth. This is accomplished through county, regional and statewide conferences, training, consultation, onsite traumatic loss response, and technical assistance. Since its inception, the TLC has trained thousands of individuals throughout the state with the purpose of saving lives and promoting post trauma healing and resiliency for the youth of New Jersey. The TLC website can be accessed at http://ubhc.rutgers.edu/tlc/

2ND Floor Youth Helpline

Accredited by the American Association of Suicidology, 2ND Floor confidentially serves youth and young adults (ages 10-24). Youth who call are assisted with their daily life challenges by professional staff and trained volunteers. The 2nd Floor website can be accessed at http://www.2ndfloor.org/

Crisis Text Line

Children's System of Care has developed an agreement with Crisis Text Line in New Jersey to provide another tool for constituents. Crisis Text Line is a free 24/7 support that connects anyone experiencing a self-defined crisis with a trained counselor. It can be accessed from anywhere in the United States. When texts are received, they are screened by an algorithm for severity, and texts that indicate imminent risk are placed at the top of the queue for faster response. Crisis counselors are trained to bring texters from "a hot moment to a cool calm" using empathic listening techniques. They collaboratively problem-solve to help the texter come up with a plan to stay safe. Calls are anonymous and confidential, unless referral to emergency services is necessary. DCF has a Memorandum of Understanding with the Crisis Text Line for sharing frequency data. For cell phone plans with AT&T, T-Mobile, Sprint or Verizon, texts are completely free and will not show up on the phone bill. For plans with another carrier, normal text rates will apply and will appear on the phone bill as 741741. Additional information about Crisis Text Line can be found at crisistextline.org.

CSOC Training and Technical Assistance

CSOC offers a broad array of training and technical assistance to system partners through contracts with several entities including Rutgers University Behavioral HealthCare, the Boggs Center, and Autism New Jersey.

SAMHSA Grant Program

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

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

The NJ CSOC/DMHAS partnership is well positioned to add services for youth and young adults at clinical high risk for psychosis to the already robust care continuum available throughout the state, as the program will utilize established behavioral health agencies who are currently providing treatment services for persons experiencing first episode psychosis (FEP). NJ PROMISE anticipates providing intervention to approximately 150 youth and young adults across three regions annually, and more than 600 youth and young adults over the four-year grant period. Through extensive outreach, coordinated care, the use of evidence-based, evidence informed, best, and promising practices as well as the expertise of a team of professionals, participants and their families will have the tools necessary to lead productive lives in their homes and communities.

The project's measurable goals are to:

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

NJ FamilyCare Comprehensive Waiver

(1115 Medicaid Comprehensive Waiver)

In 2012, the Centers for Medicare and Medicaid Services (CMS) approved New Jersey's 1115 Comprehensive Waiver for a five-year period with the goal of changing New Jersey's health care delivery to ensure a broader community base and person-centered continuum of care. Key changes for CSOC under the waiver authority included:

- Federal participation on behavioral health services for youth with severe emotional disturbance (SED);
- Targeted home and community-based services (HCBS) for populations of youth;
- In-home and community supports for children and youth with SED and/or intellectual and developmental disabilities(I/DD) and;
- Authority to provide and receive federal participation for services to youth with Autism under the Autism pilot.

In 2017, CMS granted New Jersey a five-year extension on the 1115 waiver (renamed NJ FamilyCare Comprehensive Demonstration) to include:

- Additional in-home supports for an expanded population of youth with intellectual and developmental disabilities;
- Needed services including HCBS supports for an expanded population of youth with severe emotional disabilities; and
- Needed services and HCBS for an expanded population of youth with co-occurring developmental/ mental health disabilities.

Children's Support Services Program (CSSP) SED

The Children's Support Services Program SED provides behavioral health, home and community-based services for youth under age 21 who have a serious emotional disturbance (SED) which places them at risk for hospitalization, out of home treatment, or at hospital level of care. For youth not eligible for Medicaid, this provides federal support for behavioral health services under

the State Plan amendment, and home and community-based services that are authorized through the children's Administrative Service Organization (PerformCare, also known in New Jersey as the Contracted System Administrator, CSA).

The program also allows for Medicaid eligibility based on SED determination for youth who have a plan of care through CMO, irrespective of parental income. It also adds new services that have been found to be critical for the success of youth.

Children's Support Services Program (CSSP) Intellectual/Developmental Disabilities (I/DD)

The Children's Support Services Program for youth with intellectual/developmental disabilities (I/DD) provides home and community-based services and supports to individuals under the age of 21 that meet DCF/ CSOC functional eligibility for youth with I/DD as defined by state and federal law. Youth may also have co-occurring I/DD and mental health diagnoses (I/DD-MI). For youth not eligible for Medicaid, this provides federal support for home and community-based services that are authorized through the children's ASO.

The program also allows for Medicaid eligibility based on functional eligibility for youth who have a plan of care through CMO, irrespective of parental income. It also adds new services that have been found to be critical for the success of youth.

The goals for the waivers are to: improve youth's emotional stability; maintain youth in the community and increase community integration; support youth with SED or I/DD that are transitioning into adulthood; improve youth success in a wide range of life domains; reduce lengths of stay in out of home care settings by providing a less restrictive but medically appropriate treatment option; reduce acute hospitalization lengths of stay, episodes and repeat episodes; improve social and educational functioning; reduce incidents of juvenile justice involvement.

Waiver Services Operationalized

Individual Supports (Implemented SFY 2015) assist youth with I/DD with acquiring, retaining, improving, and generalizing the behavioral, self-help, socialization and adaptive skills necessary to function successfully in the home and community.

Intensive in Community / In Home Clinical and Therapeutic Services (Implemented SFY 2015)

are rehabilitative services that are not otherwise covered by the State Plan for youth with I/DD and assist family/caregiver in carrying out individual treatment/support plans and are necessary to improve the youth's independence and inclusion in his/her community.

Intensive in Community / In Home Behavioral Services (Implemented SFY 2015) are rehabilitative services that are not otherwise covered by the State Plan that include a comprehensive integrated program to decrease challenging behaviors while assisting the youth in acquiring, retaining, and improving self-help, communication and adaptive skills.

Respite (Implemented SFY 2016) services, including assessment and respite care planning, temporarily relieve the family/caregiver from the demands of care for the youth with I/DD.

Social and Emotional Learning (implemented SFY 2017) services employ the social decision-making model to identify and implement strategies necessary in areas of self-awareness, self-management, communication, relationship skills, social awareness, interactions and responsible decision making.

Non-Medical Transportation (Implemented SFY 2018) provides short-term non-medical transportation for youth and families involved with CSOC's MRSS or CMO. Services are provided throughout New Jersey, although it is expected that most appointments will be within the youth's county of residence.

Interpreter Services (implemented SFY 2017) are delivered face to face, to support providers and families in carrying out the plan of care that are not otherwise covered by the State Plan. Services must be delivered by an individual proficient in reading and speaking or signing in the language in which the youth is most comfortable communicating.

Autism Spectrum Disorder (ASD) Pilot, is one component of the NJ FamilyCare Comprehensive Demonstration. This component is the same design as prior waiver approved (10/2012-7/31/2017). CMS will not allow any technical adjustments to be made to the Autism Spectrum Disorder (ASD) pilot under the newly approved waiver as the state is expected to include Autism services under the State Plan. Currently, CSOC's ASO authorizes ABA and the Managed Care Organization coordinates speech, occupational and physical therapy. Note: this component will become defunct when the Autism state plan amendment is approved by CMS. At approval, autism services will become an entitlement for NJFC enrolled youth (see below Autism state plan section).

Autism Benefit as part of the NJ Medicaid State Plan

Currently, some services for youth with autism are reimbursed by NJ FamilyCare through the **NJ FamilyCare Comprehensive Demonstration** Autism Spectrum Disorder Pilot. The services (Applied Behavioral Analysis) are authorized by CSOC's CSA and are eligible for federal participation for youth that are enrolled as a waiver participant and meet the medically necessity criteria for the service. In addition, these services are currently authorized through the CSA to non-waiver enrolled youth that meet medically necessity and are funded with state dollars only.

On July 7, 2014, the Centers for Medicare and Medicaid Services (CMS) issued clarification and guidance of Medicaid coverage of services to children with Autism. CMS described the overarching requirement that states must arrange for and provide coverage for individuals eligible for the Early and Periodic Screening, Diagnosis and Treatment[2] (EPSDT) benefit (ages 0-21) to receive any Medicaid coverable service listed in section 1905(a) of the Act that is determined to be medically necessary to correct or ameliorate any physical or behavioral conditions. Therefore,

[2] EPSDT is a Medicaid mandated program that covers screening and diagnostic services to determine physical and mental defects in individuals under the age of 21, and health care, treatment, and other measures to correct or ameliorate any defects and chronic conditions discovered, pursuant to N.J.A.C. 10:49-18.1 and Title XIX of the Social Security Act.

states are required to furnish all medically necessary services to children. This includes children with ASD.

The EPSDT requirements apply to all children covered under Medicaid. Federal regulatory authorities have taken great care to ensure that services furnished are not limited in amount, duration, or scope and are furnished to all eligible children if medically necessary. As a result, states are not permitted to limit the duration of services to designated timeframes such as years, months, days, and/or hours. In addition, states may not target subpopulations of the EPSDT population based on age, such as furnishing unique services to those children within a designated age range. States are unable to target specified age ranges within the EPSDT population because, in accordance with 42 CFR 440.250(b), the state plan must provide that the services available to any categorically needy beneficiary under the state plan are not less in amount, duration, and scope than those services available to any other beneficiary.
Additionally, Governor Murphy allocated $17 million in FY 2019 to expand services for youth with autism.

CSOC, the Division of Medical Assistance and Health Services (DMAHS) and a group of external stakeholders facilitated by the Center for Health Care Strategies (CHCS) met from June 2018 through October 2018 to design the elements of a state plan amendment (SPA) and a comprehensive benefit that is most advantageous to children and families. Services offered through state plan amendment will include but not be limited to therapeutic, behavioral and medical interventions such as Developmental Individual-differences Relationship (DIR)/Floortime, Applied Behavioral Analysis (ABA), naturalistic, occupational, physical and speech therapy and through waivers (respite, community inclusion).

Following a public comment period, DMAHS in partnership with CSOC, and including input from external stakeholders, drafted a SPA outlining the State's proposal to provide Autism services to youth under 21. It is anticipated that this document will be submitted to CMS no later than March 31, 2019, with the requested date of federal participation on autism services beginning January 1, 2019.

DMAHS, CSOC and CHCS are currently developing the implementation plan as the current service package includes existing services ABA authorized by the CSA and occupational, physical and speech therapy provided by the Medicaid Managed Care Organizations (MCOs).

Some salient points:

- There are about 800,000 youth with NJ FamilyCare eligibility
- The prevalence of Autism in NJ is 1:41
- This is a federal mandate for a vulnerable population (Medicaid youth) that requires a state cost-share
- Cost may include modification of PerformCare's contract due to the increase in utilization management services

Planning Steps

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

Narrative Question:

This step should identify the unmet service needs and critical gaps in the state's current M/SUD system as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state's M/SUD system. Especially for those required populations described in this document and other populations identified by the state as a priority. This step should also address how the state plans to meet the unmet service needs and gaps.

A data-driven process must support the state's priorities and goals. 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 sets including, but not limited to, the **National Survey on Drug Use and Health** (NSDUH), the **Treatment Episode Data Set** (TEDS), the **National Facilities Surveys on Drug Abuse and Mental Health Services**, and the **Uniform Reporting System** (URS). Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, substance use disorder prevention, and SUD 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 M/SUD services. This will allow states to have a more comprehensive approach to identifying the number of individuals that are receiving services and the types of services they are receiving.

In addition to in-state data, SAMHSA has identified several **other data sets** that are available to states through various federal agencies: CMS, the Agency for Healthcare Research and Quality (AHRQ), and others.

Through the **Healthy People Initiative**[16] HHS has identified a broad set of indicators and goals to track and improve the nation's health. By using the indicators included in Healthy People, states can focus their efforts on priority issues, support consistency in measurement, and use indicators that are being tracked at a national level, enabling better comparability. States should consider this resource in their planning.

[16] **http://www.healthypeople.gov/2020/default.aspx**

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Footnotes:

Planning Step 2: Identify the unmet service needs and critical gaps within the current system. Please provide a description of how the state plans to meet these identified unmet service needs and gaps.

State Mental Health Authority (SMHA)

The State of New Jersey is geographically, demographically, culturally, and socioeconomically diverse. Identifying populations historically under-served by mental health services is vital to the SMHA's success at facilitating the wellness and recovery of all of its citizens. The SMHA has undertaken needs assessments to determine underserved areas for targeting RFPs and contract efforts (e.g., Outpatient Services, Community Support Services), using a myriad of data sources in order to better understand the needs and service gaps on a statewide basis. Examples of relevant indicators to be observed on a county level include (but are not limited to): population density, racial composition, proportions of residents age 65 and older, unemployment rates, median household income, screening center admissions, and crime rates.

I. A Data Driven Process for Identifying Unmet Needs and Critial Gaps

Data Sources - The SMHA has steadily improved its capacity to organize mental health promotion initiatives utilizing prevalence estimates and epidemiological analyses at the state and county levels. The data sources SMHA will continue to utilize in driving the planning for the prevention and mental health promotion initiatives include:

- DMHAS internal data systems such as Quarterly Contract Monitoring Report (QCMR), Beds Enrollment Database (BEDS), Unified Services Transaction Form (USTF) database, System Review Committee (SRC) Data, and Oracle Hospital Census Database.
- Data obtained from different mental health community programs funded by DMHAS.
- SMHA Consumer Perception of Care Survey
- Other State and National Data Sets
    - Demographic Data from the US Census Bureau.
    - SAMHSA's New Jersey Behavioral Health Barometer.
    - SAMHSA's Uniform Reporting System (URS) Data Tables.
    - Annual Demographic Profiles summarized by New Jersey Department of Labor and Workforce Development based upon Census 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).
    - New Jersey Birth Certificate Data, Division of Maternal and Child Health Service, New Jersey Department of Health.
    - Pregnacy Risk Assessment Monitoring System (PRAMS), Division of Maternal and Child Health Service, New Jersey Department of Health.
    - The New Jersey Violent Death Reporting System (NJVDRS), a CDC-funded surveillance system, which records suicide (with known circumstances).
    - CDC-funded New Jersey Behavioral Risk Factor Survey, in which mental health modules were implemented (Depression and Anxiety Module, 2010 and 2011; and Mental Illness and Stigma Module, 2012, 2013, 2014 and 2017). The SMHA funded the collection of Mental Illness and Stigma Module in NJBRFS in 2014.

- New Jersey DOH Uniform Billing data which show hospital and emergency room use by demographic factors.
- New Jersey DOH Healthcare Facility Licensing data, with which occupancy rates for psychiatric beds in general hospitals are calculated.

The SMHA's data sources in details:

Quarterly Contract Monitoring Report (QCMR) Database. QCMR collects quarterly, cumulative, program-specific data from each of the service providers contracted by DMHAS via a web-based portal. It tracks data consisting of consumers served, as well as quantifies service utilization across the mental health system. QCMR data is provided to the SMHA by 118 separate agencies on 17 different program elements for roughly 630 separate sub-program elements (e.g., a specific program element, run by specific agency and specific site) on a quarterly basis. The 17 program elements include Acute Intensive Family Support Services, Bilingual Bicultural Services, Career Services (e.g. Supported Employment (SE), Supported Education (SEd), and Justice Involved Services (JIS)), Community Advocates, Designated Screening Centers (DSCs), Early Intervention and Support Services (EISS), Affiliated Emergency Services (AES), Integrated Case Management Services (ICMS), Intenstive Family Support Services (IFSS), IOTSS, Legal Services, Outpatient Services, Programs for Assertive Community Treatment (PACT), Partial Care, Involuntary Outpatient Commitment (IOC), and Self-help Centers. As new program elements are added, new QCMRs are developed. The two QCMRs that have recently been implemented are QCMRs' for Coordinated Specialty Care (CSC) programs for individuals with first episode psychosis and Community Support Services (CSS). These two new programs do not currently exist within the web-based QCMR portal, as is true for Supported Education, IOC, and JIS. Data for these five programs is collected separately and updated by DMHAS central office staff. But beginning with CSS, DMHAS will be working with QCMR programmers in early SFY20 to add each of these program elements into the QCMR portal, allowing for standardized and automated data collection and reporting of all DMHAS-funded programs.

The QCMR historically emphasized program-level data, but as the QCMR data field layouts change over time, increasing numbers of data points related to consumer outcomes have been included. QCMR does not collect client level data. The QCMR provides essential data for many routine reports generated by the SMHA including: DMHAS Evaluation data table for URS reporting of numbers served by program, annual Budget Briefing reports, and planning resources for the annual Consumer Perception of Care Survey. In addition, the QCMR provides reliable information for the majority of ad-hoc reports created by the Division, specifically around the topics of utilization management, provider performance and the geographic distribution of available services.

Beds Enrollment Database (BEDS). In May 2012, the SMHA began development on a web-based bed enrollment data system. BEDS is a secure web-based system designed and administered by the SMHA to facilitate the assignment of consumers from state psychiatric hospitals into safe and appropriate community-based residential settings, in accordance with SAMHSA's Supportive Housing EBP[1], the SMHA's Olmstead Settlement Agreement[2], and the

[1] http://store.samhsa.gov/shin/content//SMA10-4510/SMA10-4510-05-EvaluatingYourProgram-PSH.pdf
[2] http://www.nj.gov/humanservices/dmhas/initiatives/olmstead/olmstead_settlement_agreement.pdf

revised DMHAS Administrative Bulletin 5:11[3]. Utilization of a web-based system provides real-time access to vacancy information and helps facilitate assignments and avoid outdated spreadsheets. Analysis of the utilization of independent (e.g. Community Support Services) vs. supervised settings (e.g. group homes and supervised apartments) allows for assessment of the Division's progress toward community integration. The system also enables planning at both the individual consumer level for placement purposes and system-wide for purposes of enhancements in community resources. In addition to Community Support Services and residential (i.e. group home and supervised apartment) living arrangements, DMHAS is in the process of adding short-term care facility (STCF) placements to BEDS. This will allow for analysis and quality improvement measures geared toward improved wait times in STCF beds prior to discharge to long-term housing. For the purpose of data-driven planning, BEDS is a powerful utilization management and planning tool that will allow the SMHA to observe resource utilization, vacancy rates, and the geographic distribution of resources and housing requests.

Unified Services Transaction Form (USTF). The USTF database is an electronic client level registry originally developed in 1978 (and revised in SFY 1990) which still serves as one of the primary sources for populating the URS data tables. The current system is an Access desktop application which was rolled out in 2000 and used by all MH providers who submit their files to DMHAS each quarter. In SFY 2018, there were over 400,000 records—with each record containing the potential for over 50 separate data fields.

The development of a secure, web-based comprehensive client level data system (CLD) is essential at this time due to four key imperatives at the NJ Division of Mental Health Addiction Services (DMHAS): 1. To facilitate the transformation of DMHAS into a recovery oriented service organization, 2. to manage the transition of DMHAS to outcomes reporting), 3. to provide the public with more "forward facing" online performance data, and 4. to satisfy federal mandates of SAMHSA—including reporting of data required by the Community Mental Health Services Block Grant (CMHBG), Mental Health National Outcome Measures (NOMS), using Client-Level Data, and Mental Health Treatment Episode Data Set (MH-TEDs).

Work had begun on the development of a web-based client system during 2013-2014, but the plan to replace the the USTF database with a Client Level Database has been met with funding and resource delays. In addition, the Division has been in the midst of developing another data system (NJMHAPP) for the payment of claims using state dollars under fee-for-service. Administrative block grant dollars have enabled the Division to develop the NJMHAPP data system to track state dollars as well as eligible block grant expenditures.

The development and implementation of the proposed CLD data system would greatly facilitate the reporting of URS Data tables, MH-TEDS, and Client Level NOMS, as well as sigificiantly improve the quality of *ad hoc* reporting and production of data dashboards. In addition to the reporting mentioned above, the SMHA will be including evidence based assessment tools in the CLD with the goal of reporting client level outcomes as well as program level outcomes. The CLD will enable the SMHA to provide data dashboards for provider agencies as well as the SMHA senior leadership to drive planning. It will allow the SMHA to collect detailed data on

[3] http://www.state.nj.us/humanservices/dmhas/regulations/bulletins/Mental%20Health/5_11.pdf

various target populations to help determine unmet needs. It will serve to: 1. streamline community reporting processes by providing DMHAS (and its contracted agencies) with a single source of data entry for its users—thereby replacing several outdated data systems (e.g., the Unified Services Transaction Form (USTF), the Quarterly Contract Monitoring Report (QCMR), and the Systems Review Committee (SRC) data system) and reducing duplication of data entry, 2. provide fine-grained utilization management data that allows the Division to drill down to service use at the program level, the agency level, the county level and the client level, 3. document consumer outcome measures to evaluate program (and provider) effectiveness, 4. provide users with reliable and meaningful data to drive and inform decision-making. With the ability to utilize encounter data from Medicaid and NJMHAPP combined, along with the data from the CLD (client level of functioning, quality of life measures, etc), the SMHA will be able to gauge the impact of services and the cost of delivering those services. The SMHA would be able to significantly enhance its planning efforts and capacity for data informed decision making. It would be able to prepare a comprehensive need assessment inclusive of county based needs, barriers, critical gaps, and reporting on target populations.

The development of the CLD would eliminate the need for the QCMR database described above, the Systems Review Committee (SRC) dataset described below, and the current USTF described above. In doing so, the SMHA would be eliminating the disparate data systems that currently exist in the DMHAS and replace them with one client level database that will function as a client registry and will be able to report the aggregate data of the QCMR and the quality, volume and capacity data of the SRC.

Systems Review Committee (SRC) Datasets. SRC are a series of linked MS-Excel documents submitted monthly from 32 Short Term Care Facilities (STCFs) and 23 Designated Screening Centers (DSCs). By regulation, SRC data is collected and reviewed monthly by localized county specific committees comprised of acute care providers and governmental staff. These SRC processes include review of trends related to volume, capacity, referral patterns, system flow, length of stay and disposition. The SRC dataset provides program/agency-specific data that is the aggregate of each program's consumers served within a given month. The conversion of the SRC data submission files (from STCF and DSC provider agencies) into single 'flat files' has improved the ability of DMHAS staff to efficiently and accurately querty SRC data.

Oracle Hospital Census Database. Oracle Hospital Census database is the central information system used by the SMHA for storing client-specific records on consumers admitted into New Jersey's four inpatient adult psychiatric hospitals. To keep up with the flow of consumers entering, and exiting the SMHA's state hospitals, this data is updated on a daily basis by hospital personnel. Because Oracle is scalable, the Hospitals Census database has been modified slightly at each of the SMHA's psychiatric hospitals to meet not only the overarching needs of the SMHA, but also to meet the unique needs of each hospital. The scalable nature of the Hospital Census database has allowed the SMHA to also develop modules specific to data requirements imposed by the Olmstead Settlement Agreement, including an "Individual Discharge Needs Assessment" designed to identify barriers and consumers needs upon discharge. Although Oracle provides client-level data, this information is aggregated on a daily basis to provide critical reporting at the hospital level as well as the statewide level. Both the INDA and Oracle hospital census database provide a list of canned (i.e.pre-programmed) reports allowing for hospital and

central office users to summarize and examine hospital census data in an aggregated and/or snapshot view of over 3,000 consumers served each year. The Hospital Census database is used by the Division for utilization management; Olmstead monitoring, planning and evaluation; and reporting of URS data.

Consumer Perception of Care Survey. Since 2011, the SMHA Consumer Perception of Care Surveys have been distributed in the summer/fall of each year to a representative sample of adult consumers of all community-based, non-acute programs[4]. The survey results are reported in the annual CMHBG Implementation Report. An unmodified version of the Mental Health Statistics Improvement Program (MHSIP) Adult Survey (Draft Version 1.2, February 17, 2006)[5] is used as the survey instrument, with the addition of ten questions related to primary health, from the Behavioral Risk Factor Surveillance System (BRFSS) survey[6]. Each non-acute mental health program contracted by the SMHA, serves as sampling stratum. Agency program coordinators are instructed by the SMHA on techniques of random sampling and bias reduction. Consumers are empowered to participate in this survey with little/no intervention from direct care staff. The results of this survey are studied and used to guide the SMHA's planning efforts for future initiatives and resource allocation. The information gleaned from these survey efforts is used to populate the relevant URS Data Tables, as well as inform the SMHA on the quality of community-based, state funded mental health services, as perceived by the sample of consumers responding to these surveys. This survey data is helpful at looking at needs among specific program elements and at service needs in different parts of the state. Between 2011 and 2018 the average General Satisfaction score is 97.8% +/- 4.9%[7].

First Episode Psychosis (FEP) System. DMHAS is currently working on a data collection system to capture client level demographic and outcome data on participants in the FEP program. Before this system is completed, DMHAS has a data collection tool to capture demographic and outcome data elements using an Excel spreadsheet. The data is collected every 90 days and analyzed to track the progress of CSC clients who have received services. Client measures include client referral source; age; gender; race; psychiatric and medical hospitalizations; psychotropic medication adherence; co-cccurring substance use disorder; discharge and re-admission; insurance status; language, and global functioning by MIRECC GAF scale. In addition to the CSC data spreadsheet, CSC programs submit a quarterly progress report to DMHAS. The quarterly progress report outlines community outreach progress and any problems with the client service model, client referral demographic data, and other services on the client population.

Other Statewide and Nationwide Data Sets

The SMHA uses several independent datasets, alongside national and statewide datasets to shed light on goals, priorities and success. Specifically, this constellation of datasets is most

[4] Prior to the 2011 survey, the SMHA administered survey questionnaires to all consumers of one specific program element, which varied annually.
[5] http://media.wix.com/ugd/186708_3175909b8c1640988e6bee6edf865edd.doc?dn=%22URS_MHSIP_Adult_Survey2.doc%22
[6] http://www.cdc.gov/brfss/questionnaires/pdf-ques/2011brfss.pdf
[7] Based on the average General Satisfaction scores of all adult consumer perception of care survey data submitted in URS Table 11, from 2011 to 2018

commonly used to identify counties that are most appropriate (in terms of need and access to mental health services) for new community services and Requests for Proposals (RFPs). Additional statewide and county-specific data is obtained from the US Census Bureau (e.g. 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 Behavioral Health Barometer (https://www.samhsa.gov/data/sites/default/files/2015_New-Jersey_BHBarometer.pdf) and URS data tables, and state level detail reports provide useful information in this regard (https://www.samhsa.gov/data/report/2018-uniform-reporting-system-urs-output-tables). The National Research Institute (NRI) of the National Association of State Mental Health Program Directors (NASMHPD) is another source that the SMHA consults on a regular basis for national mental health data (http://www.nri-incdata.org/).

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.

II. Unmet Needs and Critical Gaps and How to Meet the Identified Unmet Service Needs and Gaps

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

Prevalence: According to the Federal methodology proposed for estimating the prevalence of SMI, the proportion of adults within the state with SMI is 5.4% (Federal Register, Volume 64, No. 121, p. 33890)[8].

According to figures released by the United States Census Bureau, the 2018 adult population of New Jersey was 6,948,646. The size of the New Jersey child population was 1,528,702. Using the SAMHSA's SMI prevalence rate among persons 18 and older (5.4%) the estimated number of adults with SMI in New Jersey in 2018 was 375,227. Using the upper SMI limit of 7.1%, the estimated number of adults with SMI in New Jersey in 2018 was 493,354. Accordingly, using the lower SMI limit of 3.7%, the estimated number of SMI adults in New Jersey in 2018 was 257,100.

Estimates of SMI, SED, and General Population of New Jersey, 2010, 2011, 2016 and 2018

Year	Total Adult Population	Total Adult SMI (5.4%)	Adult SMI Lower Limit of Estimate (3.70%)	Adult SML Upper Limit of Estimate (7.10%)	Total Children	Total Children SED (8%)	Total New Jersey Population
2010	6,726,680	363,241	248,887	477,594	2,065,214	165,217	8,791,894
2011	6,778,345	366,031	250,799	481,263	2,042,810	163,425	8,821,155
2016	6,959,717	375,825	257,510	494,140	1,984,752	158,780	8,944,469
2018	6,948,646	375,227	257,100	493,354	1,528,702	122,296	8,908,520

Estimates of 2010 - 2016 from http://lwd.dol.state.nj.us/labor/lpa/dmograph/est/est_index.html#state

The 2018 estimate is from https://www.census.gov/quickfacts/fact/table/NJ/PST045218

According to URS Table 2a, a total of 341,808 unduplicated consumers ages 18 and over received services in programs provided or funded by the SMHA in FY 2018. The SMHA served 132,561 unduplicated adult consumers with SMI (refer to URS data table 14a) in FY 2018. That was 35.3% of the total estimated SMI adult consumers in New Jersey (375,227).

Also shown in URS data table 14a, out of the total 132,561 unduplicated adult consumers with SMI served by the SMHA in FY 2018, 65,466 (49.4%) were ethnic minorities (and those who did not report a racial affiliation). The SMHA will ensure that ethnic minority population continue to have access to quality mental health services in New Jersey.

The demand for SMHA-funded community programs for people aged 55 and older has continued to grow in New Jersey. This population is considered older adults in mental health services. Rising enrollments are consistent with a general increase in the population size of older adult state residents. In 2010, New Jersey had 2,232,158 residents who were 55 years of age or older. The US Census estimates for 2015 is 2,523,416 New Jersey adults aged 55 and older. This represented an increase of 291,258 from 2010 to 2015 (an increase of 13.0%). In 2017 the NJ

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

Department of Labor[9] reported that there were 2,635,408 residents aged 55 and older. This is an 4.4% increase from 2015.

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. SMHA uses a few different approaches to determine unmet mental health services needs and gaps for New Jersey. They include 1) community surveys (e.g., direct survey, key informant), 2) local, state, and national data, which include the client level data and 3) the input from different stakeholders, such as members of the Behavioral Health Planning Council. With the aid of these tools, the SMHA has identified unmet needs in these target populations: SMI/SED, homeless people, older adults, LGBTQ populations, women with maternal depression, and persons with past criminal involvement. In addition, the SMHA faces the urgent needs for developing a client level database. The current situation and the future plans for addressing the needs are described. the SMHA has identified unmet needs in these target populations: SMI/SED, homeless people, older adults, LGBTQ populations, women experiencing maternal depression and psychosis, and persons with past criminal involvement.

Homeless Adults. The SMHA is the recipient of the federally funded PATH program, which is matched with state funding. The SMHA contracts with 22 non-profit agencies to operate 25 PATH programs within the state's 21 counties. The target population is homeless adults or those at risk of homelessness who have a serious mental illness, including those with co-occurring substance use disorders who are not currently engaged in and are resistant to mental health and other community support services. Programs for homeless adults are described in Planning Step 1 under Criterion 4.

The most critical gaps and unmet needs identified by PATH providers are: 1) lack of shelters in some counties and not enough emergency shelter beds in comparison to the number of individuals who need temporary housing in other counties. 2) The lack of available affordable, safe, permanent housing; 3) There is no way to pay for shelter stay if an individual does not qualify for General Assistance/Emergency Assistance because PATH dollars cannot be used to support emergency shelters. The SMHA has created some housing for the population at risk for homelessness, but sustained efforts are needed to combat the housing problem.

Through its Olmstead Initiatives, SMHA has developed supportive housing beds for individuals with SMI who are at risk for hospitalization and/or homelessness. Between 2010 and 2014, the total number of beds to be created in the community for consumers at-risk for psychiatric hospitalization and/or homeless was 370. The actual number created by DMHAS over the five-year period was 495. DMHAS exceeded this target for At Risk bed development by 125 beds, or 33.8%. DMHAS has also created an additional 19 beds for the at-risk population during SFY 2015 and 20 during SFY 2016, thus creating a total of 534 beds from 2010 to 2016. Two Hundred placements will be developed in SFY 2020.

[9] https://www.nj.gov/labor/lpa/dmograph/est/nj_single2017.xlsx

Older Adults. In 2011 the SMHA saw a need to develop specialized services to assist screening centers and nursing homes to respond to an increasing number of older adults with behavioral problems. In 2012, the SMHA awarded a contract for the development of a program to provide specialized clinical consultation, assessment, treatment and intervention to older adults who were at risk for presentation to emergency rooms for psychiatric hospitalization. Trinitas Regional Medical Center in Elizabeth, New Jersey was the recipient and has been administering this Statewide Clinical Outreach Program for the Elderly (S-COPE), which is fully funded by NJ-DMHAS and has been in operation since April 2012. Prior to S-COPE's inception, individuals with dementia were more likely to be referred to mental health crisis screening centers and emergency rooms, and many were subsequently being admitted to inpatient psychiatric facilities, including state psychiatric hospitals. With S-COPE involvement, many of these older adults were referred to S-COPE, and diverted from screening centers and hospitalizations. In 2018 there were 921 referrals to S-COPE and 189 were diverted from screening centers. Services to older adults are described in Planning Step 1 under Criterion 4.

Services for the LGBTQ Population. Since 1985, DMHAS has had the commitment to improve services to individuals from diverse cultural backgrounds, including LGBTQ. The DMHAS defines cultural competence as: "… the ability to honor and respect the beliefs, languages, interpersonal styles and behaviors of individuals and families receiving services, as well as staff members who are providing such services. Cultural competence is a dynamic, ongoing developmental process that requires a long term commitment and is achieved over time" (HHS 2003a, p-. 12). The impetus to grow this initiative further and address these system needs began with the 2015 reformation of DMHAS' multi-cultural activities into a Multi-cultural Services Group (MSG.) The MSG has developed a process for systems assessment that will begin with all contract agencies surveying their existing planning and service delivery to diverse populations. As the SMHA reviews the results of those surveys, areas of gaps in service, and needs for technical assistance (TA) will be identified. Beginning in early 2016, TA groups were held in the north and south to assist agencies in formulating multi-cultural plans. Those plans have become a part of the SMHA's contracting process in FY 2017, and followed up through DMHAS Multi-cultural Training Centers each year to ensure that the plans continue to grow. In Fiscal Year 2018, the DMHAS committed funding and resources to hire a Multicultural Diversity and Statewide Consultant. This individual provides consultation, technical assistance, development of a training curriculum, and services as a statewide resource for the DMHAS contracted mental health and addiction providers on issues relating to culture, language and diversity in the DMHAS system of care.

Moving on Maternal Depression (MOMD) Initiative. In August 2018, New Jersey was one of three states awarded a request for proposal from the Center for Law and Social Policy (CLASP) through its MOMD initiative. The 18-month initiative provides technical assistance, which is administered in the form of monthly calls with CLASP and other participating states; site visits with CLASP; and a conference with other states on promising practices toward serving populations with maternal depression. New Jersey's efforts under this initiative come from a collaborative which is co-lead by the Division of Mental Health and Addiction Services (DHS-DMHAS) and the Department of Health (DOH), and inclusive of the Division of Medical Assistance and Health Services (DHS-Medicaid) the Department of Children and Families

(DCF), and three maternal health consortia consisting of the Partnership for Maternal Child Health, Central Jersey Family Health Consortia, and South Jersey Perinatal Cooperative. The collaborative, known as the MOMD Core Team, has, as its focus, three individual goals for improving its ability to serve mothers with maternal depression. Each of these goals is the focus of its own subcommittee of core team members, which meets monthly to discuss progress, share insights, and discuss any questions or concerns arising from their efforts. The core team subsequently reports on these meetings to CLASP on monthly calls and receives feedback and consultation where necessary. The three goals comprising New Jersey's MOMD initiative consist of 1) Enhanced Data Capacity related to examination of maternal depression in New Jersey; 2) Increased Access to Services related to maternal depression; and 3) Reduced Racial, Ethnic, and Socioeconomic Disparities in utilization of maternal depression services.

Coordinated Specialty Care (CSC). Early Serious Mental Illness, which includes First Episode Psychosis (FEP), has been a rising concern with the young adult population in the state of New Jersey. According to the 2016 SAMHSA National Survey on Drug Use and Health, in New Jersey the estimated prevalence of Serious Mental Illness rose from 3.77% to 5.36% in young adults between the ages of 18-25 between 2008 and 2016[10].

Coordinated Specialty Care is a collaborative, recovery-oriented approach to treating First Episode Psychosis based on the Recovery after an Initial Schizophrenia Episode (RAISE) Model. As of 2014, there were 49 states and territories with programs that comprehensively serve the FEP population using the RAISE model[11]. Over 261 FEP treatment programs are currently active at various phases of operation. States use a combination of Mental Health Block Grant (MHBG) 10% set-aside funds, other MHBG funds, and/or other grants to support CSC programs around the country. Twenty-five states and territories have provided additional state funding to support FEP treatment programs in addition to the MHBG set-aside (not including state Medicaid matches). States are also required to measure the efficacy of CSC though federal data reporting requirements. The reporting requirements are: identification, intake, and enrollment; improved symptoms; improved functioning (including global functioning, employment, school participation, legal involvement, living situation, and social connectedness); physical health; program involvement; substance use; suicidality; psychiatric hospitalization; use of emergency rooms; and prescription adherence and side effects.

New Jersey CSC programs were implemented in November 2016. As of the end of State Fiscal Year 2019, the CSC programs have served over 266 clients total that prompted an expansion of service per agency from serving 35 clients to 70. An increase of clinical staff from 5.2 FTE to 6.8 FTE was also added to accomadate the increased client service. The increase in the block

[10] SAMHSA. (2017, December) SAMHSA Population Data / NSDUH; National Survey on Drug Use and Health: Comparison of 2008-2009 and 2015-2016 Population Percentages (50 States and the District of Columbia. Retrieved from: https://www.samhsa.gov/data/sites/default/files/NSDUHsaeLongTermCHG2016/NSDUHsaeLongTermCHG2016.pdf.

[11] NASMHPD. (2016, September) Snapshot of State Plans or Using the Community Mental Health Block Grant (MHBG) Ten Percent Set-Aside for Early Intervention Programs. Retrieved from: https://www.nasmhpd.org/sites/default/files/Information_Guide-Snapshot_of_State_Plans_Revision.pdf.

grant dollars, specifically the 10% set-aside, provided NJ with an opportunity to increase funding to the three agencies providing CSC services and expanding caseload capacity.

The success of the CSC programs has allowed for DMHAS to cover the "continuum of care" with regard to First Episode Psychosis. In addition to the CSC program DMHAS has taken a grant co-lead with the Children's System of Care (CSOC) for the Clinical High Risk for Psychosis (CHR-P)/NJ-PROMISE program to serve youths and adults who are experiencing the prodromal phase of psychosis. This provides evidence-based interventions to prevent the onset of psychosis or lessen the severity of psychotic disorders for individuals not more than 25 years old, at clinical high risk for psychosis.

Additionally, DMHAS is assessing the options for a stepped care model for those who either complete the 2 years of service in the CSC program or fall out of the range of CSC program inclusion criteria. With over 200 CSC programs across 46 states there is now a growing need for transitional programs to support the FEP population. New research has shown that many clients struggle to maintain superior outcomes after CSC[12]. Evidence also has shown that shortening the duration of untreated psychosis by limiting gaps in service can have a positive impact on long-term outcomes for the FEP population[13]. Transitional programs will provide clinical stability through reducing external triggers after care as well as a continuation of client medication motoring and referral networks that provide external community supports for FEP clients. That is why some states now have placed an emphasis on connecting clients to the best possible ongoing treatment and support services, whether formal or informal to have better long-term positive outcomes post-CSC. The EASA program in Oregon has begun to use the transitional FEP model where their FEP population has benefited from its services. A Stepped Care Model Approach will expand the current FEP model to provide the opportunity for FEP clients to titrate up or down in the level of service continuum while still remaining connected to the community provider, prescriber, and clinician.

Service for Those With Criminal Backgrounds. DMHAS funds 15 mental health Justice Involved Services (JIS) programs and several other criminal justice initiatives. DMHAS is involved in very active collaborations with the Judiciary, Office of the Attorney General, local law enforcement, State Parole Board and Department of Corrections. JIS is provided to a diverse mix of consumers, male and female as well as individuals of Caucasian, African American, Hispanic, Asian and Asian Indian backgrounds and from many different countries.

The SMHA has been providing Justice Involved Services since 2000. SMHA funded JIS services and criminal justice initiatives include, but are not limited to, Pre-booking Diversion, Post-booking Diversion, Re-entry services, and Veterans Assistance Initiative (VAI). The services work to divert from incarceration individuals whose legal involvement may have resulted from

[12] Jones, N. (2016). What comes after early intervention? Step-down, discharge and continuity of care in early intervention in psychosis programs for first episode psychosis. Retrieved from https://www.nasmhpd.org/sites/default/files/Issue%20Brief%20-%20What%20Comes%20After%20Early%20Intervention_0.pdf.

[13] Hegelstad, W. T., Larsen, T. K., Auestad, B., Evensen, J., Haahr, U., Joa, I., McGlashan, T. (2012). Long-term follow-up of the TIPS early detection in psychosis study: Effects on 10-year outcome. *American Journal of Psychiatry*, 169(4), 374-380.

untreated mental illness or co-occurring mental health and substance abuse disorders. These are essentially criminal justice case management services which link consumers who have been entangled with the criminal justice services to needed treatment, psychiatric rehabilitation and other community supports.

The SMHA funds JIS programs in fifteen New Jersey counties. Additional resources are needed to establish JIS programs in the remaining six counties. Both the Municipal Court Liaison program and the Prosecutor Diversion Program are in limited counties. Additional resources will be needed to expand them in all 21 counites. In addition, many of the existing JIS programs need additional staff to handle the increased population of probationers coming from the NJ court system. These JIS programs are the infrastructure to which additional resources can be directed to assist with re-entry from state prison and linkage for State Parole Board parolees to needed mental health services.

Pre-booking diversion. Pre-booking diversion typically involves a police based intervention to avoid arrest for non-criminal, non- violent offenses. Police are trained to identify and de-escalate situations involving consumers and diverting to mental health crisis or pre-crisis services. Crisis Intervention Team (CIT) is a local initiative designed to improve the way law enforcement and the community respond to people experiencing mental health crises. DMHAS funds the CIT Center of Excellence through Mental Health Association of Southwest New Jersey. The Center facilitated the development of new county CIT efforts. Presently sixteen of twenty-one counties as well as the NJSP provide training to law enforcement, dispatcher and mental health staff in CIT. These counties offer the training to other counties and municipalities as well as their own.

Post-booking Diversion. Post booking diversion involves intervening so that consumers are released from detention earlier than they otherwise would be; released on their own recognizance or released from jail with mental health intervention and treatment conditions or helping to avoid detention.

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

Municipal Court. DMHAS funds a Municipal Court Liaison (MCL) Program which has been working directly with the Jersey City Municipal Courts; they have a case manager/municipal court liaison, stationed at the Municipal Court who provides individual consultations to the judges and attorneys, upon request. This often results in diversion to treatment which the liaison facilitates. DMHAS also funds a similar program for Atlantic City. The city of Newark has a plea court which arranges for needed services post-plea. Asbury Park has been funding a social worker who provides similar liaison services for many years.

The DMHAS, working with the Administrative Office of the Courts (AOC) continues to expand the availability of the MCL to include two to three municipalities within Passaic, Essex, Ocean, Monmouth, Mercer, Camden, Gloucester and Cumberland counties. The JIS programs will be providing the case management. The effort is ongoing with additional municipalities expected to be included as DMHAS resources are identified.

Re-entry Services. Re-entry services (Forensic Case Management) are referrals from county correctional facilities. Programs have between 1 to 2 case managers who interview and enroll potential candidate while in jail, provide pre-release planning and then successful linkage and coordination to mental health and other social/community services. No psychiatric or treatment services are directly provided by the programs but rather link existing mental health services. Counties include: Atlantic, Bergen, Burlington, Camden, Cumberland, Essex, Gloucester, Hudson, Monmouth, Morris (also included some county funding), Middlesex, Mercer (also included county funding), Passaic, Ocean, and Union. However, as a result of Criminal Justice Reform, the number of inmates in the county jails have been reduce by up to 20%, with upwards of 90% staying no more than 24 – 48 hours. This has resulted in a reduction of referrals to the JIS programs.

Veterans Assistance Initiative (VAI). VAI program provides services to veterans / service members who get arrested and needs linkage and coordination with services through the local Veterans Service Offices of the New Jersey Department of Military and Veterans Affairs (DMAVA). DMHAS licensed providers provide case management services and also treatment services as needed. The Veterans Assistance Project is a combined effort of the Judiciary, the New Jersey Department of Military and Veterans Affairs and the New Jersey Department of Human Services, Division of Mental Health & Addiction Services (DMHAS). All vicinages in New Jersey have the VAI.

Chief Justice's Interbranch Advisory/Implementation Committee for Mental Health Initiatives. The DMHAS was represented on the Chief Justice's Interbranch Advisory Committee for Mental Health Initiatives since 2010. In 2012, the committee presented its report to the Supreme Court which accepted its recommendations which included the expansion of the Prosecutor Diversion Program, Municipal Court Liaison program and CIT. In December of 2014 the Chief Justice appointed the Interbranch Implementation Committee, the first recommendation of the report, to begin to operationalize the report's recommendations. The committee is co-chaired by an individual from DMHAS and a Judge from the AOC. The Implementation Committee has been working to operationalize the 17 recommendation of the report. Much has been done in educational activities on mental health of Judges and court staff, knowledge transfer at Superior and Municipal court conferences and enclaves. The Implementation Committee working with the Judiciary public information established a mental health resource page with links to mental health information and resources on the Judiciary webpage, NJ Courts Online.

Gaps Observed by the New Jersey Behavioral Health Planning Council

The partnership of community stakeholders with the SMHA is critical to the success of the Division. The New Jersey Behavioral Health Planning Council (NJBHPC, a.k.a., "The Planning Council") is the primary (but by no means sole) voice of the community. Through the participation of the Planning Council, and its Advocacy subcommittee, the Division has obtained the following guidance on service needs and gaps within the current system of care.

Older Adult Populations. The Planning Council expressed an interest in continued improvement on the availability of behavioral health services for older adults. Specific areas of interest include the Divisions's Medicaid Managed Long Term Services and Supports (MLTSS), and the need for inpatient psychiatric hospitalization services for seniors, following the closure of the Hagedorn State Psychiatric Hospital. DMHAS recently posted a new request for proposals (RFPs) for older adults to educate them on the use of alternative pain management strategies rather than reliance on opiate prescriptions.

Barriers to Medication Assisted Treatment (MAT). Planning Council members expressed some interest in the possible role of transportation barriers and homelessness on the delivery of MAT. Transportation barriers (especially in more rural parts of southern and northwestern New Jersey) are found to limit access to sites where MAT is offered. The SSA is working with its providers on increasing awareness among consumers about the use of public transportation, to encourage its use. The SMHA's PATH program is fostering awareness among providers about the efficacy of MAT.

Members of the Planning Council (especially those in the southern part of the state) expressed a need for additional hospital diversion programs. The SMHA will be examining this issue in SFY2020.

Training of Front Line Staff on Community Resources. The Advocacy Subcommittee of the Planning Council is currently examining differential levels of training and awareness of community-based resources among front-line behavioral health workers. The Division is working to improve this via: public presentations at the meetings of the Planning Council, and increased collaboration with county-based Mental Health Planners and their offices.

Increased attention to the knowledge base of front-line staff at contracted agencies. Members of the Council have anecdotally reported inconsistent levels of knowledge among front-line staff members of behavioral health agencies which may lead to consumers and families receiving less-than-accurate or complete information on available community-based resources. The SMHA and SSA will continue to encourage proper staff training among all contracted agencies, and also encourages providers, consumers and families to contact their respective county-based mental health administrators for the fullest, most current information on locally-available resources.

Resources for Youth leaving Juvenille Detention Centers. Members of the Planning Council who represent the NJ Juvenille Justice Commission (JJC) report a need for increased recovery environments for children leaving juvenile detention facilities.

Planning Step 2: Identify the unmet service needs and critical gaps within the current Children's System of Care (CSOC)

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

- Department of Children and Families Strategic Plan
- DCF Commissioner's Dashboard
- CSOC Child and Youth Behavioral Electronic Record (CYBER) Data Collection and Reports
- CSOC Internal Data Collection and Reports
- DCF Internal Data Collection and Reports
- CSOC Youth Services Survey for Families
- Monthly statewide system partner meetings (CMO, FSO, JJC)
- County-based Children's Inter-Agency Coordinating Council (CIACC) meetings
- Annual Needs Assessments submitted by the CIACCs
- CIACC Dashboard
- Traumatic Loss Coalitions for Youth Program Reports
- New Jersey Kids Count – The State of Our Children, Advocates for Children of New Jersey
- New Jersey Student Health Survey
- Robert Wood Johnson Foundation County Health Rankings and Roadmaps
- SAMHSA National Study on Drug Use and Health
- CSC Youth Risk Behavioral Surveillance System

In order to further operationalize the DCF vision of ensuring New Jersey children and families are safe, healthy and connected, the Department of Children and Families has revised its Strategic Plan to best align the priorities of CSOC with the DCF vision and values. The Strategic Plan identifies the following CSOC priorities:

- Promote integrated health and behavioral health
- Build capacity to deliver evidence-based interventions and services
- Enhance CSOC capacity to ensure equitable access

CSOC acknowledges the following gaps and unmet service needs within the current system of care and has identified activities to address them, as follows:

- Access to integrated physical health care and behavioral health care for youth

  Planned activities:

- Infuse integrated care and wellness activities across the CSOC continuum by expanding existing integration models and exploring development of other primary health-behavioral health integration models

- Access to evidence-based services and supports across the CSOC service continuum

  Planned activities:

  - Support evidence-based practices in the continuum by increasing EBP capacity in both community-based and out of home services

- Improved outcomes for youth through increased collaboration among system, family and other partners

  Planned activities:

  - Encourage collaboration among all partners.
  - Convene an external advisory group to encourage stakeholder feedback and promote collaboration.
  - Measure improved outcomes for youth and family through the Child Adolescent Needs and Strengths (CANS) assessment tool
  - Measure improved system outcomes through CSOC internal data collection and reports

- Strengthen and expand youth and family peer support

  Planned activities:

  - Promote the importance of youth and family support.
  - Collaborate in strategies to increase capacity in Family Support Organizations (FSO).

- Promote and sustain CSOC principles across the service continuum

  Planned activities:

  - Infuse CSOC principles and core values throughout the service array
  - Increase the number of Promising Path to Success trained providers and other partners

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

The SSA has a long tradition of conducting needs assessments to determine overall treatment need for substance abuse treatment, demand and gap, and treatment need and gaps for special populations in New Jersey. Obtaining reliable substance abuse treatment need estimates is critical to the state's ability to promote a rational planning and resource allocation process. The Division of Mental Health and Addiction Services (DMHAS) employs a variety of scientifically-valid methods for estimating substance abuse treatment needs. Primary among these are 1) surveys, 2) social indicator analysis, and 3) "synthetic" statistical estimation techniques, called modeling.

Our methodologies also allow us to determine need at the county level. This information is important for the planning and development of new substance abuse prevention and treatment services. Needs assessment data are incorporated into our RFPs for developing new substance abuse and treatment services, are incorporated into funding formulas for distribution to our counties per Alcoholism, Education, Rehabilitation and Enforcement Fund[1] (AEREF) legislation and utilized in the Division's applications for federal grants. Various social indicators that have been demonstrated to have a relationship to substance abuse are employed in our relative needs assessment methodology, such as, mortality from alcohol and drug poisoning, treatment admissions, child abuse and neglect, DUI arrests and drug law violations. The SSA utilizes numerous data sources, e.g., national, state, SSA data systems and surveys to inform its need assessment and planning processes.

The SSA uses a variety of methodologies such as large-scale population-based surveys (NJ Household Survey; Middle School Risk and Protective Factors Survey); targeted surveys such as Older Adults, Veterans; relative needs assessment; synthetic estimation such as capture-recapture; and social indicator analysis. in order to develop it needs assessment strategies. For 23 years, New Jersey has used a household survey to estimate: 1) the prevalence of both legal and illegal substance use, 2) alcohol treatment need and 3) unmet treatment demand. The SSA also utilizes Geographic Information Systems (GIS) for the spatial visualization of social service needs and advanced analytic techniques such as multiple regression, logistic regression, survival analysis and structural equation modeling.

1.Data Driven Planning Process

Data Sources Used to Identify Needs and Gaps

The SSA uses a wide variety of data sources in its needs assessment process in order to identify needs and gaps across the full continuum of care. These include:

SSA Information Systems

[1] The AEREF legislation refers to P.L.1983, c.531, amended by Chapter 51 of P.L.1989.

- New Jersey Substance Abuse Monitoring System (NJSAMS)
- Prevention Outcomes Management System (POMS)
- Contract Information Management System (CIMS)
- CSC Fiscal Agent Billing System
- Screening, Brief Intervention and Referral to Treatment (SBIRT) Module
- Clinician Roster Information System (CRIS)

SSA Surveys

- NJ Household Survey on Drug Use and Health (2003, 2009, 2016)
- NJ High School Risk & Protective Factor Survey (2008)
- NJ Middle School Risk & Protective Factor Survey (2007, 2010, 2012, 2016)
- Survey of Older Adults (2012, 2015)
- Returning Veterans Survey (2015)

Other SSA Data Sources

- NJ Epidemiological Profile for Substance Abuse (2008)
- County and Municipal Social Indicator Chartbooks (2005, 2013, 2016)
- NJ Substance Abuse Provider Performance Reports (bi-annual)
- NJ Substance Abuse Overviews (annual)

Other State Data Sources

- NJ DOH Uniform Billing (UB-04)
- Uniform Crime Reports
- NJ Department of Education Student Health Survey (2009, 2011, 2014)
- Pregnancy Risk Assessment Monitoring System (PRAMS)
- Youth Risk Behavior Survey (YRBS)
- Behavioral Risk Factor Surveillance System (BRFSS)
- New Jersey State Health Assessment Data (NJSHAD)
- Prescription Drug Monitoring Program
- Overdose Data (Medical Examiner)
- Narcan Reversals (State Police and Department of Health)
- Drug Arrests (State Police)
- Drug Seizures (State Police)
- State Police Regional Operations Information Center (ROIC) reports
- NJCARES website
- DOH Data Dashboard

Federal Data Sources

- U.S. Census Bureau
- National Violent Death Reporting System (NVDRS)
- National Survey of Drug Use and Health (NSDUH)
- SAMHSA's NJ Behavioral Health Barometer
- Treatment Episode Data System (TEDS)
- National Survey of Substance Abuse Treatment Services (N-SSATS)
- Behavioral Risk Factor Surveillance System (BRFSS)
- Fatality Analysis Reporting System (FARS)

- National Vital Statistics System (NVSS): Multiple Causes of Death (Mortality)
- Uniform Crime Reports (UCR): Police Reported Crimes
- Youth Risk Behavior Surveillance System (YRBSS)
- Web-based Injury Statistics Query and reporting System (WISQARS)
- Substance Abuse and Mental Health Data Archive (SAMDHA)
- Wide-ranging Online Data for Epidemiologic Research (CDC WONDER)

All these data sources allow the SSA to examine current data as well as to make comparisons over time for trend analysis. Also, utilizing Federal data allows New Jersey to examine its state performance in comparison to national data.

Data Collection Systems

Since the SSA promotes the use of data to drive its planning, there are several key IT systems that are instrumental in achieving this goal and are described below. Depending on the system, information is able to be reported at the client, program, financial, provider, and encounter level. Information systems exist for treatment, prevention, fiscal management and billing data. These systems provide needed data for SABG and TEDS reporting, needs assessment, evaluation and planning processes. Other new systems allow for the collection of outcome data and performance incentive payments.

New Jersey Substance Abuse Monitoring System. The client level data system, known as the New Jersey Substance Abuse Monitoring System (NJSAMS) was developed and implemented in 2005 by the SSA to be a real-time, web-based substance abuse treatment data collection and reporting system. The system is required to be used by all licensed substance abuse treatment providers in New Jersey, regardless of whether or not they contract with the SSA. It collects basic demographic, substance use, financial, clinical and service information on all clients enrolled and served in New Jersey's substance abuse treatment system. Encounter data are collected and reported for services that may have different payers. In 2018 there were 89,629 admissions to treatment. The system consists of numerous modules and contains all the clinical assessments providers are required to complete. There are 288 licensed providers reporting on NJSAMS, representing 439 sites with 2884 active users There are also 190 Intoxicated Driver Resource Center (IDRC) affiliated providers representing 237 sites and 75 active users.

NJSAMS was developed over time under the initial auspices of the Center for Substance Abuse Treatment (CSAT). The purpose was to develop the state's capacity to use web-based information technology for the collection and reporting of data necessary to meet Federal Performance Partnership Grant (PPG) and GPRA reporting requirements. NJSAMS was developed in response to the need for: timelier reporting on substance abuse treatment episodes, better monitoring of client outcomes, quality improvement, better client placement, and tracking of treatment through the continuum of care. The NJSAMS website is hosted by the Rutgers University Computer Center under a Memorandum of Agreement with the SSA. It is a secure web-based system designed to collect confidential health information and is HIPAA and 42CFR compliant.

A major IT accomplishment was the complete re-architecture of NJSAMS, which was originally written in classic ASP and included numerous webpages making data entry slow. Work began on this project in September 2011 and the new system was successfully launched mid-November

2013. The NJSAMS includes the latest Addiction Severity Index V.5, the Level of Care Index (LOCI-3), DSM-5, as well as additional modules that can collect further information on client care and needs. The system is capable of producing the CSAT National Outcome Measures (NOMs) and generates the data needed for Provider Performance Reports. Data from NJSAMS are used to fulfill Block Grant reporting requirements and are also submitted quarterly to the Treatment Episode Data System (TEDS). The system contains nearly 1000 data elements and over 1 million records, dating back to 2006.

Fiscal Intermediary MIS. A Fiscal Agent Billing system contract was awarded to the Computer Sciences Corporation (CSC) through an open competitive bid. This system went live July 1, 2010. The CSC system is a web-based billing system for all of the SSA's fee-for-service (FFS) initiatives: Drug Court, MAP-SPB, SJI, MATI, DUII, NJSI, SAPT, SHARE and STORI and the Co-Occurring Network. The amount of funding dedicated to these initiatives was approximately $72 million for FY2019 and $71 million is available for FY2020. Providers submit a request via a web service to CSC for authorization approval then submit their claims through the CSC system for payment. Detailed service data is inputted which includes the CPT code. In CY 2018, there were 22,393 FFS admissions out of 89,629 total admissions.

CSC and the SSA have developed an automated interface with NJSAMS to link services data reported in NJSAMS which correspond to the claim for payment. Approximately 1 million claims are processed each year. All the CSC billing data tables, approximately 76, are transferred to NJSAMS on a nightly basis to the SSA's server. This allows the SSA capability to analyze detailed encounter data. This information is easily linked to NJSAMS data so service utilization patterns can be analyzed by client characteristics and levels of care.

Prevention Outcomes Management System. The web-based Prevention Outcomes Management System (POMS) collects process data on evidence-based substance abuse prevention services that are delivered in New Jersey. This system went live in August 2009 and has been enhanced since that time. All New Jersey substance abuse prevention providers that receive SSA contracts are required to use the system for data reporting. POMS includes two modules that collect county-based prevention coalition and education data. The system supports download of 1-6 reports per module, and has 113 password-registered agency users (representing 25 agencies and 88 grants), 5 administrators, and 2 system administrators.

Contracted agency users report data into POMS via: (1) Environmental Module, and (2) Curriculum-based Module. The Environmental Module, deployed in March 2016, includes 10 items. It collects priority-specific data on implementation of CSAP strategies and engagement with community sectors. It also measures progress on: (1) the use of environmental strategies, (2) the development and enforcement of policies (and laws/ordinances) to: (a) Reduce Underage Drinking, (b) Reduce use of Illegal Substances, (c) Reduce Prescription Misuse Across the Lifespan, and (d) Reduce use of New and Emerging Drugs. The Environmental Module also collects data on media campaigns, public service announcements, and information that is shared with lawmakers, schools, and businesses. Quarterly reports for the Environmental Module include summary data for each item of the questionnaire. These reports are used for program monitoring and evaluation.

The POMS Curriculum-based module, updated and re-deployed in February 2018, collects priority-specific and summary demographic data for individuals that are served by evidence-based prevention education programs. It allows users to track participant attendance, retention, and program completion levels. Curriculum-based data entry includes: (1) type of service, (2) target audience, (3) priority, (4) curriculum/program name, (5) county of service, (6) date of service, (7) # of individuals/families in attendance, and (8) applicable CSAP strategy. Curriculum-based reports include participant demographic data by county, priority, strategy, and curriculum. These reports are used for program monitoring.

Contract Information Management System. The Contract Information Management System (CIMS) is a web-based, paperless contract processing system that providers use to submit their contract actions. CIMS went live July 1, 2010 for renewal contracts which included the electronic submission of the Annex B (budget). On January 1, 2011 the system went live for the Annex A and Programmatic Requirements.

The four main areas CIMS was designed to address are:

- ensure compliance with Department of Human Services (DHS) contracting policies
- provide more accountability for the utilization of state funds
- improve transparency and tracking of SSA contracting
- develop a more efficient process for submitting, reviewing and approving contract documents

Clinician Roster Information System. 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. The system will begin to be utilized more strategically by the DMHAS Workforce Coordinator to help better identify workforce training needs.

Performance Incentive Payment System (PIPS). PIPS is a new system designed to track the attainment of key outcomes for participants in the Prison Intensive Recovery Treatment and Support Program (PIRTS). The information is linked to client demographic, encounter and clinical information so that factors that impact the attainment of outcomes can be determined.

Maternal Wrap Around System (MWRAPS). MWRAPS is a new system that has been developed to capture information and outcomes on women who are participating in the MWRAP program. The data system will also be adapted to accommodate information on the women participating in our SEI/NAS program.

Opioid Overdose Recovery Program System (OORPS). A data collection system has been designed to collect detailed information on clients who are brought to the emergency department after being reversed with naloxone. Information is collected on patients, the follow-up provided by the Recovery Specialists and Patient Navigators, and the outcome of the visit.

As a result of our IT and data collection systems, the SSA can report any of its data at the client level (demographic, clinical, financial, encounter, etc.). Currently it reports on all Treatment Episode Data System (TEDS) items, which includes the System Data Set (SDS), the Minimum Data Set (MDS) and the Supplemental Data Set (SuDS). The SSA has been reporting TEDS data through NJSAMS for many years. The Fiscal Agent system allows the SSA to determine costs for episodes of care and by specific services. The new systems allow for reporting outcomes on four new programs: M-WRAP, SEI/NAS, PIRTS and OORP at multiple points in time, rather than only at admission and discharge.

2. Need Assessment Overview

Over the years, the SSA has performed regular statewide needs assessments for substance abuse prevention and treatment. Information from general and special populations surveys combined with treatment utilization data from the New Jersey Substance Abuse Monitoring System (NJSAMS), as well as the application of Geographic Information Systems (GIS) methodology using Arcview for visual data presentations, provides the SSA with data to assess both service needs and delivery capacities which drive its SAPT Block Grant Application, its statewide strategic planning, and its multi-year county comprehensive planning.

Assessing the well-being of community health through social indicators has been a long-standing concern to the Center for Substance Abuse Treatment (CSAT). To meet this objective, CSAT has encouraged the use of social indicators to assess social and health risks related to substance misuse in order to inform policy makers. Following the *Social Indicators Core Protocol* guidelines provided by CSAT, the SSA developed the *NJ Chartbook of Substance Abuse Related Social Indicators*. The Social Indicators Chartbook is intended to identify social and health problems directly or indirectly related to substance use and to aid in the assessment of needs for treatment and prevention services. This is achieved, in part, by using key social indicators outlined in the core protocol by CSAT, and by identifying risk and protective factors affecting health outcomes. Summary analysis of the core indicators is presented using census data, criminal justice data and substance abuse treatment admissions data.

Additional indicators were identified using guidance from three sources: 1) The U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration's Risk and Protective Factors for Mental, Emotional, and Behavioral Disorders Across the Life Cycle; 2) The Community Anti-Drug Coalition's (CADCA) Assessment Primer: Analyzing the Community, Identifying Problems and Setting Goals; and 3) CADCA's Community Assessment Needs Assessment Data Collection Examples of Local Data worksheet. These documents rely on the Center on Substance Abuse Prevention's (CSAP) Strategic Prevention Framework to guide the identification of individual, family, and community factors that are related to substance abuse. Additionally, CADCA's Assessment Guide is specifically concerned with aiding community coalitions during the needs assessment process and in identifying communities to

target for prevention initiatives and the organization of the county and municipal social indicators follow CADCA's conceptualization of domains useful in prevention planning.

The specific objectives of the Chartbook are to: 1) Present an objective profile of New Jersey at the state, county, and municipal levels using key social indicators related to substance abuse; 2) Show the effect of substance use and related health consequences in New Jersey at the state, county, and municipal levels; and 3) Provide information to support needs assessment and prevention, as well as treatment planning, at the community level.

At both the state and local levels, the New Jersey substance abuse planning process is designed to employ both quantitative and qualitative data to assess the relative need for alcohol and drug abuse prevention, early intervention, treatment, and recovery support services. It uses both administrative databases prepared by federal, state, and local governments, as well as general and special population and service-provider surveys conducted by DMHAS to engage in "gap" analysis of unmet treatment demand by age, race and sex among New Jersey residents. The periodic scheduling of surveys and other studies has provided the SSA with the capacity for longitudinal analysis and forecasting to estimate future prevalence of substance abuse treatment need and demand at both state and county levels and by demographic characteristics of subpopulations warranting special surveillance. Analysis of treatment admissions and delivery at the municipal level provides the SSA with the capacity for spatial analysis of unmet treatment demand and access to care. Thus, analysis of both primary and secondary data sources drives New Jersey's state planning and policy development for substance use services.

Needs Assessment: Treatment

In 1993, 1998 and 2003, the SSA was awarded a State Treatment Needs Assessment Program (STNAP) grant from SAMHSA's Center for Substance Abuse Treatment (CSAT) to conduct a "family of studies" centered around a statewide household survey supplemented by special surveys of sub-populations not expected to be included in the telephone sampling frame.

Over time, the SSA expanded the size of its household sample to 4,200 completed telephone interviews in 1998 and to 14,700 in both 2003 and 2009. The expansion to N = 14,700 provided approximately 700 completed household interviews per county, enough to allow survey data analysis for planning purposes in each county. After the STNAP ended in 2003, the SSA conducted its 2009 needs assessment "family of studies" using SAPT Block Grant funding. The SSA planned a fifth "family of studies" needs assessment program again using the SAPT Block Grant.

The SSA conducts the New Jersey Household Survey of Drug Use and Health (NJ-HSDUH) at five-year intervals using a questionnaire developed by CSAT during the STNAP that is nearly identical to the questionnaire employed for the National Survey of Drug Use and Health (NSDUH). For 23 years, New Jersey has surveyed its adult population 18 years of age or older by telephone using a random-digit dialed sample to estimate: 1) the prevalence of both legal and illegal substance use, 2) alcohol treatment need and 3) unmet treatment demand. The questionnaire employs a core set of questions provided originally by the Center for Substance Abuse Treatment. The need for alcohol treatment is derived from a series of questions based on

Diagnostic Statistical Manual (now DSM-5) criteria. Questions address use, quantity, effect on behavior, symptoms experienced, associated health problems, etc. Sample proportions are applied to state and county population estimates. Since the household survey underestimates drug treatment need due to under-reporting of illicit drug use, a statistical technique known as the two-sample capture-recapture model is applied to illicit drug treatment unique admissions data to estimate drug treatment need at both the state and county levels. The admissions data for the model are obtained from the web-based New Jersey Substance Abuse Monitoring System (NJSAMS), DMHAS' administrative, client information system for substance abuse treatment. Together with the alcohol treatment need estimates obtained from the aforementioned household survey, DMHAS produces an annual estimate of total treatment need that is used in the distribution of alcohol and drug abuse treatment funds.

The primary focus is the population distribution of substance use and the population prevalence of substance abuse and addiction. It employs DSM diagnostic criteria of abuse and dependence in combination with "past 12 month" drug use to obtain alcohol and illegal drug treatment need estimates. The questionnaire also asks those with a treatment need about their treatment histories and obtains an estimate of unmet treatment. Beyond these core elements, the SSA's questionnaire regularly includes sections on tobacco use and gambling behavior.

Typically, the NJ-HSDUH includes one or more special topics, such as the needs of pregnant women in 1993 and 1998, the needs of persons impacted by the 9/11 attacks in NYC in 2003, and in 2009, both substance use among New Jersey Veterans and obstacles to treatment access among persons who need but do not get care. For the 2013-2014 NJ-HSDUH, which was the first NJ-HSDUH after the merger of the Divisions of Mental Health and Addiction Services, the SSA included a new permanent section on mental health treatment needs and access to community-based, mental health treatment opportunities and to return to the special topic of substance use among pregnant women.

Due to changes in state procurement rules, the survey was not fielded as planned in 2014. As an interim measure, the survey was repeated in 2016 with a much smaller sample (N=1,052). Approximately 55% of the sample were households contacted via a landline while 45% were cell phone only households. The interviews were distributed by regions: north (N=422), central, (N=338) and south (N=292). The 2016 questionnaire introduced a new permanent mental health section that uses validated questions from the federal behavioral risk factor surveys to estimate New Jersey's mental health treatment needs.

Beginning in 2018, DMHAS began collecting an annual rolling statewide sample, stratified by county, of N=2,835 residents (135 per county). At the end of three years, the annual samples will be combined to create one statewide sample of N = 8,505 subjects, with 405 subjects represented per county. DMHAS intends to continue this annual data collection plan beyond 2020 so that every year thereafter the sample of N= 8,505 will be replenished with a new annual subsample of N = 2,835, while the oldest subsample of N = 2,835 subjects will be removed. In the process, DMHAS will always have an updated sample that consists of 8,505 subjects, 405 per county, that have been interviewed within the previous three years.

Longitudinal database linkage studies were also conducted for the FFY 2014-2015 program which included 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) and a study of the effectiveness of Vivitrol among alcohol dependent persons participating in the SSA's Driving Under the Influence Initiative (DUII). 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 was developed and updated in 2016.

Another keystone source of information for need assessment and gap analysis for addiction services is the NJSAMS. The SSA is able to establish the number of persons receiving substance 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. By applying the two sample capture-recapture model to multiple years of NJSAMS data, the SSA can estimate the drug treatment need which is not observed in NJSAMS. When combined with findings on alcohol treatment need obtained from the NJ Household Survey, the SSA can estimate both the need and demand for treatment and differentiate between met and unmet treatment demand.

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 individuals who have a substance use disorder and co-occurring mental illness. This network helped community advocates realize "one-stop", "treatment on demand", or "no wrong door" access to care. One County noted a service gap for early intervention services and planned for better integration of ASAM Level .5 into Level 1.0 outpatient programs and advocated for the inclusion of Level .5 (Early Intervention) into NJSAMS reporting.

As noted in Step 1, the SSA in 2014 was awarded technical assistance through the SAMHSA supported National Center on Substance Abuse and Child Welfare (NCSACW) to address the multi-faceted problems of Substance Exposed Infants (SEI) and Neonatal Abstinence Syndrome (NAS). New Jersey DHS/DMHAS as the lead State agency partnered with the Departments of Children and Families (DCF) and Health and submitted a successful application for In-Depth Technical Assistance on Substance Exposed Infants and Neonatal Abstinence Syndrome (IDTA SEI NAS). The NJ IDTA focused on strengthening collaboration and linkages across multiple systems such as substance use disorder treatment, child welfare, home visiting and early intervention systems, medical communities and other key stakeholders to improve services for pregnant women with opioid and other substance use disorders and outcomes for their babies. The goal was to develop uniform policies/guidelines that address the entire spectrum of NAS and SEI from pre-pregnancy, prevention, early intervention, assessment and treatment, postpartum and early childhood.

A key component of the IDTA involved data coordination among all the system partners involved with this issue. The IDTA established three goals: (1) Increase perinatal SEI screening at multiple intervention points (Health system, SUD/MH system); (2) Leverage existing programs and policy mechanisms to collaboratively increase the rate at which women screening positive on the 4P's Plus get connected for a comprehensive assessment by establishing formal warm-handoffs and other safety net measures; (3) Leverage existing programs and policy mechanisms to collaboratively increase the rate at which women delivering SEIs and their babies and any other eligible children, receive early support services for which they are eligible.

NJ IDTA received two extensions beyond the 18-month timeframe to improve service needs for pregnant women and their SEI, and to guide the state in facilitating a coordinated cross-disciplinary approach to improve critical service gaps and reduce barriers among providers, agencies, medical community and other stakeholders.

Estimation of the Population in Need of Treatment. The estimated size of New Jersey's 2017 resident adult population in need of treatment for *alcohol* abuse or dependence is 602,018 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 2017. The size of the 2017 adult population needing treatment for *drug* abuse or dependence in New Jersey is 276,323 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 2016 and 2018 as reported in the NJSAMS. This technique was utilized due to under-reporting of illicit drug abuse or dependence observed in the household survey. The sum of these two estimates of treatment need, one for alcohol abuse and one for drug abuse, equals the 2017 New Jersey total substance abuse treatment need or 878,341.

Table 1

Estimate of Treatment Need for Alcohol and Drug Addiction, New Jersey 2017					
	1	2	3		
County	**Adult Population 2017**	**% 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	213,204	11.3	7.5	40,137	18.8
Bergen	735,904	9.0	2.7	86,278	11.7
Burlington	352,972	6.9	2.7	33,860	9.6
Camden	392,856	7.8	5.3	51,620	13.1
Cape May	77,684	8.7	6.8	11,989	15.4
Cumberland	118,132	8.9	6.8	18,544	15.7
Essex	609,241	7.8	4.9	77,045	12.6
Gloucester	225,216	9.3	4.6	31,321	13.9
Hudson	540,877	6.3	2.5	47,391	8.8
Hunterdon	99,853	9.7	3.0	12,685	12.7
Mercer	292,953	13.2	3.6	49,317	16.8
Middlesex	653,712	6.7	3.7	68,086	10.4
Monmouth	489,700	12.3	4.7	83,510	17.1
Morris	389,293	11.8	3.0	57,470	14.8
Ocean	450,541	8.8	4.6	60,350	13.4
Passaic	387,391	5.7	3.2	34,587	8.9
Salem	49,694	7.9	5.6	6,693	13.5
Somerset	257,172	8.5	4.8	34,152	13.3
Sussex	113,376	11.2	4.2	17,471	15.4
Union	425,876	7.5	3.3	46,054	10.8
Warren	84,693	8.3	3.3	9,781	11.5
Total	**6,960,340**	8.7	**4.0**	**878,341**	**12.6**

Note: The percentages have been rounded up to the nearest tenth and will not reproduce the numbers given in the text.
[1] U.S. Census Bureau, Population Division: 2013-2017 American Community Survey.
[2] Percent of Alcohol treatment need derived from the 2009 New Jersey Household Survey on Drug Use and Health.
[3] Drug treatment need is estimated using a two-sample Capture-Recapture statistical model with the 2016 and 2018 NJSAMS data.

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 92,499 individuals who wanted substance abuse treatment, 53,209 received it. This resulted in an unmet demand of 37,795 or a gap of 40.9%.

Table 2
Substance Abuse Treatment Demand Estimate New Jersey, 2017

County	2017 Adult Population [1]	2017 Met Demand [2]	Unmet Demand [3]	Total Demand [2 + 3]	Unmet Demand As Percent of Total Demand
Atlantic	213,204	3,340	1,158	4,498	25.7
Bergen	735,904	2,703	3,996	6,699	59.7
Burlington	352,972	2,469	1,917	4,386	43.7
Camden	392,856	4,803	2,133	6,936	30.8
Cape May	77,684	1,216	422	1,638	25.8
Cumberland	118,132	1,382	641	2,023	31.7
Essex	609,241	5,561	3,308	8,869	37.3
Gloucester	225,216	2,216	1,223	3,439	35.6
Hudson	540,877	3,331	2,937	6,268	46.9
Hunterdon	99,853	671	542	1,213	44.7
Mercer	292,953	2,147	1,591	3,738	42.6
Middlesex	653,712	4,203	3,550	7,753	45.8
Monmouth	489,700	4,251	2,659	6,910	38.5
Morris	389,293	2,130	2,114	4,244	49.8
Ocean	450,541	4,991	2,446	7,437	32.9
Passaic	387,391	3,247	2,104	5,351	39.3
Salem	49,694	464	270	734	36.8
Somerset	257,172	1,545	1,396	2,941	47.5
Sussex	113,376	888	616	1,504	40.9
Union	425,876	2,411	2,313	4,724	49.0
Warren	84,693	735	460	1,195	38.5
New Jersey	**6,960,340**	**54,704**	**37,795**	**92,499**	**40.9**

[1] Source: U.S. Census Bureau. 2013-2017 American Community Survey 5-Year Estimate.

[2] Met demand: The number of unduplicated adults admitted for treatment in 2017, according to NJSAMS data.

[3] Unmet demand: Average Proportion of NJ Household Surveys (2003, 2009 & 2016) estimated adult population who did not receive treatment in the 12 months prior to the interview but who felt they needed and wanted treatment (0.0046 +0.0047+0.007=0.00543) times the 2016 adult resident population.

Relative Needs Assessment Scale. In addition to utilizing survey data, the DMHAS addiction research team developed methods for using social indicators to supplement estimates of need obtained through other methods. Because social indicator data are compiled by their primary users and archived for use by others, indicator data are somewhat convenient to obtain, especially when random samples surveys are not feasible to undertake. One such method of social indicator analysis is the Relative Needs Assessment Scale (RNAS), developed by DMHAS researchers, Mammo & French (1996), using social indicators with known correlations to the incidence and prevalence of substance abuse. The RNAS is used to target prevention and treatment resources by location and socio-economic characteristics of at-risk populations. The scale calculates an index of risk for each county for which the indicators can be obtained. Because the scale is an interval level of measurement that sums to one, scores are comparable and easily interpreted across jurisdictions. In FFY 2014, the SSA provided RNAS indexes down to the municipal level for use in the county comprehensive planning process. In the current county comprehensive planning process for 2016 to 2019, the RNAS model, updated to include data from the 2016 U.S. Census, will be used to identify areas within counties with potentially high concentrations of people with substance abuse prevention, treatment and recovery support service needs.

Geographic Information Systems. The SSA maps the spatial distribution of treatment services across all counties and modalities of care and uses this information in its county comprehensive planning. It routinely uses Geographic Information Systems (GIS) to map its treatment services in order to guide its planning of services in underserved areas. GIS is used in the County Substance Abuse Overviews to assist counties by providing color-coded choropleth maps that show the distribution of treatment admissions in their municipalities and where utilization is greatest. In the statewide report a choropleth map is also provided so the SSA can easily see the counties with the greatest treatment utilization. It is used to present spatial visualizations of key issues. It is used for the SYNAR coverage study and annual SYNAR inspections to produce walking maps for the inspectors to follow.

Treatment/Recovery Initiatives Based on Need

Medication Assisted Treatment. Data from NJSAMS for Calendar Year 2018 indicates that only 15% of methadone is planned and 7% of buprenorphine in treatment for clients admitted to treatment, yet heroin and other opiates are the primary drugs of admission for 50% of clients entering New Jersey's addiction treatment system. The development of the Medication Assisted Treatment Initiative (MATI) has been an attempt to help reduce this gap by providing increased access to medication assisted treatment by offering methadone, as well as buprenorphine, to individuals with an opioid use disorder through mobile medication units. Another attempt to increase access to MAT, specifically buprenorphine, has been the development of statewide buprenorphine training courses utilized as an educational component for physicians, Advanced Practical Nurses (APNs) and Physician Assistants (PAs) to attain their Buprenorphine Waiver. The State plans to hold a total of 16 trainings through both Rutgers University (northern region)

and Rowan University (southern region) in CY 2019 in an effort to train over 1,000 prescribers in CY 2019.

The SSA's goal is to continue to develop a system of care that offers high risk clients the means to enter and sustain recovery. In this effort, the SSA implemented a pilot program in September 2011 for the DUI offender with an alcohol or opioid use disorder that included medication assisted treatment using the FDA approved medication Vivitrol (an injectable form of naltrexone). A comprehensive research protocol was developed, and numerous client outcomes were assessed. The pilot was launched in September 2011; clients received the medication for up to six months. There was a follow-up survey six months after the client's last injection. The pilot ended in September 2013 once 100 clients had received the medication. Since results were promising, Vivitrol has since been incorporated as an enhancement in most of its current substance use disorder Fee for Service Initiatives, including Drug Court, New Jersey Statewide Initiative (NJSI), South Jersey Initiative (SJI), State Parole Board (SPB), State Targeted Opioid Response Initiative (STORI) and the Driving Under the Influence Initiative (DUI). Acknowledging that addiction is a medical disorder that postulates client-centered treatment, the purpose of this funding is to have an array of medication treatment alternatives for individuals with an opioid use disorder.

The Division has mandated trainings on medication assisted treatment for licensed substance use disorder treatment providers, incorporated language requiring acceptance of clients on all forms of medication assisted treatment into contract requirements as well as all applications for new funding, and has provided training on medication assisted treatment for systems to include, but not limited to, Drug Court, the Administrative Office of the Courts, the Department of Children and Families' Children System of Care, and the New Jersey County Jail Wardens Association. Also, the SSA continues to incorporate course work requirements in the workforce development initiative described above. Most recently, in order to decrease deaths caused by opioids, the DMHAS, alongside representatives from the NJ Professional Advisory Committee (PAC) for Addictions, the NJ Citizen's Advisory Council, the Department of Health Certificate of Need and Licensing (formerly the Office of Licensing), the Department of Children and Families and the Administrative Office of the Courts (AOC) formed a Medication Assisted Treatment (MAT) Work Group. The primary goal of the work group was to focus on areas critical to expanding the use of MAT across the State and ultimately provide recommendations regarding increased education, expanding access and policy changes to the Assistant Commissioner of DMHAS in February 2018. DMHAS continues to work on strategies for implementation of these recommendations.

State Targeted Response to the Opioid Crisis. In May 2017, SAMHSA awarded New Jersey $12,995,621 annually for two years for its State Targeted Response (STR) to the Opioid Crisis grant. New Jersey's project is known as the State Targeted Opioid Response Initiative (STORI). The goal of the STORI is to address the opioid crisis confronting New Jersey using a variety of strategies. A key objective is to increase access to treatment and reduce unmet treatment need. Another key objective is to reduce opioid related deaths. New Jersey's plan also addresses retention in care and the provision of peer and recovery supports.

To address these objectives, a new STORI fee-for-service (FFS) treatment initiative was developed within the existing addiction fee for service treatment network, which provides access to treatment for underinsured and uninsured clients. It includes a wide range of services within the continuum of care and includes the use of EBPs, particularly MAT. The STORI FFS went live July 3, 2017.

There was an expansion of DMHAS' Opioid Overdose Recovery Program (OORP) to an additional 10 counties in New Jersey using STR funds, so coverage is now statewide.

The use of peers has been incorporated in the Support Team for Addiction Recovery (STAR), which includes peer recovery specialists as part of the team. The goal is to prevent an opioid overdose and help prevent relapse. The team is charged with trying to keep clients in the "recovery zone" for as long as possible and assist them with their recovery journey. A peer-delivered statewide Telephone Recovery Support (TRS) service was developed. Family support is provided through the development of three regional Family Support Centers (FSCs).

The STORI also includes trainings related to best practices for the prescribing of opiates and expanded use of MAT. Training includes the implementation of an Extending Community Health Outcomes (ECHO) project on substance use disorder. A key objective is to expand the knowledge and capacity of primary care providers to implement best practices for substance use disorders related services in the primary care setting taking into consideration the efficacy of screening and intervention in a primary care setting, as well as how to deliver more specialized care to patients with identified addiction issues. A three-module training was developed by Rowan University School of Osteopathic Medicine. The Rowan training is a live webinar and self-paced learning series that uses a standardized, evidence-based curriculum to train and inform healthcare providers on the most up-to-date practices and guidelines regarding medication-assisted treatment for opioid use disorder. This training covers best practices in opioid treatment and management, review of MAT for opioid use disorders and buprenorphine use in the emergency department.

State Opioid Response Grant. SAMHSA, Center for Substance Abuse Treatment released the State Opioid Response (SOR) grant funding opportunity for states and territories in June 2018. New Jersey was awarded funding in October 2018. The goals of the SOR are to address the opioid crisis by: (1) increasing access to MAT, (2) using the three FDA-approved medications for the treatment of opioid use disorders, (3) reducing unmet treatment needs, and (4) reducing opioid overdose related deaths through the provision of prevention, treatment, and recovery activities for OUD.

In 2019, DMHAS entered into a Memorandum of Agreement (MOA) with both Rutgers University and Rowan University/Cooper Hospital to coordinate statewide DATA 2000 Waiver trainings for practitioners to include physicians, Advance Practice Nurses (APNs) and Physician Assistants (PAs). The goal is to have over 1,000 eligible practitioners trained in 2019 with the hopes of having them able to prescribe buprenorphine within the NJ system of care.

DMHAS plans to expand its strategy to develop infrastructure support with SOR funds to provide buprenorphine in both ambulatory substance use disorder (SUD) treatment programs as

well as other programs, such as licensed mental health programs. DMHAS is also launching a low-threshold buprenorphine induction program at two Harm Reduction Centers (HRCs) in the Summer of 2019. DMHAS also plans to fund Interim Services in October 2019 for individuals on waiting lists for outpatient and residential programs to provide immediate access to MAT to prevent relapse.

DMHAS will partner with both Rutgers University and Rowan University to ensure funding is available to support individuals at clinics who are indigent, so they can be inducted and/or maintained on MAT. Services for these individuals are planned to include other ancillary services such as care coordination and peer services.

In addition, DMHAS will assist all State county correctional facilities establish MAT programs or enhance existing MAT services for inmates with an OUD as well as provide care management services. Funding is being made available in 2019 to promote clinical stability and effective recovery processes for inmates prior to release from incarceration.

Needs Assessment: Prevention

In December 1993, the SSA was awarded a three-year contract with the Center for Substance Abuse Prevention (CSAP) to conduct studies to assess needs for prevention of alcohol, tobacco, and other drugs misuse and abuse in the state and in its health planning regions. The contract included the Middle School Survey, the Mature Citizen Survey and the Community Leaders Survey. In addition, a social indicators study and companion chart books of social and health indicators for each of New Jersey's 21 counties and selected municipalities were completed. The data generated by these surveys and studies were utilized in policy formulation, resource allocation and the provision of revised data requested within the 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 the latest covers the 2016 and 2017 school years and the next administration of the survey will take place during the 2019-2020 academic year.

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, 2013 and 2016 surveys. While the DOE does not sample at the county level, the findings still provide important information regarding factors protecting and posing risk to adolescents concerning substance use as well as reported substance use.

Through data obtained in all the prevention studies, the SSA identified risk and protective factors for substance abuse and ranked communities by risk scores. 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.

In 2012, DMHAS established seventeen coalitions in New Jersey. These regions in which the coalitions are located were identified based the "Prevention Needs Assessment Using Social Indicators: State of New Jersey Substance Abuse Prevention County Level Needs Assessment". The "Prevention Needs Assessment" utilized archival data of social indicators to develop composite indices of risks to estimate the need for prevention services among New Jersey's 21 counties. Criteria including population, substance abuse treatment admissions and rates within the region as well as prevalence of alcohol and prescription drug misuse among middle and high-school students were also considered in identifying the seventeen regions. Additional criteria used to determine the regions included that:

- Each region must be comprised of at least one county
- Each region must have reported a minimum of 2000 treatment admissions (according to the latest available data) for the previous year

Relative Needs Assessment Scale. The Relative Needs Assessment Scale (RNAS) was developed for alcohol and drug prevention planning in 1995 and updated in 2008 and 2013. It was updated for 2016. A report was prepared in May 2014 "Substance Abuse Prevention Needs Assessment Using Social Indicators" which is also being updated. The RNAS employs social indicators of substance use-related mortality and morbidity and calculates relative risk for each county and municipality, thus, permitting comparisons of relative risk among counties across the state and among municipalities within each county. The RNAS is used to target prevention and treatment resources by location and socio-economic characteristics of at-risk populations. It was utilized in the 2008 and 2014 RFP processes for awarding five-year prevention contracts utilizing SAPT Block Grant funding.

Addictions Prevention Strategic Plan. In 2012, the SSA completed an addictions strategic prevention planning process to identify prevention priorities and provide direction regarding the use of environmental management strategies to address those priorities. The planning method relied on the full range of DMHAS' available quantitative data in order to identify meaningful priorities at both the state and community levels for which measurable change could be achieved when prevention efforts employed targeted, evidence-based prevention strategies. It provides direction for all DMHAS-funded prevention services.

In keeping with the aforementioned purpose of the Plan, the priorities identified were included in the RFP entitled, "Funding for Regional Coalitions to Utilize Environmental Strategies to Achieve Population-Level Change". The primary goals of the RFP were to identify and fund regional coalitions to utilize the SPF and undertake a rigorous needs assessment process to

identify which of the statewide DMHAS prevention priorities identified in the Plan are the most significant in their region. Seventeen coalitions were awarded contracts.

State Epidemiological Outcomes Workgroup. 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 State Epidemiological Outcomes Workgroup (SEOW), comprised of individuals from various state departments including Health, Transportation, Education, Human Services, Juvenile Justice, county offices, universities, community provider agencies and statewide organizations. The SEOW continues to meet monthly to discuss ways to prevent the onset and reduce the progression of substance 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 (DOH) Division of Family Health, DOH Division of HIV, STD, and TB Services (DHSTS), Department of Military and Veterans Affairs, the NJ Poison Information and Education System (NJPIES), the New Jersey Hospital Association Behavioral Health Group, NJ Housing and Mortgage Finance Agency (NJHMFA), Office of Managed Health Care Behavioral Health Unit, Office of the Secretary of Higher Education (OSHE), representatives from the NJ State Police's Regional Operations Intelligence Center, and representation from 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 the New Jersey Epidemiological Profile for Substance Abuse, which it submitted to SAMHSA in April 2007. The plan was updated in 2008 and will be updated again during 2019.

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 New Jersey Student Health Survey of High School Students (NJSHS)
7. The Treatment Episode Data Set (TEDS)
8. The Uniform Crime Report (UCR)
9. The New Jersey Youth Tobacco Survey (NJYTS)

Other sources of governmental administrative data used to compile the above mentioned profile included:

1. The New Jersey Substance Abuse Reporting System (NJSAMS)
2. The New Jersey Department of Children and Families (DCF)
3. The New Jersey State Police Regional Operations and Intelligence Center (ROIC)
4. The National Highway Traffic Safety Administration (NHTSA)
5. The New Jersey Center for Health Statistics (NJCHS)
6. The New Jersey Department of Health: Division of HIV/AIDS Services (NJDHSS)
7. Violence, Vandalism and Substance Abuse in New Jersey Public Schools. The Commissioner's Annual Report to the Education Committees of the Senate and General Assembly (CRVV)

Originally, 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 were implemented, most were focused on the harmful consequences of alcohol consumption and in particular, motor vehicle crashes. SPF-SIG funding ended in 2012, after which, most of the SPF-SIG communities received funding (from the SABG) to continue their coalition work by focusing on the priorities identified in the prevention strategic plan.

The role of the SEOW was expanded in 2010 when the SSA charged the group with developing both treatment and prevention priorities. Upon further review of the data as described above, which included updated information, the SEOW then identified the following statewide prevention priority problems/issues in 2010: 1) Drug 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, in part made possible the development of a Social Network Analysis Project (analysis of linkages between/among the disparate prevention organizations in New Jersey). Additionally, in 2011, New Jersey received a $561,000 State Prevention Enhancement (SPE) Grant from SAMHSA, which enabled the state to expand its prevention system and make numerous enhancements to the substance abuse prevention infrastructure. New Jersey utilized SPE funding to make numerous enhancements to its prevention infrastructure by: addressing gaps in data regarding older adults and binge drinking rates among young adult women of child bearing age (21-29 years), expanding the capacity of the Prevention Outcomes Monitoring

System (POMS), DMHAS' prevention management information system) to collect data on environmental strategies and programs, in early 2016 updated its *Chartbooks of Social and Health Indicators,* the information which can be used to identify health problems directly or indirectly related to substance use and to aid in the assessment of needs for prevention and treatment services, and further enhanced the database of all prevention services and programs being delivered throughout the State. The Chartbooks will again be updated in 2020.

Selecting indicators to describe the consequences of substance use and the consumption patterns associated with those consequences is a critically important aspect of the needs assessment process. The SEOW Epidemiological (Epi) Profile Workgroup identified various dimensions that could describe the extent of a problem, including the size of the problem, its magnitude relative to other states' problems, the severity of the problem's impact on an individual and/or community, trend characteristics, attributable risk to substance abuse, and availability of data. In addition, the Epi-Profile Workgroup identified additional criteria that could impact efforts to address a problem, including capacity/resources, perceived gap between capacity/resources and need readiness (political will/public concern), economic impact, and social impact. The SEOW Epi-Profile Workgroup compiled a list of the data gaps they identified in their process. Some of the data gaps identified by the SEOW Epi-Profile Workgroup included:

- Medical Examiners data - not all counties report to state; need to search for data on presence of AD in system of homicide victims; more collaboration / cooperation between New Jersey State Police and New Jersey Medical Examiners on ALL AOD related deaths
- Secondary cause of death via alcohol data need to be collected
- Pedestrian fatalities and non-fatalities by age and substance need to be collected
- Alcoholic Beverage Commission needs to collect routine statistics on citations, fines, etc.
- Current use of ATOD by high school students
- Prescription usage patterns (misuse/abuse)
- General education referrals to school Substance Awareness Coordinators
- General education referrals to treatment
- High school dropout rate

New Jersey Regional Coalition Needs Assessment

The 17 New Jersey Regional Coalitions conducted an update to their needs assessment in 2018. Building on their initial needs assessment conducted five years prior, the Regional Coalitions built on that process to update their logic models and plans in order to capture current substance abuse prevention needs and trends. Using the Strategic Prevention Framework (PFS) as a model, the coalitions work on all steps (i.e., needs assessment, building capacity, implementation, etc.) at different times. Given the length of time that had passed since the coalitions' original needs assessment, an update was needed to assess their accomplishments so far and determine any shifts in community needs.

The primary goals of these community needs assessment updates were to assess what they have accomplished in their first several years of the statewide initiative, assess current community needs and readiness, prioritize strategies, and update logic models to reflect any changes in their plans to address current needs. The Rutgers Center for Prevention Science (RU-CPS) and New

Jersey Prevention Network (NJPN) provided guidance, technical assistance, and training as the coalitions moved through their community needs assessment updates.

The overall needs assessment questions guiding the coalitions' process include the following:

- What substance use problems (i.e., overdoses, alcohol poisoning) and related behaviors (i.e., prescription drug misuse and underage drinking) are occurring in your community?
- How often are these problems and related behaviors occurring?
- Where are these substance use problems and related behaviors occurring (i.e., at home or in vacant lots; in small groups or during big parties)?
- Who is experiencing more of these substance use issues and related behaviors? (i.e., are they males, females, youth, adults, or members of certain cultural groups?)

The needs assessment update process was broken down into major tasks, using the Strategic Prevention Framework fidelity guidance. Some of the overall tasks include the following: re-establishing their data work groups; obtaining existing and relevant data; analysis of these data; processes of prioritization; and assessing community readiness. The RU-CPS team and NJPN provided several technical assistance and training sessions to guide their needs assessment update processes and covering all of these related topics. The final step for all coalitions was to update their regional logic models based on their needs assessment update process. Across all coalitions, logic models were developed for the following substance priorities: underage drinking, marijuana, prescription drug misuse, illegal drugs, and tobacco. Most coalitions have two or three logic models. Across all coalitions, a total of 62 logic models were submitted to RU-CPS and NJPN for a review process.

RU-CPS and NJPN reviewed all logic models with the goal of providing individual feedback to each coalition as well as to capture efforts common across most or all coalitions to inform the state-level logic models. RU-CPS developed documents to show frequencies of the follow data elements across all logic models: 1) problem statements, 2) root causes, 3) local conditions, and 4) strategies. RU-CPS used these documents to also determine where there were instances in which coalitions are using slightly different language to indicate the same data element. These instances were used to collapse categories and help align language in the logic models when data elements are the same across coalitions. RU-CPS and NJPN held several technical assistance sessions with small groups of coalition staff to provide feedback and recommendations on their logic models.

Prevention Initiatives Based on Need

Regional Coalitions. Effective January 1, 2012, seventeen regional substance abuse prevention coalitions were funded under an RFP that was issued by the Division of Mental Health and Addiction Services in the fall of 2011. The goals of this project are to engage community stakeholders to address prevention priorities identified by DMHAS' Prevention Strategic Planning Committee in 2010 and to complement and reflect the first of the Substance Abuse and Mental Health Services Administration's (SAMHSA) Eight Strategic Initiatives. The prevention priorities are:

- Reduce underage drinking

- Reduce the use of illegal substances – with a special focus on the use of opioids among young adults 18-25 years of age
- Reduce prescription medication misuse across the lifespan
- Reduce the use of new and emerging drugs of abuse across the lifespan

The SSA identified 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." The "Prevention Needs Assessment" utilized archival data of social indicators to develop composite indices of risks to estimate the need for prevention services among New Jersey's 21 counties. Criteria including population, substance abuse treatment admissions and rates within the region as well as prevalence of alcohol and prescription drug misuse among middle and high-school students were also considered in identifying the seventeen regions.

The coalition intensively collaborate with Municipal Alliances in their region, which are funded and overseen by the Governor's Council on Alcoholism and Drug Abuse (GCADA). Coalitions also coordinate their efforts with those of the 29 Federally-funded Drug Free Community Support Programs in New Jersey. This initiative seeks to achieve an enhanced level of communication and collaboration among all groups and organizations that are working to reduce the misuse and the harmful consequences of alcohol and drug use among the citizens of New Jersey.

Strategic Prevention Enhancement Grant. In May 2011, the SSA submitted a Strategic Prevention Enhancement (SPE) grant to SAMHSA which was awarded. New Jersey's SPE Project served six high-need counties: Bergen, Camden, Essex, Hudson, Middlesex, and Monmouth. Archival data of social indicators were used to develop composite indices of risks to estimate need for prevention services among the 21 New Jersey counties. Risk factors related to alcohol and drug misuse in these identified counties were far more prevalent than in other counties throughout the State.

In addition to serving these high-need communities, New Jersey utilized SPE funding to make numerous enhancements to its prevention infrastructure by: addressing gaps in data regarding older adults and binge drinking rates among young adult women of child bearing age (21-29 years), expanding the capacity of the Prevention Outcomes Monitoring System (POMS), which DMHAS' prevention management information system, and to collect data on environmental strategies and programs. Additionally, DMHAS was able to update its *Chartbooks of Social and Health Indicators*, the information in which can be used to identify health problems directly or indirectly related to substance use and to aid in the assessment of needs for prevention and treatment services. Funding was also used to create a database of all prevention services and programs delivered throughout the State.

The training and services that DMHAS provided to high-need communities as well as the enhancements to its prevention infrastructure better enabled New Jersey to support more strategic, comprehensive systems of community-oriented care.

State Targeted Response (STR) Grant. Primary prevention efforts focused on community education programs for older adults with the goal of reducing demand for opiate prescriptions. Secondary prevention efforts included additional training on naloxone to schools, jails and prisons, and the distribution of naloxone kits.

Partnership for Success. In October 2013, DMHAS received a five-year Strategic Prevention Framework - Partnerships for Success (SPF-PFS) cooperative agreement from CSAP. The goals of New Jersey's SPF-PFS initiative are threefold: 1) to strengthen and enhance the work of 17 DMHAS-funded regional prevention coalitions; 2) to further develop the prevention data infrastructure and information systems capacity at the state level; and 3) in collaboration with state partners and community stakeholders, to continue work in developing a unified statewide prevention planning and service delivery system. Specifically, New Jersey's SPF-PFS seeks to 1) reduce underage drinking among persons aged 12 to 20; and 2) reduce prescription drug misuse and abuse among persons aged 12 to 25. As additional components of its PFS programming, New Jersey also focuses on unhealthy drinking patterns and prescription drug abuse among adults age sixty and older; and serves military families with prevention education, addressing military community risk levels, striving to mitigate the risk factors, and enhancing the protective factors to support military members and their families in making responsible parenting and individual choices in regards to drug and alcohol use.

DMHAS utilized these funds for numerous prevention infrastructure developments and enhancements. For instance, New Jersey is taking advantage of emerging technologies to better promote prevention messaging, and has developed a prevention-focused mobile app for iPhone and Android smartphones called "Be the One".

The Division was awarded another Strategic Prevention Framework Partnerships for Success Grant (PFS) in 2018. The focus of New Jersey's Partnership for Success is twofold. First, the Department of Human Services – Division of Mental Health and Addiction Services (DHS/DMHAS) will focus its efforts on providing prevention education and services to youth who are involved with the Department of Children and Families - Children's System of Care (DCF/CSOC). New Jersey has a fully-developed, organized statewide children's system of care, the Division of Children's System of Care (CSOC), under the auspices of the Department of Children and Families (DCF), that provides a single point of entry 24/7, for youth (under 21) and their families, with behavioral health challenges, substance use challenges, intellectual/developmental disabilities, and autism. The Division of Mental Health and Addiction Services (DMHAS), within the Department of Human Services (DHS), provides services to adults who seek behavioral health and substance abuse treatment.

The Departments and their respective Divisions (CSOC and DMHAS) will partner to implement prevention strategies that include outreach, education and training services to communities and families throughout the entire state of New Jersey. Concurrent with these services, the DMHAS-funded county coalitions will provide community-based prevention services throughout their counties, resulting in a cohesive, unified statewide prevention system.

Prevent Drug Overdose. In September 2016, DMHAS was awarded a SAMHSA grant to Prevent Prescription Drug/Opioid Overdose-Related Deaths (PDO) for $1M annually over 5 years.

Called the Opioid Overdose Prevention Network (OOPN) initiative, DMHAS will receive real-time, statewide information about drug overdoses from the state's police fusion center that uses cutting edge data collection and transmission technology. This capability will allow DMHAS to almost immediately alert front-line practitioners and to make data-driven decisions about where to deploy prevention interventions, which includes community education and distribution of naloxone.

Our project will implement an Early Warning and Rapid Response System (EWRRS) that will allow an extensive network of practitioners and community workers in a variety of healthcare settings (e.g., FQHCs, EDs, hospitals) who will be informed when their communities are affected. The alerts will also mobilize opioid overdose prevention practitioners who can provide emergency response training and distribute naloxone to at-risk individuals and their families, as well as disseminate information about addiction treatment services to the local communities that are affected.

Strategic Prevention Framework Rx. In September 2016, NJ was awarded $371,616 per year for five years. The SPF Rx provides an opportunity for states that have completed a Strategic Prevention Framework State Incentive Grant (SPF SIG) to target the priority issue of prescription drug misuse. Called NJAssessRX, the grant expands interagency sharing of the state's prescription drug monitoring program, data and gives the Division of Mental Health and Addiction Services (DMHAS) the capability to use data analytics to identify prescribers, prescriber groups and patients at high risk for inappropriate prescribing and nonmedical use of opioid drugs. Informed by the data, DMHAS and its prevention partners will strategically target communities and populations needing services, education or other interventions.

The target population is youth (ages 12-17) and adults (18 years of age and older) who are being prescribed opioid pain medications, controlled drugs, or HCG, and are at risk for their nonmedical use. One aspect of New Jersey's SPF Rx project will focus on young athletes. Literature suggests that when young athletes are prescribed opioid pain relievers for sports-related injuries, there is a risk of addiction and medication misuse. The 17 regional coalitions that were established by DMHAS will provide education regarding this issue to coaches, parents, prescribers, and young athletes.

DMHAS will conduct epidemiological analysis on the NJPMP data and employ geographic information systems (GIS) to identify communities and issues that require targeted interventions and public health initiatives. Reports will identify those populations, practice settings and geographic areas, with the highest rates of nonmedical use of opioids and opioid prescriptions.

The reports developed from the DMHAS data analysis will be shared with other state agencies and with DMHAS' Regional Prevention Coalitions to inform planning in local communities, which might, for example, target locales for naloxone distribution to prevent drug overdoses. These reports will also be the basis for a public awareness campaign and for training of providers and the health care community on addictions and the risks of opioid prescribing.

DMHAS will work with its state and community partners in promoting evidence-based practices on the prescribing opioid analgesics. DMHAS and its partners will use plans to implement soon

to be released recommendations of a state workgroup, the Pain Management Council, which will be incorporating the CDC Guideline for Prescribing Opioids for Chronic Pain. Medical practitioners and pharmacies will also be involved in efforts to promote awareness of naloxone and its availability. SAMHSA's Overdose Prevention Toolkit will be used to educate at risk individuals and their families in strategies to prevent opioid overdoses.

Prevention Statewide Request for Proposals. A Request for Proposals (RFP) for Statewide Services and Special Projects for Substance Abuse Prevention was released in September 2014 for community-based substance abuse prevention services and two special prevention projects described below. The guidelines and requirements of the RFP were developed by DMHAS in accordance with the DMHAS Substance Abuse Prevention Strategic Plan. Funding for all services is provided by the SAPT Block Grant. Each county in the state was assigned a funding allocation from the total funds available based on its relative need. The funding allocation was determined based on the presence and intensity of social indictors, past 30-day use rates, treatment admission rates, as well as need and risk factors within each county. Bidders responding to the RFP were required to utilize evidence-based programs and address the risk and protective factors specific to the prevention priority as well as the population (e.g. families, middle or high school students, older adults, workplaces, etc.) they propose to serve. In addition, bidders were required to provide quantitative data to substantiate the need for the substance abuse prevention services within the community and population they intend to target. From the 98 proposals that were received, 51 community-based contracts and two special project contracts were awarded totaling $5,700,200.

Prevention Services to Families of Military Veterans. 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.

Prevention Services to Gay, Lesbian, Bisexual, Transgendered and Questioning Youth. According to a study by University of Pittsburgh researchers published in the April 2008 issue of *Addiction*[2].the likelihood of substance use by gay, lesbian bisexual, transgendered and questioning (GLBTQ) youth are on average 190 percent higher than for heterosexual youth, the SSA funds the North Jersey Community Research Initiative to continue and expand their existing programs for high-risk GLBTQ youth of color by adapting a prevention model developed by the Centers for Disease Control and Prevention, early intervention services, social marketing, and structured recreational activities. A CSAP-sponsored evaluation of the program determined that the program was effective in reducing rates of substance use among participants and that participants were highly satisfied with the services that were provided.

Prevention Services to Older Adults. As part of the STR and SOR grants, primary prevention efforts are focused on community education programs for older adults with the goal of reducing

[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.

demand for opiate prescriptions by familiarizing them with alternative means of addressing pain other than opioid analgesics.

Opioid Overdose Prevention Program. DMHAS issued a Request for Proposals (RFP) in June 2015 to establish an annually renewable opioid overdose prevention program. The RFP funded by DMHAS and the Governor's Council on Alcoholism and Drug Abuse (GCADA) established three programs commencing in the fall of 2015 in the following regions:

North:	Bergen, Essex, Hudson, Morris, Passaic, Sussex and Warren Counties
Central:	Hunterdon, Mercer, Middlesex, Monmouth, Somerset, and Union Counties
South:	Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester, Ocean and Salem Counties.

The program provides education to individuals at risk for an opioid overdose, their families, friends and loved ones to recognize an opiate overdose and includes the distribution of naloxone kits and information on how to access treatment, including Medication Assisted Treatment, which is the best practice for someone living with an opioid use disorder.

Request for Letters of Interest (RLI) were issued in June 2017 by DMHAS for contracted OOPPs operating regionally across the State of New Jersey to partner with DMHAS in its State Targeted Opioid Response Initiative (STORI) funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) State Targeted Response to the Opioid Crisis (STR) grant. DMHAS made three awards in the amount of $75,000 each**.** DMHAS expects to educate and distribute naloxone kits to a larger spectrum of specialized groups including, but not limited to, school nurses and other personnel at statewide school districts, medical and clinical staff at jails and prisons, and medical and clinical staff working for residential substance use disorder treatment programs.

Opioid Overdose Recovery Program. A Request for Proposals (RFP) was issued in June 2015 to develop an Opioid Overdose Recovery Program to respond to individuals reversed from opioid overdoses and treated at hospital emergency departments as a result of the reversal. This new two-year initiative funded by DMHAS, the Governor's Council on Alcoholism and Drug Abuse (GCADA) and the Department of Children and Families (DCF) funded five programs. In 2017, additional funds were received from a Governor's Initiative to fund an additional six programs. With the STR funding the remaining 10 counties were funded so OORP is now in all 21 New Jersey Counties. The Opioid Overdose Recovery Program utilizes Recovery Specialists and Patient Navigators to engage individuals reversed from an opioid overdose to provide non-clinical assistance, recovery supports and appropriate referrals for assessment and substance use disorder treatment. The Recovery Specialists and Patient Navigators will also maintain follow-up with these individuals. Recovery services provided for these individuals should be fundamentally strengths-based. Additionally, they should deliver or assertively link individuals to appropriate and culturally-specific services and provide support and resources throughout the process. It is planned that, at minimum, recovery specialists will be accessible and on-call from Thursday evenings through Monday mornings in the specific locations where funding is made available. This initiative commenced in January 2016.

3.Planning Processes

County Planning

The county AEREF comprehensive planning process detailed under "Step 1: Assessing the strengths and needs of the service system...." contributes significantly to the SSA's planning for services across the full continuum of care by 1) applying state needs assessment data to four substate regions, the 21 counties and 565 municipalities, 2) comparing long term trends in statewide need, admissions, and gaps with trends in sub-state regional and county need, admissions, and gaps, 3) analyzing state, substate regional and county trends by level of care, primary drug, eight special subpopulations, and locational access, 4) and supplementing state-provided data analysis with needs assessment data developed at the community level. The counties obtain local data from 1) key informant and stakeholder focus group data, and 2) quantitative data produced from locally-funded research or made available to county planners from multiple health and behavioral health care planning initiatives occurring in their counties. The county level planning process is most informative regarding the identification of gaps in the delivery of services and recommendations for system level changes that can close these gaps. In addition to independent local planning and investment in local systems development, the SSA also relies on county level planning to provide "feedback" regarding the functioning of New Jersey's behavioral health care delivery system and policy recommendations regarding improvement of its performance.

In the current county planning cycle, 2016-2019, there were several changes that lead to challenges in planning amongst the counties. With the elimination of the federal IMD exclusion in July of 2018, Medicaid is now available to cover many of these expenses for most county residents enrolled in Medicaid. As the funder of last resort, the counties are trying to redirect their funding efforts from clinical treatment to prevention, early intervention and post-treatment, and recovery support services. The addition of federal and state initiatives to the fight against the opioid epidemic has reduced the number of county residents that must rely on county funding to afford outpatient and intensive outpatient care. Hence, counties have been reallocating planned service funding to residential withdrawal management and short- or long-term residential treatment to spend all their AEREF resources within a given year.

Continuing in the new 2020-2023 planning cycle, each county will be required to report on its quarterly progress implementing and measuring the outcomes of each year's objectives as well as monitoring of system level changes following upon the state's Medicaid expansion, the state's move to managed care for substance abuse treatment and the elimination of the IMD exclusion. These developments have begun to change the demand for the use of county dollars to subsidize access to care for the medically indigent and this in turn is expected to permit counties to emphasize the development of prevention, early intervention and recovery support services and foster innovative programming to meet the needs of their constituents. Each county planning cycle is limited to four years with the current cycle beginning in calendar year 2020 and ending in calendar year 2023. New county comprehensive plans were received by DMHAS by the end of 2018.

The SSA collaborates with the County Alcohol and Drug Abuse Directors in the administration of the aforementioned AEREF program. In 2019, the states' 21 counties received $8,756,174 from the AEREF program, based on county population size, per capita income and estimated treatment need. Additionally, each county received a $20,000 planning grant. The SSA supplemented these awards with an additional $6,908,371 for a total state investment of $16,084,545 in county provision of services. Further, each county is required to contribute 25% of its AEREF award to the program. In 2019, counties contributed an additional $2,189,044 to this program for a total combined state and county investment of $18,273,589.

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."[3]..Further, this plan "shall…demonstrate linkages with existing resources which serve alcoholics and drug abusers and their families." The law also stipulates that counties pay "special attention" to the needs of youth, drivers-under-the-influence, women, persons with disability, workers, and offenders committing crimes related to substance abuse. Thus, the counties are mandated by statute to develop unified, data-informed, comprehensive plans for the coordinated provision of community-based prevention, early intervention, treatment, and recovery support services for all county residents at both state and local levels. The SSA provides counties with quality assurance planning protocols and is responsible to review each CCP to determine: 1) whether the plan complies in form and function with the requirements of Chapter 51 by rationally relating county resources with the needs of county residents, and 2) whether it is designed and developed in a manner consistent with the state's quality assurance standards for county planning.

Local Citizen Advisory Planning Boards. A key component of the county comprehensive planning system is the county Local Advisory Committee on Alcoholism and Drug Abuse (LACADA), an independent, citizen's advisory group. The LACADA is required to assist the governing authority to develop and present to the County Board of 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

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

current CCPs to a fifth year, through 2013, in order to coordinate with the scheduled implementation of federal health care reform. As a consequence of the devastating impacts of "Superstorm Sandy" in October 2012, the SSA, in collaboration with the county planners, extended the current planning cycle for an additional year through the end of 2014. An additional one-year extension was implemented in spring 2014 for reasons related to the storm's impact and the focus of many counties on the implementation of Federal Disaster Relief Funds. The prior CCP governed the four-year period from January 1, 2016 through December 31, 2019. The new planning cycle, which is four years, encompasses January 2020 to December 2023.

SSA Planning Standards. Additionally, in 2008, the SSA established planning processes and quality standards that required: 1) state certification of CCP compliance with all Chapter 51 and the SSA planning requirements as a condition of recommending the release of county AEREF and other state discretionary funding; 2) engagement of community stakeholders in a formal community needs assessment based upon state and local data describing substance abuse treatment needs and gaps in the delivery of services required to meet those needs; 3) a logic model of the interrelationships of needs, goals, objectives, strategies, resource allocations and outcomes for prevention, early intervention, treatment, and recovery services; 4) one system-level change to enhance the local continuum-of-care; 5) an action and resource allocation plan that implements the CCP according to its goals, objectives, strategies and intended outcomes; 6) a draft RFP for the provision of those services that would implement the CCP in accordance with its corresponding planned resource allocation; and 7) establishment of an annual plan implementation and outcomes monitoring procedure to document plan implementation obstacles encountered and corrective actions taken to overcome them.

Thus, the SSA, in collaboration with its partner county governments has established planning standards intended to produce rational, goal-oriented, data-driven county plans for the development of the full continuum of care from primary prevention through recovery support. The SSA supplies counties with data from the SSA's needs assessment program. For instance, the counties review: a) primary data obtained from the household survey, b) secondary social indicator data from the county and municipal chart books, c) administrative data from sources like NJ-SAMS and facility licensure. The SSA's County Planning Guidelines also encourage county behavioral health planners to incorporate local perceptions of substance abuse issues and treatment system capacity by means of county focus groups and other encouragements to citizen participation. The SSA provides planning education, training, and technical assistance to the county directors throughout the process.

Future Developments in the State-County Collaborative Planning Process. For the 2016-2019 planning cycle, the SSA will continue to assist counties with planning data and analyses as well as understanding of federal and state level changes to health care delivery that will affect access to care for their residents. It will continue to help counties identify and implement a greater number of evidence-based prevention education programs and encourage counties to participate in planning environmental approaches to prevention at the county and municipal levels. It will encourage counties to increase their investments in recovery support services in order to help treated individuals maintain the benefits of clinical services, forestall relapses, and when necessary, return to treatment sooner before clinical treatment needs become severe.

New Jersey Prevention Unification Process

The NJ Prevention Collaborative, previously called Prevention Unification, re-activated a committee in July 2018. The NJ Prevention Collaborative includes members from the New Jersey Division of Mental Health and Addiction Services (DMHAS), New Jersey Prevention Network (NJPN), Rutgers Center for Prevention Science (RU-CPS), and the Governor's Council on Alcoholism and Drug Abuse (GCADA). The Prevention Technology Transfer Center operated by RU-CPS provided state-level technical assistance to this state-level group as well. It was decided to re-brand "Prevention Unification" and now this workgroup is referred to as the NJ Prevention Collaborative. The overall aim of the NJ Prevention Collaborative was to align all state-funded substance abuse prevention initiatives. The primary goals include the development of state-level logic models for underage drinking, prescription drug misuse, marijuana, and tobacco. These logic models will be used to integrate with the coalition logic models and then more locally, the alliances would use these to fit in their efforts.

During the earlier meetings in the summer and fall of 2018, the team created a list of objectives, action steps, and an overall plan that included milestones through the end of 2019. In the early planning, some of the expectations for what the state-level logic model included: Minimize service duplication and complement each other's work; build upon past success of prevention unification processes; continue alignment of regional coalitions, "B" grant providers, Municipal Alliances, and Division Substance Abuse Directors; determine state-wide priorities and solidify desired outcomes for prevention system; and support a state-wide cohesive message about what effective prevention looks like. The NJ Prevention Collaborative decided on a scope for the state-level logic models, which included the 17 Regional Coalitions, all Municipal Alliances, individual and family program providers, and Drug Free Communities grantees. These are also the entities that would act as primary users of the state-level logic models. Once the group decided on the overall objectives, scope, and intended audience, a planning process began. The NJ Prevention Collaborative started to meet regularly, from once a month to once a weekly, depending on the time and deadlines.

RU-CPS started with an initial first step to extract data from the regional coalitions for inclusion in the state-wide logic models. This process began by extracting problem statements, roots causes, local conditions, strategies, and outcomes from all regional coalition logic models and organized databases with frequencies for each of the substance priorities: underage drinking, prescription drug misuse, marijuana, and tobacco. Several iterations of data extraction were conducted, and the group reviewed at each iteration and worked to condense data elements. NJPN extracted data from Drug-Free Community initiatives and DMHAS extracted data from prevention agencies with block grant funding ("B grantees"). Once all of these data sources were integrated, the group began to populate a state-wide logic model.

Throughout the process, the members have presented on the NJ Prevention Collaborative to the different constituents in order to get all stakeholders involved in the process and to collect feedback along the way. For example, NJPN presented multiple times to the regional coalitions; GCADA presented to the county municipal coordinators and alliances; and DMHAS presented at their meetings.

The NJ Prevention Collaborative facilitated a statewide logic model presentation followed by a focus group in June 2019. Invited participants included regional coalition coordinators and municipal alliance coordinators whose agencies were representative of the state geographically and in terms of size (e.g. number of municipal alliances, funding resources, community partnerships, etc.). The statewide logic model was presented as an opportunity to acknowledge efforts at the state, regional, and municipal level while incorporating important factors cited in prevention literature. The logic model was also cited as a useful tool for identifying any gaps in the work being done and serve as a resource for coalitions to strategically address health disparities in their communities at the local level. The presentation was followed by a focus group in which participants expressed overall thoughts on the purpose of the logic models, cited potential challenges to successful implementation, and communicated their expectations for their agency's role going forward.

The final steps of the state-level logic models included the gathering of state level data to complete the problem statement for each of the 4 logic models. The goal is to include multiple data points for consumption patterns and consequences (i.e., crime indicators, injuries, ER visits, overdoses) for each logic model. These data points are state-level. RU-CPS led this step and built a database of over 300 outcome measures. Each data point was tracked for a minimum of three years in order to observe trends across time. Data points were collected for New Jersey as well as for the US, in order to compare New Jersey trends to the US. The NJ Prevention Collaborative reviewed all of these data elements and trends and then created a process for prioritization. It was decided to rank data indicators as high, medium, and low priority based on the prevalence of the problem, the trends over time, and how NJ compares to the US. All data points for the four substance priorities where then entered into a prioritization database, which showed prevalence, trends over time, and how NJ compares to the US in order for the group to make final decisions on which high and medium priority measures will be included into the final state-level logic models.

The group plans to finalize the prioritization process and create a list of interventions to be included in the final logic models. The NJ Prevention Collaborative plans to complete the four state-level logic models in the summer of 2019 and share them with the different state-funded groups and stakeholders. The efforts of the Prevention Collaborative will be shared with the regional coalitions for their continued assessment, planning, and evaluation processes for their regionally based prevention strategies and with the municipal alliances as they conduct their needs assessment process this Fall and Winter, 2019. Additionally, the group is working on a systems-level logic model for the state.

4.Data Gaps

Older Adult Survey. Through its strategic planning processes, DMHAS determined that one of the top data gaps in New Jersey was the lack of information on the older adult population and the prevalence of substance use, misuse, and mental health issues within this group. The first New Jersey Older Adult Survey was conducted in 2012, with a total of 800 individuals living in New Jersey who were age 60 and older responding.

DMHAS was awarded the Partnerships for Success grant by SAMHAS in 2013, and allocated funding to address the need for further research on this population relating to substance use and

mental health issues. The overall goals of the New Jersey Older Adult Survey (NJOAS) were three-fold: (1) to assess the prevalence, risk, and protective factors of substance misuse and mental health issues among New Jersey older adults; (2) to obtain enough data to create small-area estimates of the prevalence of substance abuse and mental health for the target population in specific geographic areas; and (3) to analyze the results of the survey with the aim of providing policy suggestions to the state of New Jersey that would help better allocate resources for New Jersey older adults. In February 2014, Avalon Health Economics was contracted by Rutgers University School of Social Work and the New Jersey Division of Mental Health and Addiction Services (NJ DMHAS) to conduct a needs-based survey among the New Jersey older adults. New Jersey was divided into four sections; Central, Metro, Northern, and Southern. The survey respondents represent each area equally (23%, 32%, 25%, 21%, respectively).

The NJOAS instrument was developed and then implemented through telephone interviews, using random digit dialing sampling methods and stratified by four New Jersey regions. The survey instrument included items based on commonly used and validated subscales, to measure the prevalence of substance use and misuse, mental health issues, consequences of use, risk and protective factors, and basic demographic information (race, ethnicity, education, job status, etc.). The sample was randomly selected from a database of over 600,000 New Jersey residents who were age 60 and older (older adults) at the time of the interview. A total of 3,701 responses were collected during October and December 2015. New Jersey was divided into four geographic sections; Central, Metro, Northern, and Southern. The survey respondents represent each area equally (23%, 32%, 25%, and 21%, respectively).

The PFS team worked with the Technical Assistance Team through SAMHSA's Center for the Application of Prevention Technologies (CAPT) to meet with an expert in small-area estimation techniques. The CAPT team arranged for consultation with Dr. Robert E. Fay. Dr. Fay is a Westat Senior Statistician with more than 40 years of experience in multiple aspects of sample surveys to include survey design, estimation, variance estimation, imputation and analysis of missing data, statistical modeling of data from complex samples and small area estimation. As a consultant to the CAPT and in collaboration with the CAPT Epidemiology Team, Dr. Fay provided expert guidance on small area estimation to the state of New Jersey. The PFS team consulted with Dr. Fay in June 2017, and will meet again in August 2017, after the team incorporates his recommendations into their methodology to be used with the NJOAS results. Once the methodology is finalized, the PFS team will prepare a report of findings.

Veteran's Survey. New Jersey continues to focus on returning Veterans as a priority population for its PFS initiative and other programming. This is another population for which there were limited data. DMHAS has reached out to New Jersey Department of Military and Veteran's Affairs as well as the New Jersey National Guard to solicit their active participation on the SEOW and Advisory Council in light of this priority. DMHAS collaborated with its partners at Rutgers University and Avalon Health Economics to conduct a survey of returning Veterans in order to gather information about behavioral health issues and concerns within this population in New Jersey. Interviews were completed in late 2015. Almost 1200 New Jersey veterans responded to the survey.

Municipal Level Data. A critical challenge for the 19 county prevention coalitions, as well as County Drug and Alcohol Directors, and Municipal Alliance Coordinators in New Jersey, has been the lack of available data at very specific and detailed geographic units of analysis (e.g., municipal, census tract, neighborhood, etc.). A social indicator database project was completed under the SPE grant which used a variety of methods to acquire new data and merge information from existing systems to provide a foundation for an integrated data infrastructure. Purposes of this database are: to help identify high need communities; promote data-driven planning; support funding allocation methods based on need; enhance capacity in local communities and strengthen their ability to identify meaningful local indicators; and to help produce community-level epidemiological profiles.

5.Current Gaps in the Substance Use Disorder Continuum of Care

In order for clients who have a substance use disorder it is critical that there are recovery supports in place so clients can realize their full potential and clients have access to evidence-based treatment. The following areas have been identified by the SSA as areas that need enhancement.

Relapse Prevention. Drug and alcohol rehab statistics show that the percentage of people who will relapse ranges from 50% to 90%. Data from NJSAMS for CY 15 indicated that of 48,638 individuals, 4,508 individuals experienced two or more episodes of care during the year. Of the 4,103 individuals who experienced two episodes, 52% re-entered care within three months and another 34% were back in treatment within three to six months. We plan to update these data for CY18. Our goal is to provide recovery supports to help these individuals move to and remain in recovery for longer periods of time. Several activities proposed are designed with this purpose in mind, such as the Opioid Overdose Recovery Program, the Support Team for Addiction Recovery and the Telephone Recovery Support system. However, the latter two services are only being made possible by the STR grant DMHAS received, which is for two years, and recently extended another two years with the SOR grant.

Housing. Under the leadership of Governor Phil Murphy, New Jersey has responded to the state's increasing number of opiate overdose deaths and adverse events with numerous initiatives. Stable, affordable housing is a crucial component of recovery for individuals with substance use disorders. Supportive housing combines affordable housing with services that help people who face the most complex challenges to live with stability, autonomy and dignity. Supportive housing has been proven as an effective solution to ending homelessness for active substance users; barrier-free housing provides a necessary platform to access a variety of services, participate in long-term recovery and give individuals the opportunity to engage in important community roles.

One such RFP addressed individuals with an opioid use disorder (OUD) throughout the state who are homeless or at risk of homelessness. DMHAS solicited proposals from potential community partners to provide individualized case management and supportive services to consumers with an OUD, on average, up to 8 hours per month, billable in 15 units, based on individual needs. These services will assist individuals in seeking and connecting with behavioral health and or physical healthcare needs. DMHAS will provide 200 rental subsidies,

up to the fair market rate (FMR) as defined by the Department of Community Affairs (DCA) for lease based housing. One-time funding will be available to consumers for security deposits, utility start-up costs and furnishings. Contracts were awarded four agencies to serve individuals in five counties: Atlantic, Burlington, Camden, Mercer and Monmouth.

Another such RFP, DMHAS solicited proposals from potential community partners to pilot three recovery based housing residences (a minimum of five individuals in each residence), one in each region, for individuals with an OUD who are homeless or at risk of homelessness and are in or recently discharged from treatment. Housing provided must be licensed as a Class F, Cooperative Sober Living Residence (NJAC § 5:27). Accordingly, individuals will be responsible for providing their own food and taking care of their own laundry. Treatment and counseling may not be provided in the residence; however, non-clinical recovery support services may be provided at the site and the agency may require, at its discretion, drug or alcohol testing of residents. (NJAC § 5:27-2.1). This RFP calls for individualized case management and sober housing services for 15 individuals (a minimum of five individuals in each region) who have been identified as needing a safe, healthy, peer-lead, recovery-oriented environment. Contracts were awarded to three agencies with each serving one region of the state (North, Central and South).

DMHAS has 166 supported housing slots for individuals with a substance use disorder: two 31 bed programs in Camden and Atlantic counties, a 10 bed program for women in Somerset county, and 94 supportive housing subsidies funded by the Supplemental Social Service Block Grant (SSBG). Supportive housing is a successful, cost-effective, combination of affordable housing with services that help people live more stable, productive lives. It offers permanent housing with services that work for individuals and families who face complex challenges such as homelessness and/or have serious and persistent issues that may include substance use, mental illness, and HIV/AIDS.

Studies cited by the Corporation for Supportive Housing (CSH) indicate that supportive housing has positive impacts on reducing or ending substance use. Once people with histories of substance use achieve sobriety, their living situation is often a factor in their ability to stay clean and sober. According to the Kentucky Interagency Council on Homelessness (KICH), a one-year follow-up study of 201 graduates of the Eden Programs chemical dependency treatment programs in Minneapolis found that 56.6% of those living independently remained sober, 56.5% of those living in a halfway house remained sober, while 90% of those living in supportive housing remained sober. An additional 10 beds were created for women with children known as the Women’s Intensive Supported (WISH) program.

There are also studies that documented positive impacts on health with decreases of more than 50% in tenants' emergency room visits and hospital inpatient days; decreases in tenants' use of emergency detoxification services by more than 80%; and increases in the use of preventive health care services. Positive impacts on employment have also been found, with increases of 50% in earned income and 40% in the rate of participant employment when employment services are provided in supportive housing.

Recovery Centers. There is a need for DMHAS to develop more Recovery Centers. There were only two state funded centers: Eva's Village in Paterson and Living Proof in Voorhees. Recovery support is an essential part of the continuum of care since addiction is a chronic biologically based disease of the brain and as such requires a system of care designed to treat a chronic condition rather than an acute illness. With other chronic conditions, e.g., diabetes, hypertension, heart disease, that are characterized by periods of wellness and acute episodes of care, the care system and intervention are designed to manage the illness in order to promote sustained periods of wellness and eliminate or minimize the need for acute care. Similarly, the addiction treatment system must adapt so as to support the process of sustained recovery.

Through Recovery Centers, DMHAS intends to expand the continuum of care to include an array of services that support individuals in their recovery from addiction. Recognizing the need to support individuals in their pathway to recovery, a Recovery Center is a place where individuals who have completed or left treatment, or who have never entered formal treatment, can find a nurturing and empowering environment in which they can learn new skills and develop a social network. A Recovery Center will help prevent relapse and provide support for sustained recovery within the community. Services will be provided by peers who will also serve as positive role models.

During 2018, there were 87,516 discharges from substance abuse treatment in New Jersey. Of these, 22,846 or 25%, quit or dropped out of treatment. While ALL clients can benefit from recovery support services, those clients who did not complete treatment may find recovery support beneficial and a gateway back into treatment and/or sustained recovery. It is clear that there are significant numbers of people who could benefit from ongoing recovery programs. While these figures are drawn from those who enter the formal treatment system, there is a group of people of unknown size who have never accessed formal treatment who could also benefit from recovery services. This will also be an opportunity for those for whom access to treatment is not possible or delayed due to insufficient capacity within the system. The DMHAS Recovery Centers offer training, social, educational and recreational opportunities. There are classes focused on wellness, nutrition and illness management, including classes on self-care, stress management, financial management, literacy education, job, and parenting skills. Housing assistance (e.g., finding apartments and roommates) is provided, and telephone support is available to Recovery Center participants. It is expected that this peer-delivered service will result in improved social functioning, reduced substance abuse and an improved quality of life, including more social connectedness.

DMHAS has expanded Recovery Centers through the SOR funding. Funding has been issued in 2019 through a Request for Proposals (RFP) to develop Community Peer Recovery Centers (CPRC) where individuals can access peer support, information about substance use disorder treatment, recovery support services, and information about other community resources in a supportive substance free environment. DMHAS has awarded three providers in the amount of $100,000 each which is for start-up small-scale Recovery Centers to provide peer-to-peer recovery support services to prevent recurrent of substance use and promote sustained recovery. Providers are required to provide peer-to-peer recovery support services that are responsive to community needs. All activities and services are led and drive by "peers", individuals who have experienced addiction and recovery, either directly or indirectly as a family member or friend.

The overall goal of the CPRC is to provide a safe place for recovering individuals to gather in support of one another and experience sober living in a community setting. The CPRC will be a place where those in recovery can have the opportunity to give back to their community thereby fostering senses of empowerment and independence. DMHAS will be issuing another RFP in early Summer 2019 using SOR supplemental grant funds for expansion of seven additional CPRCs.

Recovery Case Management. There were no formal case management services in the addiction service system. Research indicates that substance-dependent individuals who have prompt access to a full continuum of services that address individual client needs and co-morbidities experience improved recovery outcomes. Kirk (2007) describes a client-centered service delivery model that promotes access to a broad array of services, reduces the frequency and duration of acute care episodes, and facilitates client stabilization in the "recovery zone". The term "recovery zone" refers to a state of sustained recovery characterized by long periods of abstinence, gainful employment, stable housing, and supportive and rewarding social and spiritual connectedness. Recovery case management (RCM) interventions that support clients' entrance into and maintenance within the recovery zone not only improves the quality of life for substance-dependent individuals but reduces the cost of their care by promoting access to non-residential treatment and recovery support services which are less costly than acute residential care. A client's movement into the recovery zone varies depending on individual needs; successful recovery case management depends upon a strength-based approach that recognizes client competencies.

RCM seeks to encourage a client's mastery over their substance use disorder, thus increasing the likelihood of an individual's sustained engagement in the recovery zone. DMHAS proposes the inclusion of recovery case management within our current system of care to reduce service fragmentation, promote service continuity, and increase clients' capacity to manage their chronic health condition.

With STR funding, DMHAS was able to create 10 Support Teams for Addiction Recovery (STAR). Additional SOR funding allowed the creation of two more STAR programs, and the SOR supplemental funding will allow the development of 9 more STAR programs. This will result in statewide coverage.

Medication Assisted Treatment. NJSAMS data indicated while heroin plus other opiates were the primary drugs accounting for 50%, or 45,129, of New Jersey's treatment admissions during 2018, the use of either methadone (15%) or buprenorphine (7%), a total of just 22%, was in the treatment plan for these admissions, a difference of 28%. The number of people who entered either opioid maintenance -outpatient or -intensive outpatient was only 13% (11,091). This difference of 37% for a level of care that uses MAT, demonstrates a large gap between the number of people using heroin and other opiates admitted to treatment vs. the number receiving the most effective, evidence-based treatment available.

Based on our data and experience with our Opioid Overdose Recovery Program the greatest treatment need is for ambulatory substance use disorder treatment programs that offer Medication Assisted Treatment (MAT) in the forms of methadone, buprenorphine and Vivitrol.

Increasing this capacity could significantly reduce the demand for Inpatient Withdrawal Management (IWM) as well as other residential treatment services.

Ambulatory Withdrawal Management. Currently there are 13 licensed providers in NJ that provide Ambulatory Withdrawal Management (AWM). This is a service that would be of great benefit to individuals with opioid use disorder (OUD) as an option to the more costly, and not always clinically indicated, IWM.

Public Awareness Campaign. DMHAS, in partnership with the Department Human Services (DHS), Office of Public Relations, is currently seeking a vendor to deliver a campaign to help eliminate stigma and discrimination around the use of MAT. Various forms of messaging will be utilized including social media targeted to different audiences. DMHAS believes this campaign will assist the public in understanding that MAT is a best practice and should be considered when seeking treatment for an OUD.

Family Support Services. There were no formal family support services in the NJ addiction treatment system. Also, it has been reported that the Addiction Hotline is receiving a significant number of calls from families. DMHAS is committed to helping parents and other family members struggling with their loved one's OUD. The STR grant now supports three regional Family Support Centers (FSC) each staffed by two full-time Family Support Coordinators with lived experience trained in the Community Reinforcement Approach and Family Training (CRAFT) model. CRAFT teaches families self-protection along with non-confrontational skills to help empower their loved one to seek recovery. The FSC also offers families support, education, resources and advocacy in an environment that is safe and non-stigmatizing. It is expected that each FSC will serve 50 families.

When parents and family members of young adults who use illicit substances, abuse prescription drugs and other opiates seek access to treatment or recovery resources, navigating the treatment world can be an overwhelming experience. Families are often frustrated and dealing with many emotions. At the same time, they are worried about their loved one's life, their safety, and suffer through each crisis. Many parents and family members feel isolated with no supports and often face stigmatization about their loved one with an OUD. They are trying to figure out what the next step will be, and how their decision affects their loved one.

Narcan Reversals and Follow-up Treatment. One of the gaps identified through the SSA's data is the need to engage individuals who have undergone a naloxone reversal to enter treatment. The data clearly demonstrates that most individuals who experience a reversal do not enter treatment.

Despite 16,082 Narcan administrations in New Jersey from January 1, 2018 to December 31, 2018, NJSAMS data indicated that during that same period, there were only 1,897 admissions who reported a Narcan administration "in the past 30 days." This difference of 14,185 demonstrates that: a) very few persons who undergo a Narcan reversal access treatment and b) closing this gap will require effort to reach out to such individuals and encourage them to enter substance use disorder treatment, ideally at programs providing MAT. As a result, DMHAS is developing strategies to reduce this gap. Using STR funding, brochures have been printed which will be given to individuals who refuse transport to the hospitals by EMS that provides a list of resources for follow-up help. The brochures are tailored by county. Using SOR funding, Opioid

Overdose Response Teams (OORT) are being designed. These teams will be part of those OORPs when there is a high number of individuals who refuse transport to the ED after being reversed with Narcan. The teams will reach out to these individuals within 48 hours of their reversal.

Gaps Observed by the New Jersey Behavioral Health Planning Council. The New Jersey Behavioral Health Planning Council (BHPC) previously developed a white paper expressing concerns with the wait to admission into residential withdrawal management. The SSA invested a significant amount of funding into residential withdrawal management in FY 17. Funds were added to the SAPTI fee-for-service initiative for this level of care and a new STORI treatment initiative was developed using STR funds which included residential withdrawal management. In addition, ambulatory withdrawal management was added to this initiative once the rates were finalized.

At the June 2019 BHPC meeting, new gaps identified were: 1) a key barrier to MAT for opioid SUD is transportation and homelessness and 2) services for older adults with opioid addictions. With regards to older adults, DMHAS has made five awards for programs to educate older adults on alternate strategies for opioid prescriptions using STR funds, another five awards using SOR funds, and released an RFP for 11 more older adult programs using SOR supplemental grant funds.

6.Addressing Needs and Gaps of Services of Special/Target Populations

Pregnant Women and Women with Dependent Children. In 2014 as a SAMHSA Prescription Drug Abuse Policy Academy State, New Jersey was eligible to apply for a unique technical assistance opportunity through the SAMHSA supported National Center on Substance Abuse and Child Welfare (NCSACW) to address the multi-faceted problems of Substance Exposed Infants (SEI) and Neonatal Abstinence Syndrome (NAS). The Department of Human Services, Division of Mental Health and Addiction Services (DHS/DMHAS) as the lead State agency partnered with the Department of Children and Families (DCF) and Department of Health (DOH) and submitted a successful application for In-Depth Technical Assistance (IDTA) (no funding attached). The IDTA goal was to develop uniform policies/guidelines that address the entire spectrum of NAS and SEI from pre-pregnancy, prevention, early intervention, assessment and treatment, postpartum and early childhood. The IDTA would also provide assistance to New Jersey to strengthen collaboration and linkages across multiple systems such as addictions treatment, child welfare, and medical communities to improve services for pregnant women with opioid and other substance use disorders and outcomes for their babies. The New Jersey IDTA Core Team included over 60 individuals representing multiple State Departments and Divisions, community stakeholders, treatment providers, and the medical community.

The IDTA established three goals: (1) Increase perinatal SEI screening at multiple intervention points (Health system, SUD/MH system); (2) Leverage existing programs and policy mechanisms to collaboratively increase the rate at which women screening positive on the 4P's Plus get connected for a comprehensive assessment by establishing formal warm-handoffs and other safety net measures; (3) Leverage existing programs and policy mechanisms to

collaboratively increase the rate at which women delivering SEIs and their babies and any other eligible children, receive early support services for which they are eligible.

Three workgroups convened: (1) *Data Workgroup* looked at statewide data systems (Medicaid ICD codes and DOH) that capture prenatal screening, linkage to treatment services, follow-up for parenting women, prevalence of NAS and associated costs. During the initiative, the team analyzed 2013 and 2014 Medicaid data to establish prevalence and costs of treatment NAS.

(2) *Prenatal Screening, Early Identification of Infants & Referral to Service Workgroup* focused on how to increase connections to appropriate treatment and supportive services such as Central Intake and Perinatal Cooperatives, by mapping out current screening and referral practices across the state using Pregnancy Risk Assessment (PRA) data; New Jersey implemented the 4Ps+ across the State and embedded the tool within the PRA. The workgroup found high utilization (over 80%) of 4Ps+ within doctors serving pregnant women on Medicaid. The mapping allowed the team to target low utilization areas to increase the prevalence of prenatal screening.

(3) *Labor, Delivery and Engagement (Infants) Workgroup* developed a comprehensive survey with input from the medical community and perinatal cooperatives. The Hospital Birth Survey was disseminated statewide March 2017 to the labor and delivery hospitals. The survey sought to understand how pregnant women with SUD and substance-exposed infants are identified, treated, and triaged with partners at discharge, and if treatment for NAS was explored. The Hospital Birth Survey results is intended to guide Departments in establishing statewide guidelines for best practice; aid in the development of cross system models to ensure families get access to services; establish education needs on issues of SEI/NAS and identify high risk areas.

Throughout the IDTA process the Core team reported to the State Opioid Workgroup. The Opioid Workgroup was comprised of representatives from multiple State departments and their divisions. The Opioid Workgroup engaged the support and commitment of Department-level commissioners in directing the resources and expertise of their particular department to address the issue of opioids and its attendant problems. In order to sustain the work completed in IDTA, the Opioid Workgroup recommended the establishment of a systemic approach to infant substance exposure, prevention and intervention. The Opioid Workgroup developed an interagency workgroup to promote improved outcomes for SEIs and their families. Although, this workgroup is no longer convened, a monthly Opioid Workgroup meeting is convened under the leadership of Governor Murphy's Policy Office, that includes high level leadership representing different state departments including the Department of Human Services (DMHAS and the Division of Medical Assistance and Health Services), Department of Corrections, Department of Law and Public Safety, Department of Labor and Workforce Development, Department of Health and Department of Children and Families.

The IDTA commenced in 2017, however, DMHAS as the IDTA lead state agency requested modified technical assistance from the NCSACW to support New Jersey to interpret the key findings from the *Birthing Hospital Survey*, and apply these findings to the Project ECHO (Extending Community Health Outcomes) program design. Robert Wood Johnson and the Nicholson Foundation, in partnership with the three Departments (Health, Human Services, and Children and Families) and other stakeholders began planning to launch Project ECHO for SEIs.

The New Jersey Project ECHO is aimed at Statewide adoption of best practice clinical care and community-based interventions to support SEIs and their parents to support recovery, family formation, and child development through a multidisciplinary case-based learning platform. Project ECHO for SEI and parents focuses on prevention, birth, and the infant's first year of life.

DCF is the lead State agency on Plans of Safe Care for SEI, mothers and their families and has developed protocols for integrating Plans of Safe Care into child protection services and child welfare and child welfare assessments.

Child Welfare/Parents with Dependent Children Programs. July 1, 2015, the treatment contracts for parents with substance use disorders via a Memorandum of Understanding between the SSA and DCF Division of Child Protection & Permanency (DCP&P) transitioned to DCF.

DCF and DMHAS collaborate on multiple initiatives targeted to pregnant and parenting women with substance use disorders. This partnership focuses on a coordinated multisystem approach to enhance and integrate service delivery that will ultimately improve the outcomes for the women, their infants and families. This cross-system collaboration ensures that services are coordinated, and information is shared appropriately to facilitate better communication, maximize resources and address barriers.

Currently, 12 of New Jersey's 21 counties have monthly DCP&P Child Welfare Substance Use Disorder Consortia meetings which are held at the local DCP&P offices. Child welfare staff, DMHAS, Division of Family Development, Substance Use Disorder Provider Agencies, Work First New Jersey, Substance Abuse Initiative (WFNJ SAI) providers, and Boards of Social Services meet each month and plan on how to better serve families, leading to more effective policies and practices to meet the needs of infants, children and families. The Consortia also addresses ASFA timelines and reunification for children in out of home placement. Through collaboration, multiple agencies working with the same family can improve communication to reduce the gaps in service delivery and improve coordination of services. The Consortia allow for cross systems collaboration with local treatment programs and other community partners who can provide the expertise needed to better serve families in the child welfare system.

Women's Intensive Supportive Housing Program. The Women's Intensive Supportive Housing (WISH) program develops permanent supportive housing for pregnant and/or parenting women with a co-existing substance abuse disorder and mental illness who are homeless or at risk of homelessness and being discharged from a licensed long-term residential substance abuse treatment and/or halfway house facility. The WISH team provides case management and supportive housing services for 10 women and their children. DMHAS outpatient treatment system accommodates the substance use disorder treatment needs of the project participants. In addition to WISH, DMHAS has provided additional subsidies to DCP&P to develop housing for parents with children in the child welfare system.

Maternal Wraparound Program. The Maternal Wraparound Program (M-WRAP) is a statewide program that provides intensive case management and recovery support services for opioid dependent pregnant and postpartum women. Opioid dependent pregnant women are eligible for services through M-WRAP during pregnancy and up to one year after birth event. Intensive case

management focuses on developing a single, coordinated care plan for pregnant/postpartum women, their infants and families. Intensive Case Managers work as liaisons to all relevant entities involved with each woman. Recovery Support Specialists provide non-clinical assistance and recovery supports while maintaining follow-up with the women and their infants.

Integrated Opioid Treatment Services and Substance Exposed Infants (IOT-SEI). In December 2017 the Department of Health (DOH) awarded funding through a Request for Applications (RFA) for the expansion of integrated opioid treatment services and substance exposed infants (IOT-SEI). DMHAS manages the IOT-SEI Initiative which provides an array of services for opioid dependent pregnant women, their infants and family ranging from substance use disorder treatment, prenatal and postpartum medical/obstetric services, care coordination, recovery-based living arrangements, wraparound services such as intensive case management and recovery supports. The overall goal is to improve outcomes for pregnant women with opioid use disorder, their infant and families. This initiative promotes maternal health, improve birth outcomes and reduce the risks and adverse consequences of prenatal substance exposure. Five agencies across the State are participating in this initiative.

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

Planning Steps

Quality and Data Collection Readiness

Narrative Question:

Health surveillance is critical to SAMHSA's ability to develop new models of care to address substance abuse and mental illness. SAMHSA provides decision makers, researchers and the general public with enhanced information about the extent of substance abuse and mental illness, how systems of care are organized and financed, when and how to seek help, and effective models of care, including the outcomes of treatment engagement and recovery. SAMHSA also provides Congress and the nation reports about the use of block grant and other SAMHSA funding to impact outcomes in critical areas, and is moving toward measures for all programs consistent with SAMHSA's **NBHQF**. The effort is part of the congressionally mandated National Quality Strategy to assure health care funds – public and private – are used most effectively and efficiently to create better health, better care, and better value. The overarching goals of this effort are to ensure that services are evidence-based and effective or are appropriately tested as promising or emerging best practices; they are person/family-centered; care is coordinated across systems; services promote healthy living; and, they are safe, accessible, and affordable.

SAMHSA is currently working to harmonize data collection efforts across discretionary programs and match relevant NBHQF and National Quality Strategy (NQS) measures that are already endorsed by the National Quality Forum (NQF) wherever possible. SAMHSA is also working to align these measures with other efforts within HHS and relevant health and social programs and to reflect a mix of outcomes, processes, and costs of services. Finally, consistent with the Affordable Care Act and other HHS priorities, these efforts will seek to understand the impact that disparities have on outcomes.

For the FY 2016-2017 Block Grant Application, SAMHSA has begun a transition to a common substance abuse and mental health client-level data (CLD) system. SAMHSA proposes to build upon existing data systems, namely TEDS and the mental health CLD system developed as part of the Uniform Reporting System. The short-term goal is to coordinate these two systems in a way that focuses on essential data elements and minimizes data collection disruptions. The long-term goal is to develop a more efficient and robust program of data collection about behavioral health services that can be used to evaluate the impact of the block grant program on prevention and treatment services performance and to inform behavioral health services research and policy. This will include some level of direct reporting on client-level data from states on unique prevention and treatment services purchased under the MHBG and SABG and how these services contribute to overall outcomes. It should be noted that SAMHSA itself does not intend to collect or maintain any personal identifying information on individuals served with block grant funding.

This effort will also include some facility-level data collection to understand the overall financing and service delivery process on client-level and systems-level outcomes as individuals receiving services become eligible for services that are covered under fee-for-service or capitation systems, which results in encounter reporting. SAMHSA will continue to work with its partners to look at current facility collection efforts and explore innovative strategies, including survey methods, to gather facility and client level data.

The initial draft set of measures developed for the block grant programs can be found at **http://www.samhsa.gov/data/quality-metrics/block-grant-measures**. These measures are being discussed with states and other stakeholders. To help SAMHSA determine how best to move forward with our partners, each state must identify its current and future capacity to report these measures or measures like them, types of adjustments to current and future state-level data collection efforts necessary to submit the new streamlined performance measures, technical assistance needed to make those adjustments, and perceived or actual barriers to such data collection and reporting.

The key to SAMHSA's success in accomplishing tasks associated with data collection for the block grant will be the collaboration with SAMHSA's centers and offices, the National Association of State Mental Health Program Directors (NASMHPD), the National Association of State Alcohol Drug Abuse Directors (NASADAD), and other state and community partners. SAMHSA recognizes the significant implications of this undertaking for states and for local service providers, and anticipates that the development and implementation process will take several years and will evolve over time.

For the FY 2016-2017 Block Grant Application reporting, achieving these goals will result in a more coordinated behavioral health data collection program that complements other existing systems (e.g., Medicaid administrative and billing data systems; and state mental health and substance abuse data systems), ensures consistency in the use of measures that are aligned across various agencies and reporting systems, and provides a more complete understanding of the delivery of mental health and substance abuse services. Both goals can only be achieved through continuous collaboration with and feedback from SAMHSA's state, provider, and practitioner partners.

SAMHSA anticipates this movement is consistent with the current state authorities' movement toward system integration and will minimize challenges associated with changing operational logistics of data collection and reporting. SAMHSA understands modifications to data collection systems may be necessary to achieve these goals and will work with the states to minimize the impact of these changes.

States must answer the questions below to help assess readiness for CLD collection described above:

1. Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).

2. Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare,

etc.).

3. Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client-identifying information)?

4. If not, what changes will the state need to make to be able to collect and report on these measures?
   Please indicate areas of technical assistance needed related to this section.

Footnotes:

The Single State Authority on Substance Abuse (SSA)

Quality and Data Collection Readiness

1. Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).

The SSA has several key information systems, described below, that provide information on a variety of levels. Depending on the system, information is able to be reported at the client, program, provider, and encounter level. Information systems exist for treatment, prevention, fiscal/contract management, billing, staff licensure and other specialty programs.

New Jersey Substance Abuse Monitoring System (NJSAMS)

The client level data system, known as the New Jersey Substance Abuse Monitoring System (NJSAMS) was developed and implemented in 2005 by the SSA to be a real-time, web-based substance abuse treatment data collection and reporting system. The system is required to be used by all licensed substance abuse treatment providers in New Jersey, regardless of whether or not they contract with the SSA. It collects basic demographic, substance use, financial, clinical and service information on all clients enrolled and served in New Jersey's substance use disorder treatment system. Encounter data are collected and reported for services that may have different payers. The system consists of numerous modules and contains all the clinical assessments providers are required to complete. There are 288 licensed providers reporting on NJSAMS, representing 439 sites with 2884 active users. There are also 190 Intoxicated Driver Resource Center (IDRC) affiliated providers representing 237 sites and 75 active users. In 2018 there were 89,629 admissions to treatment.

NJSAMS was developed over time under the initial auspices of the Center for Substance Abuse Treatment (CSAT). The purpose was to develop the state's capacity to use web-based information technology for the collection and reporting of data necessary to meet Federal Performance Partnership Grant (PPG) and Government Reporting and Results Act (GPRA) reporting requirements. NJSAMS was developed in response to the need for: timelier reporting on substance use disorder treatment episodes, better monitoring of client outcomes, quality improvement, better client placement, and tracking of treatment through the continuum of care. The NJSAMS website is hosted by the Rutgers University Computer Center under a Memorandum of Agreement with the SSA. It is a secure web-based system designed to collect confidential health information and is HIPAA and 42CFR compliant.

A major IT accomplishment was the complete re-architecture of NJSAMS, which was originally written in classic ASP and included numerous webpages making data entry slow. Work began on this project in September 2011 and the new system was successfully launched mid-November 2013. NJSAMS was programmed in-house. The NJSAMS includes the latest Addiction Severity Index V.5, the Level of Care Index (LOCI-3), DSM-5, as well as additional modules that can collect further information on client care and needs. The system is capable of producing the

CSAT National Outcome Measures (NOMs) and generates the data needed for Provider Performance Reports. Data from NJSAMS are used to fulfill Block Grant reporting requirements and are also submitted quarterly to the Treatment Episode Data System (TEDS). The system contains nearly 1000 data elements and over 1 million records, dating back to 2006.

The new system is based on Object Oriented Programming (OOP) specifications, used Microsoft best practices, programmed in C#, developed in a .NET framework and runs on SQL server 2012. A tiered programming design was 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 have been added to reflect current system issues, e.g., chronic disease, Narcan reversals, etc., while old ones were retired. This new system is scalable, i.e., able to handle a growing amount of work in a capable manner, streamlined and fast. The new NJSAMS was migrated to a new faster web server, with additional RAM added. There was a dramatic improvement in performance and less maintenance is now required due to the new design. It is a relational database that has been normalized with no redundancy in data entry. NJSAMS provides encryption both in transit and at rest. 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.

The system continues with new releases as additional functionality is added. In 2015 the system was modified for utilization by the Interim Management Entity (IME).

Fiscal Intermediary MIS

A Fiscal Agent Billing system contract was awarded to the Computer Sciences Corporation (CSC) through an open competitive bid. This system went live July 1, 2010. The CSC system is a web-based billing system for all of the SSA's fee-for-service (FFS) initiatives: Drug Court, Mutual Agreement Program - State Parole Board (MAP-SPB), South Jersey Initiative (SJI), Medication Assisted Treatment Initiative (MATI), Driving Under the Influence Initiative (DUII), New Jersey Statewide Initiative (NJSI), Substance Abuse Prevention & Treatment (SAPT), State Hospital Access to Rehabilitation and Education (SHARE) and State Targeted Opioid Response Initiative (STORI) and the Co-Occurring Network. The amount of funding dedicated to these initiatives was approximately $72 million for FY 2019 and $71 million is available for FY 2020. Many of these initiatives require the provider to first obtain prior authorization from the Interim Managing Entity (IME) in order to provide treatment services other than outpatient, and then submit a request via a web service to CSC for authorization approval. Providers then submit their claims through the CSC system for payment. CSC confirms all information prior to paying any bill and verifies all requests for services through the NJSAMS Prior-Authorization Module. CSC reimburses and/or notifies the agency of claim status within 10 working days of receipt of the bill for all clients. Detailed service data are input which includes the CPT code. In CY 2018, there were 22,393 FFS admissions out of 89,629 total admissions.

CSC and the SSA have developed an automated interface with NJSAMS to link services data reported in NJSAMS which correspond to the claim for payment. Approximately 1 million claims are processed each year. All the CSC billing data tables, approximately 76, are transferred to NJSAMS on a nightly basis to the SSA's server. This allows the SSA capability to analyze

detailed encounter data. The information is easily linked to NJSAMS data so service utilization patterns can be analyzed by client characteristics and levels of care. This link includes service provider fields, services paid elements (service code, units, dates of service, amount, etc.) and client identifier elements.

Prevention Outcomes Management System (POMS)

The web-based Prevention Outcomes Management System (POMS) collects process data on evidence-based substance abuse prevention services that are delivered in New Jersey. This system went live in August 2009 and has been enhanced since that time. All New Jersey substance abuse prevention providers that receive SSA contracts are required to use the system for data reporting. POMS includes two modules that collect county-based prevention coalition and education data. The system supports download of 1-6 reports per module, and has 113 password-registered agency users (representing 25 agencies and 88 grants), 5 administrators, and 2 system administrators.

Contracted agency users report data into POMS via: (1) Environmental Module, and (2) Curriculum-based Module. The Environmental Module, deployed in March 2016, includes 10 items. It collects priority-specific data on implementation of CSAP strategies and engagement with community sectors. It also measures progress on: (1) the use of environmental strategies, (2) the development and enforcement of policies (and laws/ordinances) to: (a) Reduce Underage Drinking, (b) Reduce use of Illegal Substances, (c) Reduce Prescription Misuse Across the Lifespan, and (d) Reduce use of New and Emerging Drugs. The Environmental Module also collects data on media campaigns, public service announcements, and information that is shared with lawmakers, schools, and businesses. Quarterly reports for the Environmental Module include summary data for each item of the questionnaire. These reports are used for program monitoring and evaluation.

The POMS Curriculum-based module, updated and re-deployed in February 2018, collects priority-specific and summary demographic data for individuals that are served by evidence-based prevention education programs. It allows users to track participant attendance, retention, and program completion levels. Curriculum-based data entry includes: (1) type of service, (2) target audience, (3) priority, (4) curriculum/program name, (5) county of service, (6) date of service, (7) number of individuals/families in attendance, and (8) applicable CSAP strategy. Curriculum-based reports include participant demographic data by county, priority, strategy, and curriculum. These reports are used for program monitoring.

Contract Information Management System (CIMS)

The Contract Information Management System (CIMS) is a web-based, paperless contract processing system that substance use disorder treatment and prevention providers use to submit their contract actions. CIMS went live July 1, 2010 for renewal contracts which included the electronic submission of the Annex B (budget). On January 1, 2011 the system went live for the Annex A and Programmatic Requirements.

The four main areas CIMS was designed to address are:

- ensure compliance with 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.

Clinician Roster Information System (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.

The CRIS is used by the Addictions Contract Monitoring Unit to ensure that the appropriate credentialing ratios are being met per Division of Mental Health and Addiction Services (DMHAS) licensing regulations for substance use disorder treatment agencies. Agencies enter staff data into CRIS, review and update each quarter and certify that data was reviewed. The CRIS system also facilitates reporting on system –wide adherence to licensure requirements. If these steps are not being taken, this will result in a citation from DMHAS. The system will also begin to be utilized more strategically by the DMHAS Workforce Coordinator to help better identify workforce training needs.

Performance Incentive Payment System (PIPS)

Incentivizing provider performance or paying for performance (P4P) is an approach being explored to achieve better health and or behavioral health outcomes for clients. PIPS is a new system designed to track the attainment of key outcomes for participants in the Prison Intensive Recovery Treatment and Support Program (PIRTS). Eligible Offenders being released from Department of Corrections (DOC) custody who are receiving FDA approved medication assisted treatment (MAT) for an opioid use disorder (OUD) and will continue to receive MAT after their release from prison, and those Eligible Offenders who choose not to receive medication assisted treatment while incarcerated, are participants in the PIRTS program. The overall goal of PIRTS is to help individuals with an OUD who are being released from prison access the Recovery Zone.

The outcome information is linked to client demographic, encounter, and clinical information so that factors that impact the attainment of outcomes can be determined. Performance-based incentives will be paid as follows:

- **Retention**. If client remains in treatment for 90 days, payment will be $200.
- **Relapse Prevention**. If client remains in the community for 5 months after completion of an episode of care, payment will be $300.
- **Recidivism.** If client remains in the community for 6 months after release from prison, payment will be $300.
- **Overdose Prevention**. If client does not experience an overdose for 6 months after admission to the PIRTS Program, payment will be $500.
- **Stable Housing**. If a client is placed by PIRTS and remains in housing for 6 months payment will be $300.
- **Employment.** If a client is placed by PIRTS in employment and remains for 6 months, payment will be $300.

In order to assess whether clients remain in treatment for 90 days, client data from PIPS can be matched with client data in NJSAMS to determine what level of care the client is in and how long they remained in treatment.

Maternal Wrap Around System (MWRAPS)

The Maternal Wrap Around System (MWRAPS) is a new system that has been developed to capture information and outcomes on women who are participating in the MWRAP program. The data system will also be adapted to accommodate information on the women participating in our Integrated Opioid Treatment- Substance Exposed Infants (IOT-SEI) program. The system is capturing data on: basic demographic information, treatment and substance use information, and birth and child outcomes. Since the data are client level, various analyses can be conducted to determine what client characteristics are related to the various outcomes. It will help us understand the impact of both the MWRAP and IOT-SEI programs on outcomes for the mother and child and allow us to track and analyze changes over time on key variables (e.g., treatment engagement).

Opioid Overdose Recovery Program System (OORPS)

A data collection system has been designed to collect detailed information on clients who are brought to the emergency department after being reversed with naloxone and served by the Opioid Overdose Recovery Program (OORP). Detailed demographic and clinical information is collected on patients, as well as the follow-up provided by the Recovery Specialists and Patient Navigators, and the outcome of the visit.

2. Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.)

The DMHAS IT systems are segregated, i.e., specific for reporting substance abuse and mental health services data for clients, as well as for programs and fiscal information. The majority of the Division's data collection systems are customized to serve the unique client, and administrative needs of the SSA. The SSA data systems are all within DMHAS and not part of a

larger system. Clients provided with substance use disorder (SUD) services are documented within the data systems of the SSA (e.g., NJSAMS, CSC Fiscal Intermediary System). There are new systems developed for collecting data on the SSA's specialty programs for individuals released from prison, reversed from overdoses and pregnant women. These systems include the capability to monitor outcomes throughout the course of the episode, and not just at admission and discharge.

There are several extra-Divisional datasets that contain information on the SUD population which is collected at the Department level (e.g., the Department of Human Services' *Unusual Incident Management and Reporting System* [UIRMS]), and inter-divisional level by the Division of Medical Assistance and Health Services' *NJ Medicaid Management Information System* (NJMMIS). Children's data are reported separately by the NJ Department of Children and Families, which is autonomous and administratively separate from the SSA and the NJ Department of Human Services.

3. Is the state currently able to collect and report on measures at the individual client level (that is, by client served, but not with client-identifying information)?

As a result of our IT systems, the SSA can report any of its data at the client level (demographic, clinical, financial, encounter, etc.). Currently it reports on all Treatment Episode Data System (TEDS) items, which includes the System Data Set (SDS), the Minimum Data Set (MDS) and the Supplemental Data Set (SuDS). The SSA has been reporting TEDS data through NJSAMS for many years. The Fiscal Agent system allows the SSA to determine costs for episodes of care and by specific services for each client.

Since we utilize algorithms to create client IDs, we are able to report on clients served without client-identifying information.

4. If not, what changes will the state need to make to be able to collect and report on these measures?

The SSA does not need to make any changes to collect and report client level data. With the total re-design of the SSA client level reporting system, which was released in November 2013, the system is scalable and additional items that may be needed in the future can be easily added. Most recently, new client eligibility criteria related to OUD were added as a result of the State Targeted Response (STR) grant DMHAS received from SAMHSA.

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Pregnant Women/Women with Dependent 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.

Objective:

Increase number of pregnant women or women with children entering substance abuse treatment.

Strategies to attain the objective:

• Annual provider meetings include licensed women's treatment providers who provide gender specific treatment and system partners. Attendees, the Division of Mental Health and Addiction Services (DMHAS) women's treatment coordinator, representatives from NJ Department of Children and Families (DCF), Division of Family Development (DFD), Work First New Jersey Substance Abuse Imitative (WFNJ-SAI) and other relevant stakeholders. Meeting address issues related to best practices such as retention, engagement, access and referrals, recovery supports, medication assisted treatment, systems collaboration, Substance Exposed Infants (SEI) and Neonatal Abstinence Syndrome (NAS) and training needs.

• Professional development – women's treatment provider contract requirements include service elements and language from the National Association of State Alcohol/Drug Abuse Directors (NASADAD) "Guidance to States: Treatment Standards for Women with Substance Use Disorders" document that emphasizes best practice. Contracted providers are required to address the full continuum of treatment services: family-centered treatment, evidence-based parenting programs, trauma-informed and trauma-responsive treatment using Seeking Safety, Strengthening Families, evidence-based parenting classes, recovery supports, etc. and assist women with housing supports by linking women to transitional, permanent and/or supportive or sober living homes such as an Oxford House. Contracted women's treatment providers new staff are required to 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" and document completion of tutorials in their employee personnel files.

• Plans of Safe Care - women's treatment provider contract language requires providers to develop Plans of Safe Care for pregnant and postpartum women. Plans of Safe Care will address the needs of the mother, infant and family to ensure coordination of, access to, and engagement in services. For a pregnant woman, the Plan shall be developed prior to the birth event whenever possible and in collaboration with treatment providers, health care providers, early childhood service providers, and other members of the multidisciplinary team as appropriate. Documentation of the Plan shall be included in the woman's file.

• In Depth Technical Assistance (IDTA). In 2014 as a SAMHSA Prescription Drug Abuse Policy Academy State, New Jersey applied for a unique technical assistance opportunity through the SAMHSA supported National Center on Substance Abuse and Child Welfare (NCSACW) to address the multi-faceted problems of Substance Exposed Infants (SEI) and Neonatal Abstinence Syndrome (NAS). New Jersey Department of Human Services (DHS)/DMHAS as the lead State agency partnered with DCF and Department of Health (DOH) and submitted a successful application for IDTA (no funding attached). The IDTA goal was to develop uniform policies/guidelines that address the entire spectrum of NAS and SEI from pre-pregnancy, prevention, early intervention, assessment and treatment, postpartum and early childhood. The IDTA provided technical assistance to New Jersey to strengthen collaboration and linkages across multiple systems such as addictions treatment, child welfare, and medical communities to improve services for pregnant women with opioid and other substance use disorders and outcomes for their babies. The New Jersey IDTA Core Team included over 60 individuals representing multiple State Departments and Divisions, community stakeholders, treatment providers, and the medical community.

The IDTA established three goals: (1) Increase perinatal SEI screening at multiple intervention points (Health system, substance use disorder (SUD)/ mental health (MH) system); (2) Leverage existing programs and policy mechanisms to collaboratively increase the rate at which women screening positive on the 4P's Plus get connected for a comprehensive assessment by establishing formal warm-handoffs and other safety net measures; (3) Leverage existing programs and policy mechanisms to collaboratively increase the rate at which women delivering SEIs and their babies and any other eligible children, receive early support services for which they are eligible.

Three workgroups convened: (1) Data Workgroup looked at statewide data systems (Medicaid ICD codes and DOH) that capture prenatal screening, linkage to treatment services, follow-up for parenting women, prevalence of NAS and associated costs. During the initiative, the team analyzed 2013 and 2014 Medicaid data to establish prevalence and costs of treatment NAS. (2) Prenatal Screening, Early Identification of Infants & Referral to Service Workgroup focused on how to increase connections to appropriate treatment and supportive services such as Central Intake and Perinatal Cooperatives, by mapping out current screening and referral practices across the state using Pregnancy Risk Assessment (PRA) data; New Jersey

implemented the 4Ps+ across the State and embedded the tool within the PRA. The workgroup found high utilization (over 80%) of 4Ps+ within doctors serving pregnant women on Medicaid. The mapping allowed the team to target low utilization areas to increase the prevalence of prenatal screening. (3) Labor, Delivery and Engagement (Infants) Workgroup developed a comprehensive survey with input from the medical community and perinatal cooperatives. The Hospital Birth Survey was disseminated statewide March 2017 to the labor and delivery hospitals. The survey sought to understand how pregnant women with SUD and substance-exposed infants are identified, treated, and triaged with partners at discharge, and if treatment for NAS was explored. The Hospital Birth Survey results was intended to guide Departments in establishing statewide guidelines for best practice; aid in the development of cross system models to ensure families get access to services; establish education needs on issues of SEI/NAS and identify high risk areas. The IDTA commenced in 2017, however DMHAS as the IDTA lead state agency, requested modified technical assistance from the NCSACW to support New Jersey to interpret the key findings from the Birthing Hospital Survey, and apply these findings to the Project ECHO program design.

In late Fall of 2018, Robert Wood Johnson and the Nicholson Foundation, in partnership with the three Departments (Health, Human Services, and Children and Families) and other stakeholders began planning to launch Project ECHO (Extension for Community Outcomes) for SEIs. The New Jersey Project ECHO is aimed at Statewide adoption of best practice clinical care and community-based interventions to support SEIs and their parents to support recovery, family formation, and child development through a multidisciplinary case-based learning platform. Project ECHO for SEI and parents focuses on prevention, birth, and the infant's first year of life. DCF is the lead State agency on Plans of Safe Care for SEI, mothers and their families and has developed protocols for integrating Plans of Safe Care into child protection services and child welfare and child welfare assessments.

• Maternal Wrap Around Program (MWRAP) – MWRAP provides intensive case management and recovery support services for opioid dependent pregnant and postpartum women. Opioid dependent women are eligible for services during pregnancy and up to one year after the birth event. Intensive case management focuses on developing a single, coordinated care plan for pregnant/postpartum women, their infants and families. Intensive Case Managers work as liaisons to all relevant entities involved with each woman. The Recovery Support Specialists provide non-clinical assistance and recovery supports while maintaining follow-up with the women and their infants.

The MWRAP goal is to alleviate barriers to services for pregnant opioid dependent women through comprehensive care coordination that is implemented within the five major timeframes when intervention in the life of the substance exposed infants (SEI) can reduce potential harm of prenatal substance exposure: pre-pregnancy, prenatal, birth, neonatal and early childhood. MWRAP is intended to promote maternal health, improve birth outcomes, and reduce the risks and adverse consequences of prenatal substance exposure. MWRAP is a statewide program located in seven regions with each region serving approximately 30 unduplicated opioid dependent pregnant women, their infants and families.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Increase the number of pregnant women or women with children entering substance abuse treatment.
Baseline Measurement:	SFY 2019: 32,276 admissions count
First-year target/outcome measurement:	Increase number of pregnant women or women with children entering substance abuse treatment in SFY 2020 by 1%.
Second-year target/outcome measurement:	Increase number of pregnant women or women with children entering substance abuse treatment by 2% by the end of SFY 2021. The change in SFY 2021 will be measured by calculating the percent difference from SFY 2019 to SFY 2021.

Data Source:

The number of pregnant women and women with children from SFY 2019 – 2021 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: Persons Who Inject Drugs

Priority Type: SAT

Population(s): PWID

Goal of the priority area:

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

Objective:

Increase the number of PWID entering treatment and number of heroin and other opiate dependent individuals entering treatment.

Strategies to attain the objective:

• Referral to substance use disorder (SUD) treatment from statewide Harm Reduction Centers (HRCs) that are operational throughout New Jersey.
• Providing services in convenient locations, specifically utilizing mobile medication units, in order to reduce barriers and engage individuals in care as easily as possible.
• Promoting the use of medication assisted treatment (MAT) (e.g., methadone, buprenorphine, injectable naltrexone) for individuals with an opioid use disorder (OUD).
• Educating providers, individuals with an OUD, family members and the public about the benefits of MAT through a planned statewide public awareness campaign as well as public presentations on this topic.
• Contracts to three regional providers to provide community education and trainings for individuals at risk for an OUD, their families, friends and loved ones to recognize an opioid overdose and to subsequently provide naloxone kits to individuals in attendance.
• Increase the number of naloxone trainings specifically for underserved populations, such as schools, jails, licensed SUD treatment providers, Offices of Emergency Management, Emergency Medical Services teams, fire departments, homeless shelters and community health clinics.
• Contracts awarded to implement an opioid overdose recovery program with recovery specialists and patient navigators in all 21 counties for individuals who present in emergency departments following an opioid overdose reversal with naloxone in order to link them to treatment or other recovery support services in their communities.
• Contracts awarded to 11 providers for the Support Team for Addiction Recovery (STAR) program to provide case management and wraparound services for individuals with an OUD. Goals include linking clients to needed services, housing, primary care and treatment including MAT.
• Maternal Wraparound Program (M-WRAP) provides intensive case management and recovery support services for opioid dependent pregnant and postpartum women. Opioid dependent pregnant women are eligible for M-WRAP services during pregnancy and up to one year after birth event. Intensive case management focuses on developing a single, coordinated care plan for pregnant/postpartum women, their infants and families. Intensive Case Managers provide care coordination and warm hand-offs to appropriate service providers when necessary. Recovery Support Specialists provide non-clinical assistance and recovery supports while maintaining follow-up with the women and their infants. The M-WRAP program covers all 21 counties of NJ and alleviates barriers through comprehensive care coordination using a multi-system approach with the goal to improve outcomes for pregnant/postpartum opioid dependent women and their children.
• In September 2016, DMHAS was awarded a five-year grant to "Prevent Prescription Drug/Opioid Overdose-Related Deaths (PDO)" from SAMHSA to implement the Opioid Overdose Prevention Network (OOPN) initiative which entails the development and implementation of a comprehensive prescription drug/ opioid overdose prevention program which includes Naloxone training and distribution. Plans are to train 3,000 individuals and distribute 2,500 naloxone kits annually.
• In September 2016, DMHAS was awarded a "Strategic Prevention Framework for Prescription Drugs (SFP Rx)" five-year grant from SAMHSA to implement the NJAssessRx initiative. NJAssessRx expands interagency sharing of the state's Prescription Drug Monitoring Program data and gives DMHAS the capability to use data analytics to identify prescribers, prescriber groups and patients at high risk for inappropriate prescribing and nonmedical use of opioid drugs. Informed by the data, DMHAS and its prevention partners will strategically target communities and populations needing services, education or other interventions. The target population is youth (ages 12-17) and adults (18 years of age and older) who are being prescribed opioid pain medications, controlled drugs, or human growth hormone (HGH), and are at risk for their nonmedical use.
• In May 2017, SAMHSA awarded $12,9995,621 through the State Targeted Response (STR) to New Jersey annually for two years. The program aims to address the opioid crisis by increasing access to treatment, reduce unmet treatment need and reduce opioid overdose related deaths through the provision of prevention, treatment and recovery activities for OUD. A major activity of the grant is to implement and expand access to clinically appropriate evidence-based practices (EBPs) for OUD treatment, particularly, the use of MAT. To address these objectives, a new State Targeted Opioid Response Initiative (STORI) fee-for-service (FFS) treatment initiative was developed within the existing addiction fee for service treatment network, which provides access to treatment for under-insured and uninsured clients. It includes a wide range of services, specifically including MAT. DMHAS was awarded a no-cost extension for the STR grant to continue funding the STORI FFS treatment for part of SFY 2020.
• In September 2018, SAMHSA awarded $21.5 million through the State Opioid Response (SOR) to New Jersey annually for two years to continue to address the opioid crisis. The key objectives of the SOR grant are to increase access to MAT, reduce unmet treatment need and reduce opioid related deaths.
• In March 2019, DMHAS received notification from SAMHSA that its plan for an additional $11.2 million was approved through the SOR Grant for the period through FFY 2020. DMHAS submitted a plan proposing to use the SOR supplemental award to fund additional treatment, recovery support, prevention and education/training efforts to address the opioid epidemic.
• As part of SOR funding, the Low Threshold Buprenorphine Induction program (Low Threshold) is designed to make Buprenorphine treatment easily accessible to individuals who access syringes at Harm Reduction Centers (HRCs) located at South Jersey AIDS Alliance (SJAA) in Atlantic City and the Visiting Nurse Association (VNA) of Central Jersey in Asbury Park. Through the Low Threshold program, individuals will be offered same day, immediate enrollment in Buprenorphine treatment and care management services. The program will offer services to individuals who seek this type of service in a

safe and nonjudgmental environment, despite continued drug use or lapses in care.
• As part of SOR and state funding, DMHAS is collaborating with NJ's 21 counties to establish MAT programs or enhance existing MAT services for inmates with OUD at county correctional facilities. In addition, DMHAS is working with county correctional facilities to establish justice involved re-entry services for detainees where case managers at county jails will conduct intake assessments and establish pre-release plans for needed services in the community.
• An attempt to increase access to MAT, specifically buprenorphine, has been the development of statewide buprenorphine training courses utilized as an educational component for physicians, Advanced Practical Nurses (APNs) and Physician Assistants (PAs) to attain their Buprenorphine Waiver. The State plans to hold a total of 16 trainings through both Rutgers University (northern region) and Rowan University (southern region) in CY 2019 in an effort to train over 1,000 prescribers in CY 2019.
• Interim Services have been a requirement of provider contracts, but a new initiative allows DMHAS to pay for these services through a fee-for-service (FFS) mechanism. The Interim Services initiative provides funding to agencies to support individuals awaiting admission to treatment following a SUD assessment. Interim Services are an engagement level of service intended to link individuals to services they may not be able to access due to lack of provider capacity. This service is designed to be provided by agencies contracted for any licensed ASAM level of care. Interim services will be made available to any individual eligible for treatment within the public system who cannot be admitted for the assessed level of care within 72 hours. Prior to this initiative agencies enrolled in the Block Grant initiatives were required to provide this service. Once launched in October 2019, funding for Interim Services will be open to all contracted FFS providers.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase the number of PWID entering treatment.

Baseline Measurement: SFY 2019: 29,053 admissions count

First-year target/outcome measurement: Increase the number of PWID entering treatment by 1%.

Second-year target/outcome measurement: Increase the number of PWID entering treatment by 2% by the end of SFY 2021. The change in SFY 2021 will be measured by calculating the percent difference from SFY 2019 to SFY 2021.

Data Source:

The number of PWID in SFY 2019 through SFY 2021 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.

Indicator #: 2

Indicator: Increase the number of heroin and other opiate dependent individuals entering treatment.

Baseline Measurement: SFY 2019: 47,007 admissions count

First-year target/outcome measurement: Increase the number of heroin and other opiate dependent individuals entering treatment by 1%.

Second-year target/outcome measurement: Increase number of opiate dependent individuals entering treatment by 2% by the end of SFY 2021. The change in SFY 2021 will be measured by calculating the percent difference from SFY 2019 to SFY 2021.

Data Source:

The number of opiate dependent individuals in SFY 2019 and SFY 2021 will be tracked by the SSA's New Jersey Substance Abuse Monitoring System (NJSAMS).

Description of Data:

All agencies licensed to provide substance abuse treatment in New Jersey must report on NJSAMS, the SSA's real-time web-based client

administrative data system. The system collects basic client demographic, financial, level of care and clinical information for every client. All national outcome measures (NOMS) are incorporated into the system. Outcome measures are linked to the client at admission and discharge.

Data issues/caveats that affect outcome measures::

Outcome measures are collected at a client's admission and discharge per the approach used with TEDS and not at different periods of time during the course of treatment.

Priority #: 3

Priority Area: Heroin/Opioid Users

Priority Type: SAT

Population(s): Other (Heroin/Opioid Users)

Goal of the priority area:

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

Objective:

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

Strategies to attain the objective:

• Utilize a public awareness campaign focusing on reducing stigma/discrimination regarding MAT to assist in engaging individuals with an OUD, their families, friends, loved ones, providers and other community members so that they understand the use of MAT is a best practice in the treatment of an OUD.
• Buprenorphine Medical Support- This new initiative will focus on the challenges faced by licensed ambulatory SUD programs that require start-up funds to increase their capacity to offer MAT, specifically buprenorphine to their clients. Ambulatory SUD treatment programs will be expected to build capacity to offer MAT in compliance with all federal and New Jersey state regulations. Agencies will be required to receive referrals from other programs that offer MAT where clients stabilized on MAT.
• DMHAS will continue its Vivitrol Enhancement through its Fee-for-Service (FFS) Network. This enhancement allows providers to be reimbursed for the provision of Vivitrol as well as other ancillary services in FFS initiatives. Licensed SUD agencies can apply for the enhancement by submitting applications to DMHAS and are reviewed for approval on a quarterly basis.
• DMHAS is collaborating with NJ's 21 counties to establish MAT programs or enhance existing MAT services for inmates with OUD at county correctional facilities. In addition, DMHAS is working with county correctional facilities to establish justice involved re-entry services for detainees where case managers at county jails will conduct intake assessments and establish pre-release plans for needed services in the community, which include linking individuals to community MAT services.
• DMHAS will continue to distribute American Society of Addiction Medicine (ASAM) booklets entitled "Opioid Addiction Treatment: A Guide for Patients, Families and Friends" which provide facts about treatment, including MAT as a best practice, and provides NJ-specific resources to accessing treatment and recovery services.
• DMHAS has a Memorandum of Agreement (MOA) with Rutgers University, Robert Wood Johnson Medical School to develop a train-the-trainer program on MAT, the opioid epidemic (specific to New Jersey) and concepts of SUD (specific to OUD) for a minimum of 40 graduate students at Rutgers University. The goal of this project is to educate, support, and mentor graduate students to give free educational talks, through use of PowerPoint presentations, to the community.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase the number of heroin/other opiate admissions for whom MAT was planned.

Baseline Measurement: SFY 2019: 20,887 heroin/other opiate admissions for whom MAT was planned.

First-year target/outcome measurement: Increase the number of heroin/other opiate admissions for whom MAT is planned by 1%

Second-year target/outcome measurement: Increase the number of heroin/other opiate admissions for whom MAT is planned by 2%. The change in SFY 2021 will be measured by calculating the percent difference from SFY 2019 to SFY 2021.

Data Source:

The number of heroin/other opiate admissions for whom MAT was planned from SFY 2019 - 2021 will be tracked by the SSA's New Jersey Substance Abuse Monitoring System (NJSAMS).

Description of Data:

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

Data issues/caveats that affect outcome measures::

None

Priority #: 4

Priority Area: Tobacco

Priority Type: SAP

Population(s): PP, Other (Persons aged 12 – 17)

Goal of the priority area:

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

Objective:

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

Strategies to attain the objective:

Beginning in January 2012, DMHAS funded 17 Regional Prevention Coalitions, all of whom utilize the SPF model to guide their work. These coalitions are all required to address tobacco use among youth. The coalitions use, primarily, environmental strategies along with occasional individual approaches as appropriate. Below is a listing of approaches used by the coalitions to address tobacco use among adolescents in their regions.

Environmental Strategies
• Enhance Access/Reduce Barriers – Enhance access to effective prevention strategies and information through the use of a social media campaign and the development of human capital and networks of support.
• Enhance Barriers/Reduce Access - Increase education among merchants who sell tobacco products.
• Enhance Barriers/Reduce Access – Work with municipal and county government to ban smoking from restaurants and other public places, including schools, workplaces, and hospitals.
• Change Consequences/Enhance Access/Reduce Barriers – Work with municipal and county government to assure that tobacco laws are enforced at the local level.
• Change Physical Design – Through the compliance check report and GIS mapping, provide municipalities and state tobacco control with details regarding how outlet density and location impact tobacco availability to youth.
• Modify/Change Policies – Enhance or create policies related to smoking among 12-17 years olds on a countywide level.

Individual Strategies
• Provide information – Educate parents and youth on the dangers of tobacco use by youth through awareness efforts, workshops, and countywide events. These programs will be provided through county alcohol and drug funding, municipal alliances, and other community organizations.
• Provide Information – Educate youth on the dangers of tobacco use through by means of evidence-based middle and elementary school prevention programs and other community-based initiatives.

Legislation
• The State of New Jersey enacted a statute to raise the age to sell tobacco products from persons 19 years of age to 21 years of age effective November 1, 2017 (P.L.2017, Chapter 118).

Additionally, DMHAS funds community-based services targeting high-risk individuals or groups in each of New Jersey's 21 counties. Many of these providers are also focused on the prevention of tobacco use among youth.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Past month tobacco product use (any) among persons aged 12 to 17.

Baseline Measurement: According to 2016-2017 NSDUH data, 4.14 percent of the target population reported

tobacco product use (any) during the month prior to participating in the survey.

First-year target/outcome measurement: A reduction of .50% below the baseline measure.

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

Data Source:

National Survey on Drug Use and Health: Model-Based Prevalence Estimates (50 States and the District of Columbia), Tobacco Product Use in the Past Month, by Age Group and State: Percentages, Annual Averages Based on 2016 and 2017 NSDUH – data for New Jersey

Description of Data:

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

Data issues/caveats that affect outcome measures::

None

Priority #: 5

Priority Area: Alcohol

Priority Type: SAP

Population(s): PP, Other (Persons aged 12-17)

Goal of the priority area:

Reduce the percentage of persons aged 12 – 17 who report binge drinking in the past month

Objective:

Decreased past month of binge drinking among persons aged 12 to 17

Strategies to attain the objective:

Beginning in January 2012, DMHAS funded 17 Regional Prevention Coalitions, all of whom utilize the SPF model to guide their work. These coalitions are all required to address underage drinking among youth. The coalitions use, primarily, environmental strategies along with occasional individual approaches as appropriate. Below is a listing of approaches used by the coalitions to address underage drinking among adolescents in their regions.

Environmental Strategies
• Enhance Access/Reduce Barriers – Enhance access to effective prevention strategies and information through the use of a social media campaign and the development of human capital and networks of support.
• Enhance Barriers/Reduce Access - Increase education among merchants, bars, and restaurants who sell alcoholic beverages. Also, provide education to parents and guardians.
• Change Consequences/Enhance Access/Reduce Barriers – Work with municipal and county government to assure that underage drinking laws are enforced at the local level.
• Change Physical Design – Through the compliance check report and GIS mapping, provide municipalities and state Alcoholic Beverage Commission with details regarding how outlet density and location impact tobacco availability to youth.
• Modify/Change Policies – Enhance or create policies related to underage drinking among 12-17 years olds on a countywide level.

Individual Strategies
• Provide information – Educate parents and youth on the dangers of underage drinking by youth through awareness efforts, workshops, and countywide events. These programs will be provided through county alcohol and drug funding, municipal alliances, and other community organizations.
• Provide Information – Educate youth on the dangers of underage drinking by means of evidence-based middle and elementary school prevention programs and other community-based initiatives.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Binge Alcohol Use in the Past Month by persons aged 12-17.

Baseline Measurement: According to 2016-2017 NSDUH data, 5.48 percent of the target population reported binge drinking during the month prior to participating in the survey.

First-year target/outcome measurement: A reduction of .20% below the baseline measure.

Second-year target/outcome measurement: An additional reduction of .20% below the baseline measure.

Data Source:

Binge Alcohol Use in the Past Month, by Age Group and State: Percentages, Annual Averages Based on 2016 and 2017 NSDUH – data for New Jersey

Description of Data:

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

Data issues/caveats that affect outcome measures::

None

Priority #: 6

Priority Area: Marijuana

Priority Type: SAP

Population(s): PP, Other (Persons aged 12-17)

Goal of the priority area:

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

Objective:

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

Strategies to attain the objective:

Beginning in January 2012, DMHAS funded 17 Regional Prevention Coalitions, all of whom utilize the SPF model to guide their work. These coalitions are all required to address marijuana use among youth. The coalitions use, primarily, environmental strategies along with occasional individual approaches as appropriate. Below is a listing of approaches used by the coalitions to address marijuana use among adolescents in their regions.

Environmental Strategies
• Enhance Access/Reduce Barriers – Enhance access to effective prevention strategies and information through the use of a social media campaign and the development of human capital and networks of support.
• Change Consequences/Enhance Access/Reduce Barriers – Work with municipal and county government to assure that marijuana use and possession laws are enforced at the local level.
• Modify/Change Policies – Enhance or create policies, laws, and ordinances related to marijuana use among 12-17 years olds on a countywide level.

Individual Strategies
• Provide information – Educate parents and youth on the dangers of marijuana use by youth through awareness efforts, workshops, and countywide events. These programs will be provided through county alcohol and drug funding, municipal alliances, and other community organizations.
• Provide Information – Educate youth on the dangers of marijuana use by means of evidence-based middle and elementary school prevention programs and other community-based initiatives.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Marijuana Use in the Past Year by persons aged 12-17.

Baseline Measurement: According to 2016-2017 NSDUH data, 10.28 percent of the target population reported marijuana use during the year prior to participating in the survey.

First-year target/outcome measurement: A reduction of .10% below the baseline measure.

Second-year target/outcome measurement: An additional reduction of .10% below the baseline measure.

Data Source:

Marijuana Use in the Past Year, by Age Group and State: Percentages, Annual Averages Based on 2016 and 2017 NSDUH – data for New Jersey

Description of Data:

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

Data issues/caveats that affect outcome measures::

None

Priority #: 7

Priority Area: Prescription Drugs

Priority Type: SAP

Population(s): PP, Other (All residents in New Jersey)

Goal of the priority area:

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

Objective:

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

Strategies to attain the objective:

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

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Opioid Dispensations in New Jersey.

Baseline Measurement: According to data from NJ CARES – A Realtime Dashboard of Opioid-Related Data and Information (maintained by the Office of the New Jersey Attorney General), in 2018, 4,266,645 prescriptions for opioids were provided in New Jersey.

First-year target/outcome measurement: A reduction of 1% below the baseline measure.

Second-year target/outcome measurement: An additional reduction of .50% below the baseline measure.

Data Source:

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

Description of Data:

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

Data issues/caveats that affect outcome measures::

None

Priority #: 8

Priority Area: Heroin

Priority Type: SAP

Population(s): PP, Other (Persons aged 12-17)

Goal of the priority area:

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

Objective:

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

Strategies to attain the objective:

Beginning in January 2012, DMHAS funded 17 Regional Prevention Coalitions, all of whom utilize the SPF model to guide their work. These coalitions are all required to address the use of illegal substances (including heroin) among youth. The coalitions use, primarily, environmental strategies along with occasional individual approaches as appropriate. Below is a listing of approaches used by the coalitions to address perceptions of risk regarding heroin use among adolescents in their regions.

Environmental Strategies
• Enhance Access/Reduce Barriers – Enhance access to effective prevention strategies and information through the use of a social media campaign and the development of human capital and networks of support.
• Change Consequences/Enhance Access/Reduce Barriers – Work with municipal and county government to assure that laws regarding the use of illegal substance (including heroin) are enforced at the local level.
• Modify/Change Policies – Enhance or create policies designed to increase perceptions of risk and harm related to the use of heroin among 12-17 years olds on a countywide level.

Individual Strategies
• Provide information – Educate parents and youth on the dangers of illegal substances (including heroin) by youth through awareness efforts, workshops, and countywide events. These programs will be provided through county alcohol and drug funding, municipal alliances, and other community organizations.
• Provide Information – Educate youth on the dangers of illegal substance and heroin use by means of evidence-based middle and elementary school prevention programs and other community-based initiatives.

Annual Performance Indicators to measure goal success

Indicator #: 1

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

Baseline Measurement: According to 2016-2017 NSDUH data, 68.23 percent of the target population reported Perceptions of Great Risk from Trying Heroin Once or Twice.

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

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

Data Source:

Perceptions of Great Risk from Trying Heroin Once or Twice, by Age Group and State: Percentages, Annual Averages Based on 2016 and 2017 NSDUH – data for New Jersey

Description of Data:

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

Data issues/caveats that affect outcome measures::

None

Priority #: 9

Priority Area: TB

Priority Type: SAT

Population(s): TB

Goal of the priority area:

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

Objective:

Increase the percentage of DMHAS' SAPT Block Grant contracted agencies offering every client a tuberculosis evaluation

Strategies to attain the objective:

• Notifications. All block grant recipients will be notified of the contractual and regulatory requirements to screen all clients for TB symptoms. Methods used will be a formal letter to all block grant recipients and an overview presented at the next quarterly Professional Advisory Committee (PAC) and other upcoming Division/agency meetings.
• Ongoing monitoring. Monitors will review compliance during the annual site visit, and require an acceptable plan of correction for non-compliance. If repeat deficiencies are found, an alternate plan of correction and proof of implementation will be required.

Annual Performance Indicators to measure goal success

Indicator #: 1

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

Baseline Measurement: According to SFY 2019 Annual Site Monitoring Reports of DMHAS' SAPT Block Grant contracted agencies, 75% of the agencies that were monitored (27 of 36 agencies) were in compliance with offering every client a tuberculosis evaluation.

First-year target/outcome measurement: An increase of 5% above the baseline measure.

Second-year target/outcome measurement: An additional increase of 5% above the baseline measure.

Data Source:

Annual Site Monitoring Reports of DMHAS' SAPT Block Grant Contracted Agencies

Description of Data:

The grants monitoring program at DMHAS monitor SAPT Block Grant recipients. Onsite visits are made to each SAPT Block Grant recipient a minimum of one time per calendar year. The reviewer conducts chart reviews for the selected sample and completes an Annual Site Monitoring Report. The Annual Site Monitoring Report addresses at a minimum five core areas of performance: Facility, Staff, Treatment Records, Quality Assurance, Specialized Services, and Other contract requirements.

Data issues/caveats that affect outcome measures::

None

Priority #: 10

Priority Area: In coordination with New Jersey's Aligning Early Childhood with Medicaid (AECM) technical assistance project, DCF/ Children's System of Care (CSOC) will develop and implement screening, identification, and intervention among at risk children age 0-3

Priority Type: MHS

Population(s): SED

Goal of the priority area:

NJ Children's System of Care (CSOC) will collaborate with system partners to develop and implement screening, identification, and intervention among at risk children age 0-3.

Objective:

CSOC will develop a completed plan for screening, care coordination, and development of infant mental health service capacity for at risk children age 0-3.

Strategies to attain the objective:

New Jersey has joined Aligning Early Childhood and Medicaid, a multi-state initiative aimed at improving the health and social outcomes of low-income infants, young children, and families through cross-agency collaboration. This national program is led by the Center for Health Care Strategies (CHCS) in partnership with the National Association of Medicaid Directors and ZERO TO THREE. Through this 20-month initiative, participating states will:

1.Align state programs and investments between Medicaid and other early childhood systems to drive more strategic, evidence-based investments for infants and toddlers in low-income families; and
2.Demonstrate the value of early childhood cross-sector alignment for improving near- and long-term health and social outcomes.

NJ DCF/CSOC has identified the following goals:

1. Identify and adopt best practice standards to identify social-emotional, behavioral, and social determinant health risk in the pediatric medical home, including creating a plan to implement a strategy to increase capacity for stratified care coordination in the pediatric medical home to effect linkage to behavioral health and other services by January 2020.

2. Develop a written strategy, including programmatic recommendations and funding options to provide infant mental health services on a statewide basis by July 2020.

3. Drafting a State Plan Amendment expanding the use of care coordination and community health workers to ensure new mothers and their infants stay connected to physical and behavioral health care, and other health influencing benefits, such as food, housing and child care across the health care delivery system.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Completed plan for screening, care coordination, and development of infant mental health srvice capacity for at risk children age 0-3
Baseline Measurement:	To be determined after the first year of implementation of screening services to children age 0-3
First-year target/outcome measurement:	An increase in the percentage of children age 0-3 receiving screening srvices in SFY 2021. The percentage will be determined when the baseline measure is set.
Second-year target/outcome measurement:	An increase in the percentage of children age 0-3 receiving screening srvices in SFY 2022. The percentage will be determined when the baseline measure is set.

Data Source:

DCF will implement their anticipated project-related goals(s) and activities, and track progress over time.
PerformCare NJ - the CSOC Administrative Services Organization

Description of Data:

DCF self- assessment and written organizational plans.
The number of children age 0-3 receiving screening services during a specified state fiscal year.

Data issues/caveats that affect outcome measures::

The baseline measurement of will be determined after the first year of implementation of screening services to children age 0-3.

Priority #: 11

Priority Area: NJ Children's System of Care (CSOC) will continue to increase the integration of community-based physical and behavioral health services for children, youth and young adults with mental/behavioral health challenges and/or substance use challenges and chronic medical conditions

Priority Type: MHS

Population(s): SED

Goal of the priority area:

The New Jersey Children's System of Care (CSOC) will increase integration of community-based physical and behavioral health services for children, youth and young adults with mental/behavioral health challenges and/or substance us challenges and chronic medical conditions.

Objective:

1. Implement at least one expansion or enhancement of integrated health and behavioral health services.

2. Increase the number of children youth and young adults receiving integrated physical and behavioral health care services.

Strategies to attain the objective:

In order to further operationalize the DCF vision of ensuring New Jersey children and families are safe, healthy and connected, the Department of Children and Families has revised its Strategic Plan to best align the priorities of CSOC with the DCF vision and values. The Strategic Plan identifies promoting integrated health and behavioral health as a priority. Integrated care and wellness activities will be incorporated across the CSOC continuum by expanding existing integration models and exploring development of other primary health-behavioral health integration models.

Currently, NJ's Behavioral Health Homes (BHH) are operational in Bergen, Mercer, Cape/Atlantic, and Monmouth counties. Each BHH is a designated Care Management Organization (CMO) with enhanced care management teams that include medical expertise and health/wellness education for purposes of providing fully integrated and coordinated care for youth remaining in their home and who have chronic medical conditions. Each BHH employs Nurse Managers (1-40 ratio) and Health and Wellness coaches (1-65 ratio). Nurse Managers are required to hold a New Jersey Registered Nurse (RN) license or higher nursing credential. Health and Wellness Coaches are required to have a Bachelor's Degree and two years of experience in nutrition, health education or a related field.

BHH services are a "bridge" that connects prevention, primary care, and specialty care. Medical and wellness staff are integrated into the existing CMO Child Family Team (CFT) structure responsible for care coordination and comprehensive treatment planning for youth and their families which includes planning for the holistic needs of the youth. The CFT structure and approach (CMO, FSO, Family, Youth and other designated service providers and supports) enhanced with BHH RN, Health/Wellness Coach staffing plans for the holistic needs of a youth with both behavioral health and medical needs (inclusive of substance use and developmental and intellectual challenges). Nurse Manager and Health/Wellness staff communicate with youth's medical providers (primary care specialty providers, urgent or emergent medical care) and connect the medical domain and planning with the existing CFT process.

New Jersey is among the first states using Targeted Case Management (TCM) to deliver Behavioral Health Home services for youth only.

The structure of the CMO is a strategic fit for the health home program. The BHH Core Team builds on the current CMO array of staff with the intent to provide a holistic approach to care for children. This expanded team will constitute the services of the BHH and will broaden the current CMO care coordination and care management functions to include the ability to identify, screen and coordinate both primary care and specialty medical care.

During SFY 2018, 484 youth were enrolled in BHH services. To be eligible, youth must meet the criteria for CMO and have a qualifying medical condition which is inclusive of intellectual and developmental challenges as well as substance use.

Place background information on Certified Community Behavioral Health Clinics (CCBHCs) here. Include number of children served during SFY 2018

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Increased number of children, youth or young adults provided with integrated physical and behavioral health services.
Baseline Measurement:	In SFY 2019 CSOC proved Behavioral Health Home services to 503 youth.
First-year target/outcome measurement:	CSOC will increase the number of youth served by Behavioral Health Homes/other Integrated Care models by 5%. Target outcome measurement is 528 youth.
Second-year target/outcome measurement:	CSOC will increase the number of youth served by Behavioral Health Homes/other Integrated Care models by 5%. Target outcome measurement is 554 youth.

Data Source:

Performcare NJ - the NJ DCF/CSOC Administrative Services Organization

Description of Data:

Number of youth receiving Behavioral Health Home/integrated physical and behavioral health services in a specified state fiscal year.

Data issues/caveats that affect outcome measures::

None.

Priority #:	12
Priority Area:	NJ Children's System of Care (CSOC) will increase access to evidence-based services and supports across the CSOC service continuum
Priority Type:	MHS
Population(s):	SED

Goal of the priority area:

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

Objective:

Plan, implement, and evaluate at least 1 evidence-based program, the In-Home Recovery Program, to support youth and families with substance use disorders who are involved with the Department of Children and Families Division of Child Protection and Permanency. The In-Home Recovery Program is an innovative pilot program seeking to improve outcomes for parents who have a substance use disorder and are actively parenting a child under 36 months.

Strategies to attain the objective:

In order to further operationalize the DCF vision of ensuring New Jersey children and families are safe, healthy and connected, the Department of Children and Families has revised its Strategic Plan to best align the priorities of CSOC with the DCF vision and values. The Strategic Plan identifies building capacity to deliver evidence-based interventions and services as a priority. CSOC will support evidence-based practices in the continuum by increasing EBP capacity in both community-based and out of home services

The Nicholson Foundation, in partnership with New Jersey Department of Children and Families (NJDCF), issued a Request for Proposals (RFP) to solicit proposals for a family-based recovery program from New Jersey–based mental health and substance use disorder treatment providers serving adults, families, and/or young children.

The goals of the In-Home Recovery Program (the Program) are to improve outcomes for parents who have a substance use disorder and are actively parenting a child under 36 months old and to expand the service array for these families through implementation of a specific evidence-informed, in-home treatment program. Post-intervention changes on parental substance use and involvement with child protective services will be evaluated. The RFP process will result in one award for the implementation of two (2) Project sites within Ocean County, NJ managed by one agency. Each Project team will treat a caseload of twelve (12) families concurrently and serve a minimum of eighteen (18) families over the 18-month grant period, beginning on September 1, 2019, for a budget not to exceed $1,064,855.

An important objective of the Program is to demonstrate the effectiveness of a trauma informed in-home treatment for families involved with the NJDCF Division of Child Protection and Permanency (DCP&P) who have an index parent (client) with a substance use disorder and an index child (child) under the age of 36 months. Outcome measures will include parental substance use, child placement at discharge, and a client's repeat involvement with child protective services.

Key model components include toxicology testing (for clinical purposes only); positive reinforcement in the form of gift cards/vouchers for positive behavioral change (negative toxicology screen); collaboration with DCF regarding the clients progress, success, or any concerns about functioning; collaboration with MAT providers; outreach to support client's participation; utilization of standardized measures to inform and guide treatment, and identify and track symptoms over the course of the intervention; and tools for obtaining family history and the fit between the client and the clients family system.

Measures are divided into three domains: client, child, and parent-child relationship. Areas of focus in the three domains are as follows:
a. client: depression, anxiety, post-traumatic stress, and childhood trauma history;
b. child: development, resilience, behaviors, and trauma exposure; and
c. parent-child relationship: parenting stress, parental reflective capacity, attachment styles, and parenting attitudes.

The full text of the RFP is available here:
https://thenicholsonfoundation.org/news-and-resources/request-proposals-trauma-informed-recovery-program-ocean-county

Additionally,the following evidence based programs are currently provided by CSOC

Functional Family Therapy for Foster Care (FFT-FC)

CSOC in partnership with the Division of Child Protection and Permanency (DCP&P) and a local provider offer access to and service delivery of Functional Family Therapy – Foster Care (FFT-FC) through the CSOC Mobile Response and Stabilization Service and Intensive In-Community service lines. FFT is a relationally focused, trauma informed, evidence-based treatment model for youth in resource care that increases the likelihood of successful adjustment for youth in their resource placements as well as positive permanency outcomes. This treatment model is targeted toward youth aged 12-18 who are demonstrating behaviors that place them at risk of disruption in their resource care placement and are in the legal custody of the DCP&P and have the intellectual capacity to benefit from the treatment intervention. The model uses the relationally focused techniques of Functional Family Therapy (FFT) in a comprehensive and systemic approach adapted to helping youth and families involved with DCP&P to overcome individual and relational trauma to promote placement stability, increase youths' lifelong connections and improve youths' permanency outcomes.

Function Family Therapy (FFT) and Multi-Systemic Therapy (MST)

Beginning in 2008, through an RFP process DCF established providers of Multi-systemic Therapy (MST) and Functional Family Therapy (FFT) in New Jersey. MST and FFT have proven efficacy with youth involved in the juvenile justice system through dozens of empirically validated and peer-reviewed

studies. Too often, the child welfare system endeavors to serve these youth and families with inadequate resources and misdirected efforts. Consistent with the needs of many families served by the child welfare system, the challenges at hand are best served by intensive, "whatever it takes" treatment by well-trained and qualified professionals. As evidence-based practices, the licensing and program requirements for providers of MST and FFT, from start-up through on-going delivery of service, are stringent. The goal was to have national organizations ensure that local implementation maintains fidelity to the treatment model to ensure outcomes are consistent with other states. Awards were granted around June 2008. There are currently 5 CSOC-contracted agencies providing FFT/MST. During SFY XXXchildren, youth and young adult received FFT/MST services.

ARC-GROW Model
CSOC, through the Intensive In-Community (IIC) service line, in partnership with the Children's Center for Resilience and Trauma Recovery (CCRTR), and MRSS and CMO partners, offers access to and delivery of the ARC-GROW model. The ARC-GROW Model is an adaptation of the Attachment, Regulation, and Competency framework for intervention with youth and families who have experienced multiple and/or prolonged traumatic stress. The Attachment, Self-Regulation, and Competency (ARC) framework is a core-components treatment model, developed to provide a guiding framework for thoughtful clinical intervention with complexly traumatized youth from early childhood to adolescence and their caregiving systems. GROW is a caregiver skill building intervention designed to enhance resilient outcomes for families who are impacted by chronic adversity or stress (Kinniburgh et al. 2011). This parenting support program is delivered as a 12-session home visiting service by parent support workers or clinical staff providing safety and stabilization support. The home visiting hours include psychoeducation and skill practice in areas including, but not limited to, caregiver self-care, attunement to the developmental impact of trauma, supporting child/youth regulation, effective parenting practices and strategies for building daily routines.

Functional Family Therapy for Foster Care (FFT-FC)

CSOC in partnership with the Division of Child Protection and Permanency (DCP&P) and a local provider offer access to and service delivery of Functional Family Therapy – Foster Care (FFT-FC) through the CSOC Mobile Response and Stabilization Service and Intensive In-Community service lines. FFT is a relationally focused, trauma informed, evidence-based treatment model for youth in resource care that increases the likelihood of successful adjustment for youth in their resource placements as well as positive permanency outcomes. This treatment model is targeted toward youth aged 12-18 who are demonstrating behaviors that place them at risk of disruption in their resource care placement and are in the legal custody of the DCP&P and have the intellectual capacity to benefit from the treatment intervention. The model uses the relationally focused techniques of Functional Family Therapy (FFT) in a comprehensive and systemic approach adapted to helping youth and families involved with DCP&P to overcome individual and relational trauma to promote placement stability, increase youths' lifelong connections and improve youths' permanency outcomes.

Under New Jersey's child welfare modified settlement agreement (MSA), the State was required to seek approval from the federal government for a Medicaid rate structure "to support the use of new services for children and families, including community-based and evidence-based informed, or support practices, such as Functional Family Therapy and Multi-Systemic Therapy" (Section II.C.2 of the MSA).

Function Family Therapy (FFT) and Multi-Systemic Therapy (MST)

Beginning in 2008, through an RFP process DCF established providers of Multi-systemic Therapy (MST) and Functional Family Therapy (FFT) in New Jersey. MST and FFT have proven efficacy with youth involved in the juvenile justice system through dozens of empirically validated and peer-reviewed studies. Too often, the child welfare system endeavors to serve these youth and families with inadequate resources and misdirected efforts. Consistent with the needs of many families served by the child welfare system, the challenges at hand are best served by intensive, "whatever it takes" treatment by well-trained and qualified professionals. As evidence-based practices, the licensing and program requirements for providers of MST and FFT, from start-up through on-going delivery of service, are stringent. The goal was to have national organizations ensure that local implementation maintains fidelity to the treatment model to ensure outcomes are consistent with other states. Awards were granted around June 2008.
There are currently 5 CSOC-contracted agencies providing evidence-based practices.

• Functional Family Therapy (FFT):
• Atlantic and Ocean Counties
Cape Counseling and Jewish Family Services
• Burlington and Ocean Counties
Community Treatment Solutions
• Cumberland, Gloucester and Salem Counties
Robins' Nest

• Multisystemic Therapy (MST):
• Camden County
Center for Family Services
• Hudson and Essex Counties
Community Solutions, Inc.

CSOC plans to undertake a comprehensive review of its evidence-based practices, in terms of utilization and outcomes, to ensure these services are having the expected, positive impact on the lives of children and families.

ARC-GROW Model
CSOC, through the Intensive In-Community (IIC) service line, in partnership with the Children's Center for Resilience and Trauma Recovery (CCRTR), and

MRSS and CMO partners, offers access to and delivery of the ARC-GROW model. The ARC-GROW Model is an adaptation of the Attachment, Regulation, and Competency framework for intervention with youth and families who have experienced multiple and/or prolonged traumatic stress. The Attachment, Self-Regulation, and Competency (ARC) framework is a core-components treatment model, developed to provide a guiding framework for thoughtful clinical intervention with complexly traumatized youth from early childhood to adolescence and their caregiving systems. GROW is a caregiver skill building intervention designed to enhance resilient outcomes for families who are impacted by chronic adversity or stress (Kinniburgh et al. 2011). This parenting support program is delivered as a 12-session home visiting service by parent support workers or clinical staff providing safety and stabilization support. The home visiting hours include psychoeducation and skill practice in areas including, but not limited to, caregiver self-care, attunement to the developmental impact of trauma, supporting child/youth regulation, effective parenting practices and strategies for building daily routines.

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CSOC plans to undertake a comprehensive review of its evidence-based practices, in terms of utilization and outcomes, to ensure these services are having the expected, positive impact on the lives of children and families.

ARC-GROW Model
CSOC, through the Intensive In-Community (IIC) service line, in partnership with the Children's Center for Resilience and Trauma Recovery (CCRTR), and MRSS and CMO partners, offers access to and delivery of the ARC-GROW model. The ARC-GROW Model is an adaptation of the Attachment, Regulation, and Competency framework for intervention with youth and families who have experienced multiple and/or prolonged traumatic stress. The Attachment, Self-Regulation, and Competency (ARC) framework is a core-components treatment model, developed to provide a guiding framework for thoughtful clinical intervention with complexly traumatized youth from early childhood to adolescence and their caregiving systems. GROW is a caregiver skill building intervention designed to enhance resilient outcomes for families who are impacted by chronic adversity or stress (Kinniburgh et al. 2011). This parenting support program is delivered as a 12-session home visiting service by parent support workers or clinical staff providing safety and stabilization support. The home visiting hours include psychoeducation and skill practice in areas including, but not limited to, caregiver self-care, attunement to the developmental impact of trauma, supporting child/youth regulation, effective parenting practices and strategies for building daily routines.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: In coordination with the NJ Department of Children and Families, the Nicholson Foundation will fund one award for the implementation of the In-Home Recovery Program (IHRP) which provides two (2) Project sites managed by one agency. Each Project team will treat a caseload of twelve (12) families concurrently and serve a minimum of eighteen (18) families over the 18-month grant period, beginning on September 1, 2019

Baseline Measurement: This in-home service does not exist within NJ DCF at this time

First-year target/outcome measurement: Total number of families served between January 1, 2020 and June 30, 2020

Second-year target/outcome measurement: Each Project team will treat a caseload of twelve (12) families concurrentlyand serve a minimum of eighteen (18) families over the 18-month grant period, beginning on September 1, 2019

Data Source:

Grant awardee

Description of Data:

Total number of families served over the 18-month grant period. Target measurement is 36 families served.

Data issues/caveats that affect outcome measures::

None.

Priority #: 13

Priority Area: Housing Services in Community Support Services

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

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

Objective:

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

Strategies to attain the objective:

Community Support Services (CSS) is a mental health rehabilitation service that assists the consumer in achieving mental health rehabilitative and recovery goals as identified in an individualized rehabilitation plan (IRP). CSS promotes community inclusion, housing stability, wellness, recovery, and resiliency. Consumers are expected to be full partners in identifying and directing the types of support activities that would be most helpful to maximize successful community living. This includes use of community mental health treatment, medical care, self-help, employment and rehabilitation services, and other community resources, as needed and appropriate. The adoption of CSS enhances Supportive Housing.

The SMHA will utilize a number of strategies to help attain the objective.
1. The Office of Olmstead, Compliance, Planning, and Evaluation works collaboratively with provider agencies, state hospital key personnel, DMHAS staff and other Divisions across the state to implement an overall paradigm of community integration.
2. Continued use of the Individual Needs for Discharge Assessment (INDA) facilitates the treatment and discharge planning processes. The INDA serves as both an assessment tool geared toward evaluating needs or barriers that the consumer may face upon discharge and a mechanism by which to assign state hospital consumers to prospective community service providers. The INDA will be continually used by the SMHA to facilitate transition into the community and anticipate and address any barriers that may hinder or preclude placement within the community.
3. Separation of Housing and Services in service delivery has enabled consumers to choose a housing provider and a different service provider. Consumers will no longer be restricted to the same agency. This separation will also enable the SMHA to track expenditures, utilization, outcomes, and demands for services.
4. The Bed Enrollment Data System (BEDS)/Vacancy Tracking System was developed to help DMHAS manage and track vacancies. The system has

replaced the process of cold calls to agencies and the utilization of quickly outdated paper tracking sheets. Utilization of a web-based system provides real-time access to vacancy information and helps facilitate assignments and avoid outdated spreadsheets. Analysis of the utilization of Supportive Housing vs. supervised settings (e.g. group homes and supervised apartments) allows for assessment of the Division's progress toward community integration. The system will also enable planning at both the individual consumer level for placement purposes and system-wide for purposes of enhancements in community resources.
5. Assignment Process - In May 2015, New Jersey DMHAS revised its Administrative Bulletin 5:11 directing engagements of consumers by community providers. Under this revision, assignments of consumers replaced the concept of referrals to community providers by hospital treatment teams, requiring providers to either accept the assigned consumer or communicate their needs to DMHAS for additional supports necessary to serving the assigned consumer. The goal of this new policy was the early familiarity of consumers and providers through mandatory provider participation in the discharge planning process and engagements such as recreational day trips; visits to prospective apartments for rent; discharge preparations; and overnight visits (upon request of the consumer and/or hospital treatment team).

SMHA staff will monitor the continued development of new Supportive Housing opportunities. The BEDS data system will foster more timely and accurate tracking of residential resources, as well as facilitate their more efficient utilization (e.g., to reduce vacancy rates and increase community placements), and enable monitoring of compliance with Administrative Bulletin 5:11 (Residential Placement from Psychiatric Hospital).

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Consumers who remain in Community Support Services (CSS) during the fiscal year as a proportion of total consumers served in Community Support Services.

Baseline Measurement: The total number of clients served in CSS in SFY 2018 were 4,762. 80.72% of the total consumers served in CSS remained in CSS during SFY 2018. The total number of clients served in CSS in SFY 2019 will be available by September 2019. At that time, the percentage for SFY 2019 will be calculated.

First-year target/outcome measurement: The percentage of consumers who remain in Community Support Services during SFY 2020 will be no less than 85% of total consumers served in Community Support Services.

Second-year target/outcome measurement: The percentage of consumers who remain in Community Support Services during SFY 2021 will be no less than 87% of total consumers served in Community Support Services.

Data Source:

The number of consumers served by Community Support Services is tracked by the SMHA's QCMR database starting SFY 2018.

Description of Data:

The QCMR Database collects quarterly, cumulative, program-specific data from each of the service providers contracted by DMHAS. The current QCMR for Community Support Services contains 50 data elements. The key data fields relevant for this performance indicator are "Ending Active Caseload (Last Day of Quarter)" and Number of terminations in the Quarter. Currently 39 agencies contracted by the SMHA to provide QCMR data for Community Support Services.

Data issues/caveats that affect outcome measures::

The QCMR emphasizes aggregate program processes and units of service/persons served, rather than individual consumer outcomes. Proposals awarded under current and forthcoming RFPs for Community Support Services will be monitored through contract negotiations. Data will be maintained through the QCMR database.

Priority #: 14

Priority Area: Olmstead Access to Service/Occupancy Rate

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

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

Objective:

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

Strategies to attain the objective:

Community Support Services (CSS) is a mental health rehabilitation service that assists the consumer in achieving mental health rehabilitative and recovery goals as identified in an individualized rehabilitation plan (IRP). CSS promotes community inclusion, housing stability, wellness, recovery and resiliency. Consumers are expected to be full partners in identifying and directing the types of support activities that would be most helpful to maximize successful meaningful community living. This includes use of community mental health treatment, medical care, self-help, employment and rehabilitation services, supported education, and other community resources, as needed and appropriate. The adoption of CSS enhances Supportive Housing.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Improved Utilization of Housing Service Slots measured by occupancy rates of Community Support Services (CSS) housing units.

Baseline Measurement: In SFY2019, the occupancy rate (of CSS housing units that are occupied and/or have a consumer assigned to them) was 95.9%. Conversely, the vacancy rate (state-funded CSS housing units that are vacant and/or have no consumers assigned to them) was 4.1%.

First-year target/outcome measurement: In SFY 2020, the occupancy rate (i.e., occupied CSS housing units and those units with an assignment) is expected to be 97%.

Second-year target/outcome measurement: In SFY 2021, the occupancy rate (i.e., occupied CSS housing units and those units with an assignment) is expected to be 97%.

Data Source:

The 2019 baseline value was generated from newer and slightly improved Provider Weekly Reports. The denominator was the sum of capacity reported from 33 different CSS programs. The numerator was the number of needed assignments requested by those same organizations.

Description of Data:

For the 2020-2021 application, this priority indicator has been refined to focus on increased access to community-based housing among its largest segment—those served by Community Support Services (CSS). Although DMHAS has developed data systems (e.g., the Bed Enrollment Data System/BEDS) that are well-suited for the tracking of group homes and supervised apartments, different reporting mechanisms are preferable for the tracking of CSS housing—which is uniquely client-driven. Therefore, the data used for this indicator is from an analysis of Provider Weekly Reports, which are submitted to the SMHA on a weekly basis by each contracted CSS agency. Provider Weekly Vacancy Reports gather data from the community providers regarding their current census, current occupancy, and identify availability for state hospital assignments. These reports provide current information regarding active assignments, which includes any unforeseen post-assignment barriers, identifies any follow-up needed, and provides additional information used for tracking the progress of the assignment to allow for timely discharge and/or intervention. Prior to the development of this report, two of the three catchment areas implemented a similar tool. The new report has standardized the process in all three regions and across all providers. The Provider Weekly Vacancy Report provides information in order to validate the current BEDs Data System, as well as provide continuous updates to maintain its accuracy. This report is also used to develop and maintain the Hospital Vacancy Report, which is used for notifying state hospital treatment teams of bed vacancies and assignment opportunities. All DMHAS community providers were invited to participate in a webinar training on June 19, 2019. The Provider Weekly Vacancy Report went into effect on July 1st, 2019.

The 2019 values were calculated by dividing the sum of the reported number of requested assignments, by the sum of the reported capacities at each program. The SMHA collected this data from 33 CSS providers at the end of SFY19.

Data issues/caveats that affect outcome measures::

The reporting of occupancy strictly among CSS provider agencies necessitated the use of the Provider Weekly Reports (PWRs). The rollout of the standardized PWRs came late in SFY19, so there is a small number of providers who have yet to submit their data in the proscribed fashion. This performance indicator is expressed as a proportion, and the SMHA does not feel that the SFY19 occupancy rate of 95.9% would be materially different if/when all of the data was reported.

Priority #: 15

Priority Area: First Episode Psychosis (FEP)

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

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

Objective:

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

Strategies to attain the objective:

Objectives will be addressed through the implementation of a Coordinated Specialty Care (CSC) model. CSC is an evidence-based recovery-oriented approach involving clients and family members as active participants. All services are highly coordinated with primary medical care.

New Jersey's CSC services are provided for youth and adults between the ages of 15 to 35 years who have experienced psychotic symptoms for less than 2 years with or without treatment. Since November 2016, three teams in New Jersey have been funded to provide CSC services. They cover all 21 counties using extensive outreach efforts. The three provider agencies are Oaks Integrated Care for Southern region, Rutgers University Behavioral Health Center for Central region, and CarePlus NJ for Northern region.

Each CSC team is comprised of six members, mostly masters level clinicians, who contribute to high levels of care. They take on the roles of Team Leader, Recovery Coach, Supported Employment and Education Specialist, Pharmacotherapist, Outreach and Referral Specialist, and Peer Support Specialist. The New Jersey CSC model emphasizes treatment through the following components: outreach, low-dosage medications, cognitive and behavioral skills training, Individualized Placement and Support (IPS), supported employment and supported education, peer support, case management, and family psychoeducation.

In SFY 2019, the three CSC programs had over 277 referrals and served 215 clients in their programs. New Jersey plans to continue utilizing the 10% set-aside funding in the FY 2020-21 to support these three CSC teams in providing evidence-based services for individual with FEP. With increased demand for FEP services, the CSC programs have expanded from serving 35 clients to 70 clients per agency and increased clinical staff from 5.2 FTE to 6.8 FTE levels in FY 2019.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Medication adherence among clients who need psychotropic medication prescribed for FEP treatment.
Baseline Measurement:	In SFY 2018, among clients who were taking or in need of antipsychotic medication for the treatment of their psychosis at intake, 78.4% adhere to their medication regimen. In SFY 2019, out of 215 clients being served, 190 were taking or in need of antipsychotic medication. Among them, 86.8% (165) adhered to their psychotropic medication regimens.
First-year target/outcome measurement:	In SFY 2020, it is anticipated that at least 88% of the client who are taking or in need of antipsychotic medication adhere to the medication regimen.
Second-year target/outcome measurement:	In SFY 2021, it is anticipated that at least 90% of the client who are taking or in need of antipsychotic medication adhere to the medication regimen.

Data Source:

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

Description of Data:

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

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

Data issues/caveats that affect outcome measures::

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

Priority #: 16

Priority Area: System wide assessment for delivering services to diverse populations

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

System wide assessment for delivering services to diverse populations.

Objective:

All agencies are required to have a Cultural Competence Plan in place. The multicultural plans are required of both mental health and substance use agencies.

Strategies to attain the objective:

Since 1985, the Division of Mental Health and Addiction Services (DMHAS) has had the commitment to improve services to individuals from diverse backgrounds, including LGBTQ. The mechanism for addressing these system needs began with the 2015 reformation of DMHAS' multicultural activities into a Multicultural Services Advisory Committee (MSAC). The MSAC has developed a process for systems assessment that will begin by surveying all contracted agencies about their existing planning and service delivery to diverse populations. As the SMHA reviewed the results of these surveys, gaps in service and needs for technical assistance (TA) were identified. Beginning in early 2016, TA groups were held in the north and south to assist agencies in formulating multicultural plans. Those plans became a part of the SMHA's contracting process in FY 2017 and have been followed by the DMHAS Multicultural Training and Technical Assistance Center each year to ensure that the plans continue to grow. In addition, in FY 2018, DMHAS contracted with a diversity consultant to provide administrative and research-based assistance with this initiative. The diversity consultant was charged with securing scholarly presenters for trainings and workshops to further educate and engage providers with completing their Cultural Competence Plan. The diversity consultant's role expanded in FY 2019 to include qualitative and quantitative analysis of data in order to present a more robust picture of DMHAS' agency gaps and trends leading to greater concentration of creating and sustaining a culture of inclusion.

The MSAC, with assistance from DMHAS and the diversity consultant, is developing a "Center for Cultural Competency Excellence" designation for agencies that meet exemplary criteria in addition to completing their Cultural Competency Plans.

Each mental health community provider is required to develop a Cultural Competence Plan describing the integration of cultural and linguistic competence throughout the organization, including direct attention to issues of gender, age, and culture. An organizational self-assessment helps prioritize the steps needed to develop those congruent behaviors and improve culturally responsive services. The plan that results from that assessment, which has 47 items, should address all diverse groups that are served within the agency: for example, cultural, ethnic and linguistically diverse people, individuals who are deaf and hard of hearing, Lesbian, Gay, Bisexual, Transgender people, older people; and outline strategies for recruiting, hiring, retaining, and promoting culturally competent, diverse staff members; the use of interpreters or bilingual staff members; staff training, professional development, and education; fostering community involvement; facilities design and operation; development of cultural and diversity appropriate program materials; how to incorporate diverse treatment approaches; and development and implementation of supporting policies and procedures, including reassessment processes.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Proportion of agencies that have three areas identified from their self-assessment included in their Cultural Competence Plans.

Baseline Measurement: The baseline variable is the number of provider agencies that complete their self-assessments and have a written Cultural Competence Plan containing at least three of the areas needed to enhance cultural competency. The establishment of a baseline is still in process and is expected to be completed in SFY 2020. The MSAC will complete the "Center for Cultural Competency Excellence" designation for agencies.

First-year target/outcome measurement: Thirty (30) percent of all providers will have written Cultural Competence Plans which include at least three areas identified in their self-assessment. Agencies will apply for "Center for Cultural Competency Excellence" designation.

Second-year target/outcome measurement: Fifty percent (50%) of all providers will have written Cultural Competence Plans which include at least three areas identified in their self-assessment. Agency "Center for Cultural

Competency Excellence" designations will be reviewed and awarded.

Data Source:

Self assessments and written plans checked by SMHA, Multicultural Training and Technical Assistance Center staff, and analyzed by the diversity consultant.

Description of Data:

The establishment of written organizational plans for addressing culture and diversity based upon agency self-assessment. The areas covered: Governance, Leadership, and Workforce; Communication and Language Assistance and Engagement, Continuous Improvement, and Accountability. Plans identify a minimum of at least three activities from these areas.

Data issues/caveats that affect outcome measures::

Some agencies have been reluctant to initiate a multicultural plan due to staffing demands, cultural competency misinformation, and fiscal issues. The addition of the diversity consultant and "Center for Cultural Competency Excellence" agency designation may help in this regard.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [SA]

States must project how the SSA will use available funds to provide authorized services for the planning period for state fiscal years FFY 2020/2021. ONLY include funds expended by the executive branch agency administering the SABG

Planning Period Start Date: 7/1/2019 Planning Period End Date: 6/30/2021

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	$65,451,884		$0	$30,609,769	$294,968,640	$0	$0
a. Pregnant Women and Women with Dependent Children**	$11,733,916		$0	$0	$4,023,036	$0	$0
b. All Other	$53,717,968		$0	$30,609,769	$290,945,604	$0	$0
2. Primary Prevention	$0		$0	$0	$0	$0	$0
a. Substance Abuse Primary Prevention	$27,705,918		$0	$17,011,808	$8,607,708	$0	$0
b. Mental Health Primary Prevention							
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)							
4. Tuberculosis Services	$0		$0	$0	$0	$0	$0
5. Early Intervention Services for HIV	$0		$0	$0	$0	$0	$0
6. State Hospital							
7. Other 24 Hour Care							
8. Ambulatory/Community Non-24 Hour Care							
9. Administration (Excluding Program and Provider Level)	$2,975,778		$0	$1,052,961	$2,296,272	$0	$0
10. Total	**$96,133,580**	**$0**	**$0**	**$48,674,538**	**$305,872,620**	**$0**	**$0**

* Prevention other than primary prevention

** The 20 percent set-aside funds in the SABG must be used for activities designed to prevent substance misuse.

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [MH]

States must project how the SMHA will use available funds to provide authorized services for the planning period for state fiscal years 2020/2021.

Planning Period Start Date: 7/1/2019 Planning Period End Date: 6/30/2021

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. Primary Prevention							
a. Substance Abuse Primary Prevention							
b. Mental Health Primary Prevention*		$0	$0	$0	$0	$0	$0
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)**		$3,872,557	$0	$0	$0	$0	$0
4. Tuberculosis Services							
5. Early Intervention Services for HIV							
6. State Hospital			$0	$0	$0	$0	$0
7. Other 24 Hour Care		$2,149,931	$564,951,836	$0	$163,204,955	$0	$0
8. Ambulatory/Community Non-24 Hour Care		$30,766,800	$865,763,033	$4,085,940	$666,647,722	$0	$800,000
9. Administration (Excluding Program and Provider Level)***		$1,936,278	$2,138,000	$420,248	$30,365,207	$0	$0
10. Total	**$0**	**$38,725,566**	**$1,432,852,869**	**$4,506,188**	**$860,217,884**	**$0**	**$800,000**

* While the state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED

** Column 3B should include Early Serious Mental Illness programs funded through MHBG set aside

*** Per statute, Administrative expenditures cannot exceed 5% of the fiscal year award.

Footnotes:

(1) Medicaid data for NJ above now include estimated spending for adults with Serious Mental Illness. Prior year submissions only included spending for children (from the NJ Department of Children and Families. The new approach is consistent with reporting for other tables and with Maintenance of Effort reporting.

(2) Above Medicaid data reflects an estimate of the breakdown between 24 and non 24 Hour Care. The NJ Division of Mental Health and Addiction Services is obtaining data to refine this estimate and will report any material changes to SAMHSA as soon as possible.

Planning Tables

Table 3 SABG Persons in need/receipt of SUD treatment

	Aggregate Number Estimated In Need	Aggregate Number In Treatment
1. Pregnant Women	3253	741
2. Women with Dependent Children	46763	9933
3. Individuals with a co-occurring M/SUD	133604	31143
4. Persons who inject drugs	19799	14799
5. Persons experiencing homelessness	11520	3154

Please provide an explanation for any data cells for which the state does not have a data source.

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Footnotes:

Source: 2018 NJSAMS data
Percentage in treatment based on the total (55,784) unduplicated number of treatment admissions in 2018.
Pregnant Women 1.3%
Women with Dependent Children 17.8%
Individuals with a co-occurring 55.8%
Persons who inject drugs 26.5%
Persons experiencing homelessness 5.6%

Planning Tables

Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2019 Planning Period End Date: 9/30/2021

Expenditure Category	FFY 2020 SA Block Grant Award	FFY 2021 SA Block Grant Award
1 . Substance Abuse Prevention and Treatment*	$32,725,942	$34,714,827
2 . Primary Substance Abuse Prevention	$13,852,959	$11,861,963
3 . Early Intervention Services for HIV**	$0	$0
4 . Tuberculosis Services	$0	$0
5 . Administration (SSA Level Only)	$1,487,889	$1,490,000
6. Total	**$48,066,790**	**$48,066,790**

* Prevention other than Primary Prevention

** For the purpose of determining the states and jurisdictions that are considered ?designated states? as described in section 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 45 CFR § 96.128(b) of the Substance Abuse Prevention and Treatment Block Grant; Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the HIV Surveillance Report produced by the Centers for Disease Control and Prevention (CDC,), National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention. The most recent HIV Surveillance Report will be published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be are required to set-aside 5 percent of their respective SABG allotments to establish one or more projects to provide early intervention services for regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a ?designated state? in any of the three years prior to the year for which a state is applying for SABG funds with the flexibility to obligate and expend SABG funds for EIS/HIV even though the state a state?s AIDS case

rate does not meet the AIDS case rate threshold for the fiscal year involved for which a state is applying for SABG funds. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance would will be allowed to obligate and expend SABG funds for EIS/HIV if they chose to do so.

Footnotes:

Planning Tables

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2019 Planning Period End Date: 9/30/2021

	A	B	C
Strategy	**IOM Target**	**FFY 2020 SA Block Grant Award**	**FFY 2021 SA Block Grant Award**
1. Information Dissemination	Universal		
	Selective		
	Indicated		
	Unspecified		
	Total	**$0**	**$0**
2. Education	Universal		
	Selective		
	Indicated		
	Unspecified		
	Total	**$0**	**$0**
3. Alternatives	Universal		
	Selective		
	Indicated		
	Unspecified		
	Total	**$0**	**$0**
4. Problem Identification and Referral	Universal		
	Selective		
	Indicated		
	Unspecified		
	Total	**$0**	**$0**
	Universal		

5. Community-Based Process	Selective		
	Indicated		
	Unspecified		
	Total	**$0**	**$0**
6. Environmental	Universal		
	Selective		
	Indicated		
	Unspecified		
	Total	**$0**	**$0**
7. Section 1926 Tobacco	Universal	$0	$0
	Selective	$0	$0
	Indicated	$0	$0
	Unspecified	$0	$0
	Total	**$0**	**$0**
8. Other	Universal		
	Selective		
	Indicated		
	Unspecified		
	Total	**$0**	**$0**
Total Prevention Expenditures		**$0**	
Total SABG Award*		**$48,066,790**	**$48,066,790**
Planned Primary Prevention Percentage		**0.00 %**	**0.00 %**

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

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Footnotes:

DMHAS has selected the option to complete Table 5b, rather than Table 5a; however, as required, we are reporting the amount spent on Section 1926 Tobacco, herein, on Table 5a, which as indicated above is $0 for each column.

Planning Tables

Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2019 Planning Period End Date: 9/30/2021

Activity	FFY 2020 SA Block Grant Award	FFY 2021 SA Block Grant Award
Universal Direct	$2,366,605	$2,021,025
Universal Indirect	$3,463,719	$2,949,046
Selective	$3,057,118	$2,598,461
Indicated	$3,213,119	$2,742,819
Column Total	**$12,100,561**	**$10,311,351**
Total SABG Award*	**$48,066,790**	**$48,066,790**
Planned Primary Prevention Percentage	**25.17 %**	**21.45 %**

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

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Footnotes:

Planning Tables

Table 5c SABG Planned Primary Prevention Targeted Priorities

States should identify the categories of substances the state BG plans to target with primary prevention set-aside dollars from the FFY 2020 and FFY 2021 SABG awards.

Planning Period Start Date: 10/1/2019 Planning Period End Date: 9/30/2021

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

Footnotes:

Planning Tables

Table 6 Non-Direct Services/System Development [SA]

Planning Period Start Date: 10/1/2019 Planning Period End Date: 9/30/2021

Activity	FY 2020			FY 2021		
	A. SABG Treatment	B. SABG Prevention	C. SABG Combined*	A. SABG Treatment	B. SABG Prevention	C. SABG Combined*
1. Information Systems	$1,301,238	$8,858		$1,301,238	$8,858	
2. Infrastructure Support						
3. Partnerships, community outreach, and needs assessment				$215,849		
4. Planning Council Activities (MHBG required, SABG optional)						
5. Quality Assurance and Improvement	$6,300			$6,300		
6. Research and Evaluation	$2,594,195	$1,743,540		$2,605,523	$1,541,754	
7. Training and Education	$63,030			$254,026		
8. Total	**$3,964,763**	**$1,752,398**	**$0**	**$4,382,936**	**$1,550,612**	**$0**

*Combined refers to non-direct service/system development expenditures that support both treatment and prevention systems.

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Footnotes:

a. Amount of SABG Primary Prevention funds to be used for SABG Prevention Non-Direct Services/System Development activities (from Table 4, Row 2) = $__1,752,398_____

b. Amount of SABG Administration funds to be used for SABG Prevention Plan Non-Direct Services/System Development activities (from Table 4, Row 5) = $_0_____

Planning Tables

Table 6 Non-Direct-Services/System Development [MH]

MHBG Planning Period Start Date: 07/01/2019 MHBG Planning Period End Date: 06/30/2021

Activity	FFY 2020 Block Grant	FFY 2021 Block Grant
1. Information Systems		$600,000
2. Infrastructure Support		
3. Partnerships, community outreach, and needs assessment		
4. Planning Council Activities (MHBG required, SABG optional)	$47,826	$23,913
5. Quality Assurance and Improvement		
6. Research and Evaluation		
7. Training and Education		
8. Total	**$47,826**	**$623,913**

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Footnotes:

Environmental Factors and Plan

1. The Health Care System, Parity and Integration - Question 1 and 2 are Required

Narrative Question

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.[22] Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but "[h]ealth system factors" such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease.[23] It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.[24]

Currently, 50 states have organizationally consolidated their mental and substance use disorder authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.[25] SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity.[26] For instance, some organizations have established medical-legal partnerships to assist persons with mental and substance use disorders in meeting their housing, employment, and education needs.[27]

Health care professionals and persons who access M/SUD treatment services recognize the need for improved coordination of care and integration of physical and M/SUD with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.[28]

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.[29] The state should illustrate movement towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders. The plan should describe attention to management, funding, payment strategies that foster co-occurring capability for services to individuals and families with co-occurring mental and substance use disorders. Strategies supported by SAMHSA to foster integration of physical and M/SUD include: developing models for inclusion of M/SUD treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between M/SUD providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as Federally Qualified Health Centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including EHRs and telehealth are examples of important strategies to promote integrated care.[30] Use of EHRs - in full compliance with applicable legal requirements - may allow providers to share information, coordinate care, and improve billing practices. Telehealth is another important tool that may allow M/SUD prevention, treatment, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time, and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes[31] and ACOs[32] may be important strategies used by SMHAs and SSAs to foster integrated care.

Training and assisting M/SUD providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes.

SMHAs and SSAs also may work with state Medicaid agencies, state insurance commissioners, and professional organizations to encourage development of innovative demonstration projects, alternative payment methodologies, and waivers/state plan amendments that test approaches to providing integrated care for persons with M/SUD and other vulnerable populations.[33] Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.[34]

One key population of concern is persons who are dually eligible for Medicare and Medicaid.[35] Roughly, 30 percent of persons who are dually eligible have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.[36] SMHAs and SSAs also should collaborate with state Medicaid agencies and state insurance commissioners to develop policies to assist those individuals who experience health insurance coverage eligibility changes due to shifts in income and employment.[37] Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with M/SUD conditions still may experience challenges in some areas in obtaining care for a particular condition or in finding a provider.[38] SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of M/SUD conditions and work with

partners to mitigate regional and local variations in services that detrimentally affect access to care and integration.
SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.[39] Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists, and others will need to understand integrated care models, concepts, and practices.

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to M/SUD services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. The SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds. The SSAs and SMHAs should collaborate with their states' Medicaid authority in ensuring parity within Medicaid programs.
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.
Another key part of integration will be defining performance and outcome measures. The Department of Health and Human Services (HHS) and partners have developed the National Quality Strategy, which includes information and resources to help promote health, good outcomes, and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.[40]
SAMHSA recognizes that certain jurisdictions receiving block grant funds - including U.S. Territories, tribal entities and those jurisdictions that have signed a Compact of Free Association with the United States and are uniquely impacted by certain Medicaid provisions or are ineligible to participate in certain programs.[41] However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment, and recovery support for persons with, or at risk of, mental and substance use disorders.

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Please respond to the following items in order to provide a description of the healthcare system and integration activities:

1. Describe how the state integrates mental health and primary health care, including services for individuals with co-occurring mental and substance use disorders, in primary care settings or arrangements to provide primary and specialty care services in community -based mental and substance use disorders settings.

Division of Mental Health and Addiction Services (DMHAS)

Through a Medicaid State Plan Amendment NJ has implemented Behavioral Health Homes to provide integrated care to individuals with serious mental illness. The service is available in Bergen, Mercer, Atlantic, and Monmouth Counties. The agencies certified to provide services in Mercer County include Oaks Integrated Services (Formerly Greater Trenton), Catholic Charities, and All Access for Mental Health. In Bergen county, CarePlus NJ and Vantage Health are certified to provide services with Comprehensive Behavioral Health Care. In Atlantic county, services are provided by: Helping Hand Behavioral Health, and Jewish Family Services. In Monmouth county, there are three providers, CPC Behavioral Health, Meridian and Stress Care.

NJ has continued its SAMHSA demonstration grant to implement Certified Community Behavioral Health Clinics (CCBHCs), which began on July 1, 2017. This is done jointly with the Division of Medical Assistance and Health Services (DMAHS), our sister Division in the Department of Human Services (DHS). The CCBHCs serve children and adults and provide a comprehensive array of mental health and addiction services. including physical health screening and case management. There are seven CCBHCs in NJ. The Federal Demonstration was extended to September 13, 2019. The state is making plans for a short-term funding mechanism to continue the programs until the decision is made about an extension of the grant program or a more permanent state funding is established.

DMAHS is also working with the federally qualified health care clinics (FQHCs) and other and primary care providers to allow them to provide Medicaid reimbursable behavioral health services. An Office-Based Addiction Treatment (OBAT) initiative will incorporate medication assisted treatment (MAT) for substance use disorders (SUDs) in a variety of primary care settings. The initiative provides enhanced Medicaid rates for MAT opioid use disorder in primary care, which includes payments for a navigator position to provide care management. The OBAT incorporates a systems level approach in that individuals with SUD can be referred for treatment to the levels of SUD treatment services needed, and Centers of Excellence are available to support OBAT providers in providing SUD services.

Children's System of Care (CSOC)

The Children's System of Care (CSOC), in coordination with the Department of Human Services Division of Mental Health and

Addiction Services developed and implemented Behavioral Health Homes (BHH) in Bergen, Mercer, Cape May, Atlantic, and Monmouth counties. BHHs serve as a "bridge" that connects prevention, primary care, and specialty care, and is designed to avoid fragmented care that leads to unnecessary use of high-end services (i.e. emergency rooms and inpatient hospital stays.). The Behavioral Health Home initiative provides services to children with serious emotional disturbance with the goal of improving health outcomes; promoting better functional outcomes (such as increased school attendance); decreasing overall cost, and the cost associated with the use of acute medical and psychiatric services; improving child/family's satisfaction with care; and, improving the family's ability to manage chronic illness.

To help address these goals, the current child family teams are to include medical expertise and health/wellness education for purposes of providing fully integrated and coordinated care for children who have chronic medical conditions. With a Nurse Care Manager and a Health and Wellness Coach on staff, each BHH Core Team builds on the current Care Management Organization (CMO) array of staff with the intent to provide a holistic approach to care for children. This expanded team constitutes the services of the BHH and will broaden the current CMO care coordination and care management functions to include the ability to identify, screen and coordinate both primary care and specialty medical care.

2. Describe how the state provide services and supports towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders, including management, funding, payment strategies that foster co-occurring capability.

Division of Mental Health and Addiction Services (DMHAS)

• Certified Community Behavioral Health Clinics (CCBHCs) are designed to provide integrated substance use disorder and mental health services for those with co-occurring disorders. The CCBHC includes family supports services. The CCBHCs are required to treat all who seek services, without regard to income, private health insurance, or eligibility for Medicaid/NJ.
• The Department of Human Services (DHS) / Division of Mental Health and Addiction Services (DMHAS) is also working with the Department of Health (DOH) to establish a single set of integrated regulations for primary care providers and behavioral health providers. The new regulations will remove barriers and address conflicting regulations so that services can be more fully integrated. Unifying the regulations will promote integration and co-location of behavioral health and primary care services.
• In recent years, reimbursement rates for mental health and substance use disorder treatment have increased to cover cost of services. More uniform payment methodologies for publicly funded mental health and substance use disorder services have been established. DMHAS has established a co-occurring network of substance use disorder providers in the fee-for-service system.

Children's System of Care (CSOC)

The Children's System of Care (CSOC) offers an array of substance use treatment services, including withdrawal management, outpatient, intensive outpatient, partial care, short-term residential and long-term residential. In addition, residential treatment services for youth with both substance use and significant behavioral health needs can be accessed through the Care Management Organization (CMO) in the defined service area.

A parent/legal guardian may contact the CSOC Contracted System Administrator (CSA) to access any CSOC contracted service. Licensed clinicians employed by the CSA complete assessments over the phone, provide referrals and appropriate authorizations. If a youth meets clinical criteria for out of home co-occurring services, he/she will be opened to a Care Management Organization (CMO) from their county. The CMO Care Manager will help with paperwork, coordinate services and support families through the process.

Families may also access services directly through one of the CSOC contracted substance use treatment providers. Providers complete an assessment and submit it to the CSA. These services may also be accessed through a CMO, MRSS, DCPP and/or juvenile courts if any of these entities are involved with the youth.

Service consideration is based upon the American Society of Addiction Medicine (ASAM) criteria, also known as the ASAM patient placement criteria. These decisions are made by Licensed Clinical Alcohol and Drug Counselors (LCADCs) with appropriate specialized training.

Youth/young adult age 13 -20.99 may access out of home substance use treatment services through the CSA and youth age 13-18 may access ambulatory substance use treatment services through the CSA. If a youth turns 19 while receiving ambulatory services or 21 in out of home substance use services CSA will continue to provide authorization until that episode of care is completed and then transition youth/young adult to the Division of Mental Health and Addiction Services (DMHAS) to access continued substance use services. Further information is available online at: http://www.performcarenj.org/provider/substance/index.aspx.

3. **a)** Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs? (●) Yes ( ) No

b) and Medicaid? (●) Yes ( ) No

4. Who is responsible for monitoring access to M/SUD services by the QHP?

• The NJ Department of Banking and Insurance is responsible for the monitoring of M/SUD services in QHPs for the Commercial

health insurers in the State.
• The Department of Human Services is responsible for monitoring access to M/SUD services for the Medicaid Managed Care Organizations contracted with the State.

5. Is the SSA/SMHA involved in any coordinated care initiatives in the state? (●) Yes ( ) No

6. Do the M/SUD providers screen and refer for:

a) Prevention and wellness education (●) Yes ( ) No

b) Health risks such as

ii) heart disease (●) Yes ( ) No

iii) hypertension (●) Yes ( ) No

iv) high cholesterol (●) Yes ( ) No

v) diabetes (●) Yes ( ) No

c) Recovery supports (●) Yes ( ) No

7. Is the SSA/SMHA involved in the development of alternative payment methodologies, including risk-based contractual relationships that advance coordination of care? (●) Yes ( ) No

8. Is the SSA and SMHA involved in the implementation and enforcement of parity protections for mental and substance use disorder services? (●) Yes ( ) No

9. What are the issues or problems that your state is facing related to the implementation and enforcement of parity provisions?

The state is working how best to implement the evaluation of Non-Qualitative Treatment Limits for Medicaid. Department of Human Services is also working with New Jersey Department of Banking and Insurance on the implementation of this and other evaluations for compliance with parity for the private insurance market.

10. Does the state have any activities related to this section that you would like to highlight?

• The State has established an interdepartmental Work Group (including Departments/Divisions represented on Work Group) to address parity. This group applied and received a grant for participation in SAMHSA's Parity Academy and is actively involved in this technical assistance for parity.
• Mental health condition and substance use disorder parity laws – P.L. 2019, c. 58 was signed into law on April 11, 2019. The law requires health insurers to provide coverage for mental health conditions and substance use disorders under the same terms and conditions as provided for any other sickness and to meet the requirements of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act. Additionally, the law includes reporting requirements for insurance carriers and the New Jersey Department of Banking and Insurance. The following health insurers fall under the law: health service corporations, commercial insurers, health maintenance organizations, health benefits plans issued pursuant to the New Jersey Individual Health Coverage and Small Employer Health Benefits Programs, the State Health Benefits Program, and the School Employees' Health Benefits Program.

Please indicate areas of technical assistance needed related to this section

Not at this time due the State's participation in the SAMHSA Parity Academy.

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Footnotes:

Environmental Factors and Plan

2. Health Disparities - Requested

Narrative Question

In accordance with the **HHS Action Plan to Reduce Racial and Ethnic Health Disparities**[42], **Healthy People, 2020**[43], **National Stakeholder Strategy for Achieving Health Equity**[44], and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and M/SUD outcomes among individuals of all cultures, sexual/gender minorities, orientation and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for **Culturally and Linguistically Appropriate Services in Health and Health Care** (CLAS)[45].

The Action Plan to Reduce Racial and Ethnic Health Disparities, which the HHS Secretary released in April 2011, outlines goals and actions that HHS agencies, including SAMHSA, will take to reduce health disparities among racial and ethnic minorities. Agencies are required to assess the impact of their policies and programs on health disparities.

The HHS Secretary's top priority in the Action Plan is to "assess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits."[46]

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status[47]. This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations[48]. In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBTQ populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide M/SUD services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

In the block grant application, states define the populations they intend to serve. Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, lack of Spanish primary care services may contribute to a heightened risk for metabolic disorders among Latino adults with SMI; and American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community. While these factors might not be pervasive among the general population served by the block grant, they may be predominant among subpopulations or groups vulnerable to disparities.

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is and is not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations.

[42] **http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf**

[43] **http://www.healthypeople.gov/2020/default.aspx**

[44] **https://www.minorityhealth.hhs.gov/npa/files/Plans/NSS/NSS_07_Section3.pdf**

[45] **http://www.ThinkCulturalHealth.hhs.gov**

[46] http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

[47] https://aspe.hhs.gov/basic-report/hhs-implementation-guidance-data-collection-standards-race-ethnicity-sex-primary-language-and-disability-status

[48] https://www.whitehouse.gov/wp-content/uploads/2017/11/Revisions-to-the-Standards-for-the-Classification-of-Federal-Data-on-Race-and-Ethnicity-October30-1997.pdf

Please respond to the following items:

1. Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, sexual orientation, gender identity, and age?

a) Race	(•) Yes ( ) No
b) Ethnicity	(•) Yes ( ) No
c) Gender	(•) Yes ( ) No
d) Sexual orientation	( ) Yes (•) No
e) Gender identity	(•) Yes ( ) No
f) Age	(•) Yes ( ) No

2. Does the state have a data-driven plan to address and reduce disparities in access, service use and outcomes for the above sub-population? (•) Yes ( ) No

3. Does the state have a plan to identify, address and monitor linguistic disparities/language barriers? (•) Yes ( ) No

4. Does the state have a workforce-training plan to build the capacity of M/SUD providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations? (•) Yes ( ) No

5. If yes, does this plan include the Culturally and Linguistically Appropriate Services(CLAS) Standards? (•) Yes ( ) No

6. Does the state have a budget item allocated to identifying and remediating disparities in M/SUD care? (•) Yes ( ) No

7. Does the state have any activities related to this section that you would like to highlight?

Division of Mental Health and Addiction Services (DMHAS)

The Division of Mental Health and Addiction Services (DMHAS) has had a long-standing commitment to issues of culture and diversity, originally forming a Multicultural Advisory Committee in 1981. Since that time, the role and membership of this group has changed to meet the evolving needs of the system. In June 2015, the Multicultural Services Group (MSG) was formed to devise strategies that are appropriate to the lifestyles, special needs and strengths of New Jersey's diverse minority and cultural groups receiving services in the behavioral health system of care. The MSG strives to address the needs for ongoing plans within all contracted agencies in the system as it improves the quality of care for: minority, cultural, linguistic, deaf and hard of hearing and aging population.

In Fiscal Year 2012, DMHAS awarded two agencies to serve as Cultural Competence Training Centers. The Centers provide training and technical assistance specializing in the support of cultural and ethnic diversity and the dynamics of differences among contracted agencies of the DMHAS. Cultural Competence Training Centers play an important role in the on-going development of clinician and agency cultural competence skills by designing curriculum, training, technical assistance and tools to increase agency capacity to provide culturally competent behavioral health care.

In Fiscal Year 2017, the DMHAS awarded an agency to provide a Multicultural and Diversity Statewide Consultant to create increased sensitivity on issues relating to culture and diversity within the mental health and addictions systems of care. This individual works in collaboration with the Cultural Competence Training Centers to facilitate training curriculum and delivery, assist in service bridging in collaboration with the DMHAS and develop technical assistance packages for use throughout the system of care.

The SSA funds the North Jersey Community Research Initiative to continue and expand their existing programs for high-risk LGBTQ youth of color by adapting a prevention model developed by the Centers for Disease Control and Prevention, early intervention services, social marketing, and structured recreational activities. A CSAP-sponsored evaluation of the program determined that the program was effective in reducing rates of substance use among participants and that participants were highly satisfied with the services that were provided.

In August 2018, New Jersey was one of three states awarded a grant from the Center for Law and Social Policy (CLASP) through its Moving on Maternal Depression (MOMD) initiative. The 18-month grant exclusively provides technical assistance, which is administered in the form of monthly calls with CLASP and other participating states; site visits with CLASP; and a conference with

other states on promising practices toward serving populations with maternal depression. New Jersey's efforts under this initiative come from a collaborative which is co-lead by the Division of Mental Health and Addiction Services (DHS-DMHAS) and the Department of Health (DOH), and inclusive of the Division of Medical Assistance and Health Services (DHS-Medicaid) the Department of Children and Families (DCF), and three maternal health consortia consisting of the Partnership for Maternal Child Health, Central Jersey Family Health Consortia, and South Jersey Perinatal Cooperative. The MOMD initiative, has as its focus three individual goals for improving its ability to serve mothers with maternal depression. Each of these goals is the focus of its own subcommittee of core team members, which meets monthly to discuss progress, share insights, and discuss any questions or concerns arising from their efforts. The core team subsequently reports on these meetings to CLASP on monthly calls and receives feedback and consultation where necessary.

Since receiving the award for technical assistance from CLASP, New Jersey has also joined a Policy Academy focused on maternal depression, and the 2019 Population Health Summit hosted by the state's Department of Health will also highlight the issue of maternal depression. As a result, the goals developed by New Jersey to improve their ability to serve those affected by maternal depression have garnered attention and support from agencies both within the state and throughout the country. These goals are defined as follows:

1. Enhanced data capacity and data sharing across all offices invested in treating maternal depression: Progress toward this goal will begin with a data inventory across all of the pertinent DMHAS, DOH-MCH, MEDICAID, and DCF data systems, exploring existing capabilities for studying maternal depression among all four agencies, and examining these systems for opportunities to improve research in this area as well as communicate among the offices in order to achieve a comprehensive understanding of maternal depression at all levels. It is expected that the data inventory will be complete within six months, followed by a shift in focus to the planning for improved communication across each office's individual data systems. Once the initial data inventory is completed, the primary focus of the subcommittee can begin, and the remaining 12 months of the technical assistance award will be dedicated to enhancing existing systems in the form of common fields, options, and terminologies as well as working toward real-time linkages between individual division systems. The efforts and success of this MOMD subcommittee will enable a comprehensive examination of the problem of maternal depression from the angle of any New Jersey state division responsible for addressing it.

2. Increased access to services for those with maternal depression: Simultaneous with the efforts of the subcommittee described above, each office within the MOMD collaborative will begin immediately examining its existing data systems and initiatives for strategies to improve access to treatment for maternal depression. This subcommittee be tasked with 1.) establishing a data-driven analysis of service utilization and any disparities across demographics and special populations, to the end of developing quantitative methods for examining access to maternal depression treatment by anyone in need; and 2.)examining current practices and initiatives geared toward treating maternal depression and developing improvement strategies focused on closing any gaps in the access to such services. The efforts of this subcommittee will continue throughout the 18-month duration of the award, taking full advantage of the technical assistance afforded by CLASP, and will yield a well-rounded evaluation of existing resources and enhancements to New Jersey's maternal depression services capacity. The final six months of the CLASP MOMD award will be spent by this subcommittee on the collaborative establishment of outcomes designed to ensure improvement and sustainability of access to services by anyone in New Jersey in need of treatment for maternal depression.

3. Reduced disparities across races, ethnicities, socioeconomic status, and citizenship status in the delivery of necessary services to mothers with maternal depression: As mentioned on page 5 of New Jersey's MOMD RFP application, postpartum depression is higher among Medicaid/uninsured populations and non-Hispanic blacks. Moreover, Hispanic mothers are more likely than non-Hispanic mothers to lack health insurance which would facilitate the pursuit of medical treatment. The subcommittee dedicated to this goal will spend the full 18-months of the CLASP award researching best and promising practices related to addressing racial, ethnic, and socioeconomic barriers to receiving treatment for maternal depression, and developing strategies for tailoring the implementation of these practices to New Jersey's populations. Efforts of this subcommittee will include, but not be limited to conferences with other states on best and promising practices in bridging service gaps; consultation as needed from subject-matter experts such as the Office of Multicultural Services and the Office of Legal affairs; continuous consultation with the data-driven subcommittees from Goals 1 and 2 on quantitative evidence of successes and barriers related to accessing treatment; and collaboration with the policy and practice-based subcommittee from Goal 2 on ensuring that any service enhancements include a specialized focus on alleviating disparities within these specific indicators. As with Goal 2, the final six months of the technical assistance award will be spent developing outcomes to ensure sustained growth and improvements in accessing services to the black and Hispanic populations, lower-income mothers, and undocumented immigrants.

Children's System of Care (CSOC)

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.

Within the NJ children's system of care language needs of disparity-vulnerable subpopulations are identified, addressed and tracked by the Children's System of Care (CSOC) CSA, PerformCare. Needs assessments are also conducted on the local level by the Care Management Organizations (CMO) and governing bodies within each county.

CSOC 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.

CSOC does not utilize Block Grant funds to measure, track or address to these disparities.

Please indicate areas of technical assistance needed related to this section

The Division of Mental Health and Addiction Services (DMHAS) could use assistance in engaging contacted and licensed mental health providers with developing and completing cultural competency plans. Although all of the DMHAS initiatives in the area of cultural competency provide training, technical assistance, and strategic and practical recommendations in developing cultural competency plans, the field is slow to make changes.

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Footnotes:

Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question

While there are different ways to define value-based purchasing, its purpose is to identify services, payment arrangements, incentives, and players that can be included in directed strategies using purchasing practices that are aimed at improving the value of health care services. In short, health care value is a function of both cost and quality:

Health Care Value = Quality ÷ Cost, (**V = Q ÷ C**)

SAMHSA anticipates that the movement toward value based purchasing will continue as delivery system reforms continue to shape states systems. The identification and replication of such value-based strategies and structures will be important to the development of M/SUD systems and services.

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including M/SUD services. Over the past several years, SAMHSA has collaborated with CMS, HRSA, SMAs, state M/SUD authorities, legislators, and others regarding the evidence of various mental and substance misuse prevention, treatment, and recovery support services. States and other purchasers are requesting information on evidence-based practices or other procedures that result in better health outcomes for individuals and the general population. While the emphasis on evidence-based practices will continue, there is a need to develop and create new interventions and technologies and in turn, to establish the evidence. SAMHSA supports states' use of the block grants for this purpose. The NQF and the IOM recommend that evidence play a critical role in designing health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. SAMHSA's Evidence Based Practices Resource Center assesses the research evaluating an intervention's impact on outcomes and provides information on available resources to facilitate the effective dissemination and implementation of the program. SAMHSA's Evidence-Based Practices Resource Center provides the information & tools needed to incorporate evidence-based practices into communities or clinical settings.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with SED. The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General,[49] The New Freedom Commission on Mental Health,[50] the IOM,[51] NQF,and the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC).[52]. The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."[53] SAMHSA and other federal partners, the HHS' Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the M/SUD field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA's Treatment Improvement Protocol Series **(TIPS)**[54] are best practice guidelines for the SUD treatment. SAMHSA draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPS is expanding beyond public and private SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation **(KIT)**[55] was developed to help move the latest information available on effective M/SUD practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement M/SUD practices that work. KIT covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, 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 M/SUD services.

[49] United States Public Health Service Office of the Surgeon General (1999). Mental Health: A Report of the Surgeon General. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service

[50] The President's New Freedom Commission on Mental Health (July 2003). Achieving the Promise: Transforming Mental Health Care in America. Rockville, MD: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

[51] Institute of Medicine Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders (2006). Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series. Washington, DC: National Academies Press.

[52] National Quality Forum (2007). National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices. Washington, DC: National Quality Forum.

[53] **http://psychiatryonline.org/**

[54] **http://store.samhsa.gov**

[55] **http://store.samhsa.gov/shin/content//SMA08-4367/HowtoUseEBPKITS-ITC.pdf**

Please respond to the following items:

1. Is information used regarding evidence-based or promising practices in your purchasing or policy decisions? (●) Yes ( ) No

2. Which value based purchasing strategies do you use in your state (check all that apply):

- **a)** ☐ Leadership support, including investment of human and financial resources.
- **b)** ☐ Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
- **c)** ☑ Use of financial and non-financial incentives for providers or consumers.
- **d)** ☐ Provider involvement in planning value-based purchasing.
- **e)** ☑ Use of accurate and reliable measures of quality in payment arrangements.
- **f)** ☑ Quality measures focus on consumer outcomes rather than care processes.
- **g)** ☐ Involvement in CMS or commercial insurance value based purchasing programs (health homes, ACO, all payer/global payments, pay for performance (P4P)).
- **h)** ☐ The state has an evaluation plan to assess the impact of its purchasing decisions.

3. Does the state have any activities related to this section that you would like to highlight?

During spring of 2016, the SSA developed a summary rating scale (1 = far below average to 4 = far above average) for each provider of treatment services. The scale used the State Outcomes Measures plus some additional outcomes. The purpose of the scale was to promote value-based purchasing by county governments when spending state dollars to purchase treatment services for their residents. Counties used these ratings to challenge potential or existing vendors to accept quality improvement strategies that are incorporated into their service contracts. This process will be revisited in FY 2020.

The SSA has developed a Performance Incentive Payment System (PIPS). It will be paying incentives to its Prison Intensive Recovery Treatment Supports (PIRTS) provider for outcomes achieved by clients upon release from prison. These include: retention in treatment for at least 90 days, no relapse within 5 months, no overdose within 6 months, no recidivism to jail/prison within 6 months, stable housing for 6 months, and full-time employment for 6 months. The first three quarters of incentive payments (July 2018 to March 2019) are expected to be made in fall 2019 after verification.

As part of its Certified Community Behavioral Health Clinics (CCBHC) project, the Division of Mental Health and Addiction Services (DMHAS) will provide Quality Bonus Payments (QBPs) since it is utilizing the Prospective Payment System 2 (PPS 2) methodology. The first set of QBPs are ready to be made and need to be reviewed. QBPs are based on HEDIS measures.

New Jersey's Coordinated Specialty Care (CSC) program is based upon the Recovery After an Initial Schizophrenia Episode (RAISE) model in the treatment of First Episode Psychosis and the principles of Coordinated Specialty Care. CSC is a recovery model promoting shared decision making and personalized treatment planning. Services offered under CSC include psychotherapy, medication management, case management, supported employment and education, family education and support, cognitive behavioral therapy, motivational interviewing, and peer and recovery supports. In September 2018, the SMHA developed a tool to monitor fidelity to the model and began site reviews of the agencies in October 2018.

Please indicate areas of technical assistance needed related to this section.

Incorporation of consumer and provider outcomes in developing value-based purchasing rates. Reform funding policies, processes and mechanisms to support value-based purchasing.

Approaches based on paying providers for incentives per person or for an aggregate percentage attained on an outcome by the agency.

Footnotes:

Programs in Assertive Community Treatment (PACT) contracts and regulations use evidence based practices. In addition, Coordinated Specialty Care contracts use evidence based practices.

The SSA requires that all its prevention programs funded by SABG are evidence-based.

SABG Women's Set-Aside programs require evidence-based trauma-informed care.

Environmental Factors and Plan

4. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) - 10 percent set aside - Required MHBG

Narrative Question

Much of the mental health treatment and recovery service efforts are focused on the later stages of illness, intervening only when things have reached the level of a crisis. While this kind of treatment is critical, it is also costly in terms of increased financial burdens for public mental health systems, lost economic productivity, and the toll taken on individuals and families. There are growing concerns among consumers and family members that the mental health system needs to do more when people first experience these conditions to prevent long-term adverse consequences. Early intervention* is critical to treating mental illness before it can cause tragic results like serious impairment, unemployment, homelessness, poverty, and suicide. The duration of untreated mental illness, defined as the time interval between the onset of a mental disorder and when an individual gets into treatment, has been a predictor of outcomes across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be viewed as a negative prognostic factor for those who are diagnosed with mental illness. Earlier treatment and interventions not only reduce acute symptoms, but may also improve long-term prognosis.

SAMHSA's working definition of an Early Serious Mental Illness is "An early serious mental illness or ESMI is a condition that affects an individual regardless of their age and that is a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-5 (APA, 2013). For a significant portion of the time since the onset of the disturbance, the individual has not achieved or is at risk for not achieving the expected level of interpersonal, academic or occupational functioning. This definition is not intended to include conditions that are attributable to the physiologic effects of a substance use disorder, are attributable to an intellectual/developmental disorder or are attributable to another medical condition. The term ESMI is intended for the initial period of onset."

States may implement models that have demonstrated efficacy, including the range of services and principles identified by National Institute of Mental Health (NIMH) via its Recovery After an Initial Schizophrenia Episode **(RAISE)** initiative. Utilizing these principles, regardless of the amount of investment, and by leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, states should move their system to address the needs of individuals with a first episode of psychosis (FEP). RAISE was a set of NIMH sponsored studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP. The NIMH RAISE studies, as well as similar early intervention programs tested worldwide, consist of multiple evidence-based treatment components used in tandem as part of a Coordinated Specialty Care (CSC) model, and have been shown to improve symptoms, reduce relapse, and lead to better outcomes.

State shall expend not less than 10 percent of the MHBG amount the State receives for carrying out this section for each fiscal year to support evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset. In lieu of expending 10 percent of the amount the State receives under this section for a fiscal year as required a state may elect to expend not less than 20 percent of such amount by the end of such succeeding fiscal year.

* MHBG funds cannot be used for primary prevention activities. States cannot use MHBG funds for prodromal symptoms (specific group of symptoms that may precede the onset and diagnosis of a mental illness) and/or those who are not diagnosed with a SMI.

Please respond to the following items:

1. Does the state have policies for addressing early serious mental illness (ESMI)? ○ Yes ◉ No

2. Has the state implemented any evidence-based practices (EBPs) for those with ESMI? ◉ Yes ○ No

If yes, please list the EBPs and provide a description of the programs that the state currently funds to implement evidence-based practices for those with ESMI.

The State has not directly implemented evidence-based practices for ESMI. However, through the MHBG 10 percent set-aside, the state has implemented the Coordinated Specialty Care (CSC) programs for the treatment of First Episode Psychosis.

For the FY 2020, the SMHA will continue to implement the Coordinated Specialty Care (CSC) programs for the treatment of First Episode Psychosis. Coordinated Specialty Care is a collaborative, recovery-oriented approach, involving the individual, treatment members, and, when appropriate, family/relatives as active participants. All services are highly coordinated with primary medical care and focus on optimizing the individual's overall mental and physical health.

Three New Jersey agencies are providing CSC services in all 21 counties. They are Oaks Integrated Care, Rutgers UBHC, and Care Plus NJ Inc. CSC services are provided to those between the ages of 15-35 years old with psychotic symptoms for less than 2 years with or without treatment. Services are provided in home, community, and clinic settings that include

evidence-based pharmacological treatment, supported employment and education services, individual and group psychotherapy, care management, family therapy, and recovery support with 24-hour accessibility. The CSC team members include: a Team Leader, a Recovery Coach, a Supported Employment and Education Specialist, a Pharmacotherapist/Prescriber, an Outreach and Referral Specialist, and a Peer Support Specialist.

Evidence Based Practice methods used to treat clients are recommended by the Recovery After an Initial Schizophrenia Episode (RAISE) Manuals and include:

- Individual Placement and Support
- Person-Centered Therapy
- Motivational Interviewing
- Cognitive behavioral therapy (CBT)
- Cognitive remediation
- Trauma treatment
- Peer wellness coaching
- Trauma-informed care
- Individual Resiliency Training (IRT)
- Psychoeducation
- Supported Education & Employment

3. How does the state promote the use of evidence-based practices for individuals with ESMI and provide comprehensive individualized treatment or integrated mental and physical health services?

Through the Coordinated Specialty Care program, the state promotes the use of EBPs to provide treatment for individuals with FEP. Comprehensive and individualized treatment is specifically provided through the Individual Placement and Support (IPS) where shared decision making with the individual and CSC providers are practiced. The IPS model is used to provide a strong foundation to help the individual achieve recovery.

4. Does the state coordinate across public and private sector entities to coordinate treatment and recovery supports for those with ESMI? (●) Yes ( ) No

5. Does the state collect data specifically related to ESMI? (●) Yes ( ) No

6. Does the state provide trainings to increase capacity of providers to deliver interventions related to ESMI? (●) Yes ( ) No

7. Please provide an updated description of the state's chosen EBPs for the 10 percent set-aside for ESMI.

Several Evidence Based Practice methods are used by the three CSC providers. These methods are:

Individual Placement and Support – Provides supported employment and education services for individuals with FEP while focusing on the strengths of the individual and their recovery.

Person-Centered Therapy- Evidence based therapy used as non-directive method for individuals to reach fulfillment of their personal potentials through sociability and peer support.
Motivational Interviewing- A treatment that addresses ambivalence to change though a conversational approach designed to help people build confidence on the way to recovery.
Cognitive Behavioral Therapy (CBT) – A psychotherapy method used to help clients change their unhelpful thinking and behavior to positive thinking which can lead to enduring improvement in their mood and functioning.
Cognitive Remediation- Cognitive remediation is a behavioral treatment that uses drill and practice, compensatory and adaptive strategies to facilitate improvement in targeted cognitive areas in individuals with FEP.
Peer Wellness Coaching- Service provision to provide motivational and supportive counseling from peers to show the individual that recovery can be achieved.
Trauma-Informed Care (TIC) - A therapeutic approach to care that helps the individual prevent violence and coercion while working together for change to bring the individual closer to recovery.
Individual Resiliency Training (IRT)- a psychosocial treatment for individuals recovering from an initial episode of psychosis that is part of the larger team-based NAVIGATE program across 6 domains: illness self-management; substance use; residual and/or emerging symptoms; trauma and PTSD; health; and functional difficulties. NAVIGATE is a comprehensive program designed to provide early and effective treatment to individuals who have experienced a first episode of psychosis.

Psychoeducation- Face-to-face contacts with a client and/or a family member with the primary purpose of providing information related to a psychiatric condition, wellness, skill building, and/or recovery options.

Supported Employment and Education- Coaching that will give the client guidance as to receiving education though attaining their GED, H.S diploma or post-secondary education and employment training though goal-oriented practices.

8. Please describe the planned activities for FFY 2020 and FFY 2021 for your state's ESMI programs including psychosis?

In FY 2020-2021, the focus will continue to be providing services for people with FEP. The state has expanded CSC service teams to accommodate a caseload from 35 to 70 clients. The three service providers will continue to provide CSC services to treat FEP population in all 21 counties in New Jersey. CSC services will be provided to those between the ages of 15-35 years old with

psychotic symptoms for less than 2 years with or without treatment. Services will be provided in home, community, and clinic settings that include evidence-based pharmacological treatment, supported employment and education services, individual and group psychotherapy, care management, family therapy, and recovery support. Services are provided by certified professionals with 24-hour accessibility. In SFY 2019, the three CSC programs had a total 277 referrals and treated a total of 215 clients.

9. Please explain the state's provision for collecting and reporting data, demonstrating the impact of the 10 percent set-aside for ESMI.

The SMHA is utilizing several data collection tools to determine the efficacy of the CSC program to treat FEP. The providers submit the data to SMHA quarterly.

• The Quarterly Contract Monitoring forms (QCMR) tracks aggregate client data with regard to client caseload and client movement in and out of the program in a contract quarter. Client insurance and service provisions within the CSC program are also detailed along with quarterly staffing information.

• Client Clinical Evaluation data tracks client clinical outcomes from Intake to discharge over 3-month intervals. Clinical scores from the MIRECC Version of the Global Assessment of Functioning (GAF) scale are used to track mental health progress and functionality of clients in the CSC program. Other data fields include client psychotropic medication adherence and psychiatric hospitalization before and after clients receiving CSC services.

• Client Clinical Demographic data is designed to track essential client demographic data such as age, race/ethnicity, gender, county of residence, referral source, client primary health and hospitalization, insurance information, primary language, discharge information, and CSC re-admission. The state is currently in the process of adding additional data fields that would track client employment, education status, and substance use.

• Quarterly Progress Reports is designed to track client referral progress and any problems the service agencies experience so that the SMHA is aware of how the quality of service is affected.

10. Please list the diagnostic categories identified for your state's ESMI programs.

Client diagnostic criteria for Coordinated Specialty Care in New Jersey are:

• Diagnosis: schizophrenia, schizoaffective and schizophreniform disorders, delusional disorder, psychosis not otherwise specified (NOS)

• Duration of psychotic symptoms greater than 1 week and less than 2 years

Please indicate areas of technical assistance needed related to this section.

FY2019 Technical Assistance-- The state has procured technical assistance from SAMHSA though OnTrack NY in FY 2018 and 2019. The SMHA also disseminates training information received from SAMHSA related to the implementation of CSC. The SMHA continued its efforts to procure technical assistance opportunities for the New Jersey providers that serve the ESMI population. Two important trainings are highlighted in SFY 2019. A two-day training workshop on assessing and diagnosing clinical high risk and early psychosis in youth using the Structured Interview of Psychosis-risk Syndromes (SIPS) and Scale of Prodromal Syndromes (SOPS) screening tools was provided by Dr. Barbara Walsh from the Yale University School of Medicine on August 1-2, 2019 on the campus of the Rutgers University UBHC. The SIPS screening tool is a validated and most used diagnostic instrument of clinical high risk throughout the world. A group of New Jersey mental health service providers that include the members of the three CSC service providers (Oaks Integrated Care; Rutgers UBHC; Careplus NJ) and staff administrators from the DMHAS attended the training workshop and became certified users of the SIPS screening tool. A second full-day training with Dr. Walsh has been scheduled to take place on September 9, 2019 at Rutgers University UBHC. The focus of this training is on serving clinical high risk youth with SMI/SED. The members of New Jersey FEP-CSC teams as well as providers who serve the prodromal psychosis population will attend the training. This training will be funded by MHBG Technical Assistance funds SMHA received in SFY 2019.

FY2020 Technical Assistance-- The SMHA is pursuing TA opportunities to address topics such as Medicaid and third party payer funding opportunities such as a bundled rate; FEP stepped care models; suicide prevention in the FEP population; and substance use disorders in the FEP population. The FEP would like the opportunity to receive TA from a state or states that has been able to expand their FEP programs to meet the statewide need, inclusive of expansion of FEP services and the implementation of stepped care models in the continuum of care.

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Footnotes:

Environmental Factors and Plan

5. Person Centered Planning (PCP) - Required MHBG

Narrative Question

States must engage adults with a serious mental illness or children with a serious emotional disturbance and their caregivers where appropriate in making health care decisions, including activities that enhance communication among individuals, families, caregivers, and treatment providers. Person-centered planning is a process through which individuals develop their plan of service. The PCP may include a representative who the person has freely chosen, and/or who is authorized to make personal or health decisions for the person. The PCP team may include family members, legal guardians, friends, caregivers and others that the person or his/her representative wishes to include. The PCP should involve the person receiving services and supports to the maximum extent possible, even if the person has a legal representative. The PCP approach identifies the person?s strengths, goals, preferences, needs and desired outcome. The role of state and agency workers (for example, options counselors, support brokers, social workers, peer support workers, and others) in the PCP process is to enable and assist people to identify and access a unique mix of paid and unpaid services to meet their needs and provide support during planning. The person?s goals and preferences in areas such as recreation, transportation, friendships, therapies, home, employment, education, family relationships, and treatments are part of a written plan that is consistent with the person?s needs and desires.

1. Does your state have policies related to person centered planning? (•) Yes ( ) No

2. If no, describe any action steps planned by the state in developing PCP initiatives in the future.

3. Describe how the state engages consumers and their caregivers in making health care decisions, and enhance communication.

The Division of Mental Health and Addiction Services (DMHAS) endorses person-centered planning for mental health consumers in its Vision Statement: At any point of entry the service system will provide access to appropriate and effective person-centered, culturally-competent services delivered by a welcoming and well trained workforce.

Furthermore, person-centered planning is recognized in the DMHAS statement about its Values: Staff with the Division and its partner agencies value consumers' dignity and believe that services should be person-centered and person-directed.

DMHAS has endorsed consumer empowerment and decision-making in the delivery of treatment and support services. It supports the hiring of peer specialists and ensures that they have a prominent role in assisting consumers. The Division currently supports 34 consumer-run Wellness/Self-Help Centers statewide, as well as many initiatives to train and support peer specialists (these are described elsewhere). DMHAS initiatives also encourage the engagement of caregivers. DMHAS empowers family members of those with a mental illness in its ongoing programs of Intensive Family Support Services (IFSS) that are situated statewide. Family members work with professionals to acquire the knowledge, skills and supports they need to improve functioning and gain a sense of control.

In the last year, DMHAS used a TTI grant for training in Recovery-Oriented Cognitive Therapy (CT-R) at four behavior Health Homes; the initiative implemented a “Train the Trainer” approach through a collaboration between the Aaron T. Beck Center, the New Jersey Division of Mental Health and Addiction Services (DMHAS) and Rutgers University Behavioral Health Care (UBHC). The trainees included peer specialist members of the Behavioral Health Home Team. This project demonstrated that training peers in CT-R in Behavioral Health Home (BHH) settings improves the effectiveness of peer support specialists and empowers them in assisting consumers’ recovery.

In cooperation with Rutgers Behavioral Healthcare, it has supported development of various tools to promote and facilitate consumer autonomy. These include a toolkit addresses use of tobacco called, Learning About Healthy Living, which has been used by several other states. A toolkit completed last year, Your Wellness Counts, which is a self-care/consumer-directed manual that teaches about healthy lifestyle choices and wellness goal setting. DMHAS also developed a ‘Shared Decision Making around Medication’ tool that guides consumers to prepare for medication appointments and create a record for future use. The tools are also posted on the DMHAS website for access and use.

DMHAS continues to support consumers’ development of Psychiatric Advance Directives (PADs) to express their wishes about their mental health care and other assistance during a personal mental health crisis. This year, DMHAS implemented an electronic registry of PADs, so that providers and consumers can retrieve PADs during episodes of crisis care.

Early this year, the PAD Registry went live at http://www.state.nj.us/humanservices/dmhas/resources/mental/pad/. Both providers and peers were invited to meet at a training provided by DMHAS and were provided with information not only on how to “upload documents” in to the Registry, but were also provided with informational supplements on the laws regarding PADs; elements to include in a PAD; and the actual technical demonstration for the upload as well as the accessing of the Registry by the provider. Peers were also provided with regional trainings on what constitutes a legally acceptable PAD, how to assist someone in

preparing/writing their own PAD, and how the self-help/community wellness centers can assist members with uploading their documents to the Registry. Persons with PADs also receive wallet cards with information to access their PADs once they have completed the process.

The Division staff are planning to work with their community partners to continue to raise awareness about the self-empowering nature of having a PAD in the Registry, and offering support in instances where individuals need some guidance or technical assistance uploading their document to the Registry.

DMHAS also supports training to the provider community about how to engage consumers and promote their decision-making about their recovery. Illness Management and Recovery (IMR) training and follow up consultation and technical assistance is conducted by Rutgers-UBHC with the support of DMHAS. Before DMHAS transferred to the Department of Human Services (DHS), it held a Statewide Wellness Committee meeting with representatives of each of the four state hospitals to promote person centered planning, and assist with wellness initiatives and programs. Individuals with lived experience were active participants on the committee.

4. Describe the person-centered planning process in your state.

Division of Mental Health and Addiction Services (DMHAS)

A person centered planning process is integrated in a number of services offered to consumers in New Jersey. These include Illness Management and Recovery (IMR), Supported Employment (SE), Coordinated Specialty Care (CSC) and Community Support Services (CSS). Each of these services engages the individual in soliciting their wants, needs and desires as well as the skills and supports available to them. The consumers' goals are typically tied to a role and environment that they would like to attain or successfully remain in. The SMHA has incorporated IMR into the foundation of principles and practices central to a recovery-oriented, person-centered system of community mental health services; decrease symptoms, reduce relapses and hospitalizations and make progress towards personal goals through recovery. IMR is incorporated into the partial care systems and it is supported by the regulations. It is incorporated into the supportive housing now CSS systems. SE begins with a discussion of consumers' preferred field of work, occupation and or job. The consumer's employment background is reviewed to determine transferable skills and then individualized job development is initiated based upon the consumer's choice. While SE begins with paid support, natural supports provided by family, co-workers, friends or others are identified.

CSC uses person-centered planning in the engagement process to provide a vision of recovery and hope that communicates the program's person-centered focus, as opposed to an illness-focused approach. PCP is first introduced to CSC clients in the shared decision-making model that incorporates suggestive advice from CSC therapists based on Evidence Based Practice methods. All of the eleven core EBP treatment methods address PCP in client care though engaging the client in weekly sessions to improve their quality of life while reducing symptomology. All of the CSC service modalities use PCP that include: Supported Employment and Education, Peer Support, Medication Monitoring, and Client Therapy.

CSS is a mental health rehabilitation services and support process designed to assist the consumer in achieving rehabilitative and recovery goals as identified in an individualized rehabilitation plan; including achieving and maintaining valued life roles in the social, employment, educational, and housing domains; and assisting the consumer in restoring or developing his or her level of functioning to that which allows the consumer to achieve community integration, and to remain in an independent living setting of his or her choosing.

Children's System of Care (CSOC)

The goal of the Department of Children and Families' (DCF) Children's System of Care (CSOC) is to enable the youth to remain at home, in school, and within their community. Therefore, through an organized system of care approach, CSOC is committed to providing services that are:
A. Clinically appropriate and accessible;
B. Individualized, reflecting a continuum of services and/ or supports, both formal and informal, based on the unique strengths of each youth and his or her family/ caregivers;
C. Provided in the least restrictive, most natural setting appropriate to meet the needs of the youth and his or her family/ caregivers;
D. Family-guided, with families engaged as active participants at all levels of planning, organization, and service delivery;
E. Community-based, coordinated, and integrated with the focus of having services, decision-making responsibility, and management resting at the community level;
F. Culturally competent, with agencies, programs, services, and supports that are reflective of and responsive to the cultural, racial, and ethnic differences of the populations they serve;
G. Protective of the rights of youth and their family/caregivers; and
H. Collaborative across child-serving systems, involving; child protection, juvenile justice, and other system partners who are responsible for providing services and supports to the target populations.

The NJ Children's System of Care is founded on the following Core Values and Principles:
• Family Driven and Youth Guided– Families are engaged as active participants at all levels of planning, organization, and service

delivery.
• Culturally and Linguistically Competent – learning and incorporating the youth and family's culture, values, preferences, and interests into the planning process, including the identified language of the family.
• Community Based – identifying and utilizing supports that are least restrictive, accessible, and sustainable to maintain and strengthen the family's existing community relationships.

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

CFT members include, but are not limited to, the following individuals:
• Child/Youth/Young Adult
• Family Support Partner
• Parent(s)/Legal Guardian
• Care Management Organization
• Natural supports as identified and selected by youth and family
• Treating Providers (in-home, out-of-home, etc.)
• Educational Professionals
• Physical Health Providers (pediatrician, specialist)
• Probation Officer (if applicable)
• Child Protection & Permanency (CP&P) (if applicable)

Family Support Organizations
Family Support Organizations are operated by 15 agencies under contract with CSOC to: ensure that service plans developed for families are child-centered and family-focused; provide support to families through peer counseling, family training and workshops; advocate for families at the local level with other system partners; and cultivate and empower youth development consistent with the wellness and recovery model. The FSOs offer support to families of youth with behavioral health needs, substance use needs, and intellectual and developmental challenges. Family Support Partners within the FSOs are assigned to each family of youth enrolled in CMOs to offer and provide individual family peer-to-peer support. Additionally, the FSOs offer community-based supports to all youth and families in their service area. They provide community outreach and education on peer support and CSOC, family and youth support groups, youth partnership structure and activities, and telephonic support for families. The FSO NJ Alliance is contracted to provide training and technical assistance to FSOs.

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

The CSA creates a common single point of entry for youth and families. The CSA registers all youth requesting services and authorizes services in a single electronic record. The CSA tracks and coordinates care for all New Jersey youth enrolled in CSOC.

CSOC retains all regulatory and policy-making authority. The CSA is not a pre-paid health plan; instead it functions as and is inclusive of the activities of a non-risk Administrative Services Organization (ASO). As such, there are key functions that remain the responsibility of CSOC, including, but not limited to, network development, provider contracting, and provider outcome standards. As a partner to CSOC, the CSA provides administrative support and is encouraged to offer recommendations for improvements to the delivery of services which may be implemented with the approval of CSOC.

The CSA performs a broad range of administrative service functions including, but not limited to, the following:
• Providing a Call Center with 24-hour/7-day intake and Customer Service capability;
• Providing a web-based application/interface with the CSA's Management Information System (MIS);
• Managing care, which includes utilization management, outlier management (including authorization of services), and care coordination; if youth are involved with a Care Management Organization, PerformCare reviews service requests based on the youth's comprehensive plan of care which is developed by the Child Family Team (CFT).
• Coordinating access to services for all youth, including facilitating access to specialized services for youth involved with the Division of Child Protection and Permanency (DCP&P);

• Coordinating Third Party Liability and medical coverages;
• Coordinating a transition to adult services for youth;
• Providing Quality and Outcomes Management, and System Measurement that supports CSOC's goal to promote best practices, and providing assistance to the State to assure compliance with State and federal guidelines;
• Providing training and training materials;
• Providing support for Provider Network Development; and
• Completing annual audit reviews.

To support these administrative services, the CSA provides an MIS called CYBER (Child and Youth Behavioral Electronic Record) that is backed by strong, clinical guidance and fosters flexibility, system integration, comprehensive information management, and production of management reports that support business decisions. The contract for PerformCare was renewed for five years upon RFP award in November 2017.

Please indicate areas of technical assistance needed related to this section.

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Footnotes:

Environmental Factors and Plan

6. Program Integrity - Required

Narrative Question

SAMHSA has placed a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds.

While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for M/SUD services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 U.S.C. §§ 300x-5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 U.S.C. § 300x-55(g), SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for SUD. SAMHSA guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: **http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf**. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SABG resources are to be used to support, not supplant, services that will be covered through the private and public insurance. In addition, SAMHSA will work with CMS and states to identify strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance use disorder prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for M/SUD services funded by the MHBG and SABG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered M/SUD benefits; (3) ensuring that consumers of M/SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of M/SUD benefits in light of utilization review, medical necessity, etc. Consequently, states may have to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please respond to the following items:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers? (●) Yes ( ) No

2. Does the state provide technical assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards? (●) Yes ( ) No

3. Does the state have any activities related to this section that you would like to highlight?

The following activities are done for program integrity of the SABG.

• Technical assistance is provided through in-person trainings and webinars, specifically when implementing new initiatives or programming throughout the State (i.e. State Targeted Opioid Response Initiative (STORI) Fee-For-Service (FFS) Initiative, Vivitrol Enhancement Network, etc.)

• The grants monitoring program at the Division of Mental Health and Addiction Services (DMHAS) monitor SAPT Block Grant recipients. Onsite visits are made to each SAPT Block Grant recipient a minimum of one time per calendar year. More frequent reviews are conducted on an as needed basis for agencies recommended by the Contract Coordination meeting as needing additional technical assistance or monitoring because of violations, other deficiencies, or special grant requirements. The Contract Coordination meeting includes representatives from the Monitoring, Prevention, Fiscal and Treatment program units within DMHAS.

Site visits may be anywhere from 1 to 5 days in duration depending on the size and scope of the program. The reviewer conducts chart reviews for the selected sample and completes an Annual Site Monitoring Report. The Annual Site Monitoring Report

addresses at a minimum five core areas of performance: Facility, Staff, Treatment Records, Quality Assurance, Specialized Services, and Other contract requirements. Site visit report is sent to the subrecipient and subrecipient is to reply with a plan of correction (PoC) for areas found to be in noncompliance. Sub-recipients are notified in writing of the acceptance or non- acceptance of the plan of correction and the monitoring staff continues to follow up until an acceptable plan of correction is submitted. Agencies who continue to submit an unacceptable plan of correction are referred to the Contract Monitoring Meeting for further action.

• The DMHAS fiscal office has prepared a Policy and Procedure Manual that: covers disclosures to sub-recipients of federal award information; addresses the SABG fiscal compliance requirements, develops fiscal controls to maintain sufficient documentation for expenditures reported to SAMHSA, and develops appropriate internal controls for reporting expenditures. This manual was recently submitted to the Center for Substance Abuse Treatment (CSAT) Project Officer for review by the appropriate fiscal staff at SAMHSA.

The following activities are done for program integrity of the MHBG.

Letters are sent to provider agencies, on a state fiscal year basis, notifying them of their MHBG award amount, the CFDA number, and the restrictions on the use of the funds.

These agencies are also monitored by the DMHAS Office of Community Services (OCS). One of the responsibilities of the OCS is to ensure that the services provided by contracted programs meet contractual expectations, and that appropriate action is taken to address performance issues. For licensed programs, the Office of Licensing validates that standards are met to achieve and maintain licensure, which include standards for quality and life safety. The OCS, however, has a role in the review of staff qualifications, particularly if a waiver is sought, access to services, and also in monitoring the implementation of Evidence Based Practices. Additionally, the OCS receives and responds to complaints and concerns from constituents, which often address issues of compliance with standards, safety considerations and access to services. By monitoring access to services, the OCS ensures that the target population is prioritized to receive contracted services.

The OCS uses Quarterly Contract Monitoring Reports (QCMR's) to compare actual volume of service to contracted volume of service. When discrepancies are noted, follow-up occurs to identify the reasons for the discrepancies, and to require corrective action as needed. If a Corrective Action Plan is required of a provider agency, the regional office monitors the implementation of the plan until such time as either satisfactory improvement is achieved, or alternatively, contract modifications are made. The OCS may provide technical assistance to providers to help them to achieve the desired service outcomes and may engage other DMHAS staff to render technical assistance. It may be necessary to reduce or terminate a contract if the expected level of service is not achieved.

Technical assistance is provided through in-person trainings and webinars, specifically when implementing new initiatives or programming throughout the State and includes Medicaid and non-Medicaid services and providers.

The Medical Assistance Customer Service Centers conducts site reviews for Medicaid behavioral health providers that include chart reviews, program monitoring and regulatory compliance. Technical assistance is provided if warranted. Serious and extreme violations of a requirement are reported to the Office of Licensing or other governing authority, and if appropriate, the Medicaid Fraud Division for additional follow up with the agency. Site visit report is sent to the provider with a plan of correction (PoC) for areas found to be in noncompliance.

Please indicate areas of technical assistance needed related to this section

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Footnotes:

Environmental Factors and Plan

7. Tribes - Requested

Narrative Question

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the **2009 Memorandum on Tribal Consultation**[56] to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Improving the health and well-being of tribal nations is contingent upon understanding their specific needs. Tribal consultation is an essential tool in achieving that understanding. Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues.

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state?s plan. Additionally, it is important to note that approximately 70 percent of American Indians and Alaska Natives do not live on tribal lands. The SMHAs, SSAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the states.

States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

[56] **https://www.energy.gov/sites/prod/files/Presidential%20Memorandum%20Tribal%20Consultation%20%282009%29.pdf**

Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?
2. What specific concerns were raised during the consultation session(s) noted above?
3. Does the state have any activities related to this section that you would like to highlight?

   Please indicate areas of technical assistance needed related to this section.

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Footnotes:

New Jersey does not have any federally recognized tribal governments or tribal lands within its borders.

Environmental Factors and Plan

8. Primary Prevention - Required SABG

Narrative Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder 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 requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. ***Problem Identification*** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. ***Community-based Process*** 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.

Please respond to the following items

Assessment

1. Does your state have an active State Epidemiological and Outcomes Workgroup(SEOW)? (●) Yes ( ) No

2. Does your state collect the following types of data as part of its primary prevention needs assessment process? (check all that apply) (●) Yes ( ) No

- **a)** ☑ Data on consequences of substance-using behaviors
- **b)** ☑ Substance-using behaviors
- **c)** ☑ Intervening variables (including risk and protective factors)
- **d)** ☑ Other (please list)

  Social Indicator Data
  Treatment Data
  NJ State Police Data
  NJ Prescription Drug Monitoring Data
  State Medical Examiner Data – Drug-related Deaths
  Naloxone Reversal Data

3. Does your state collect needs assesment data that include analysis of primary prevention needs for the following population groups? (check all that apply)

- ☑ Children (under age 12)
- ☑ Youth (ages 12-17)
- ☑ Young adults/college age (ages 18-26)
- ☑ Adults (ages 27-54)
- ☑ Older adults (age 55 and above)
- ☑ Cultural/ethnic minorities
- ☑ Sexual/gender minorities

- [ ] Rural communities
- [ ] Others (please list)

4. Does your state use data from the following sources in its Primary prevention needs assesment? (check all that apply)

- [x] Archival indicators (Please list)

New Jersey Middle School Risk and Protective Factor Survey
New Jersey Chartbook of Substance Abuse Related Social Indicators
New Jersey Household Survey of Drug Use and Health

- [x] National survey on Drug Use and Health (NSDUH)
- [x] Behavioral Risk Factor Surveillance System (BRFSS)
- [x] Youth Risk Behavioral Surveillance System (YRBS)
- [ ] Monitoring the Future
- [ ] Communities that Care
- [x] State - developed survey instrument
- [x] Others (please list)

Older Adult Survey
Survey of Returning Veterans

5. Does your state use needs assesment data to make decisions about the allocation SABG primary prevention funds? (●) Yes ( ) No

If yes, (please explain)

Presence and Intensity of Social Indicators, Past 30-Day Use Rates, Treatment Admission Rates, Need and Risk Factors at County Level, Data on Harmful Consequences

If no, (please explain) how SABG funds are allocated:

Narratve Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder 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 requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. ***Problem Identification*** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. ***Community-based Process*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental Strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Capacity Building

1. Does your state have a statewide licensing or certification program for the substance use disorder prevention workforce? (●) Yes ( ) No

If yes, please describe

The Addictions Certification Board of NJ administers and awards the International Certification and Reciprocity Consortium (IC & RC) recognized Certified Prevention Specialist Credential.

2. Does your state have a formal mechanism to provide training and technical assistance to the substance use disorder prevention workforce? (●) Yes ( ) No

If yes, please describe mechanism used

By means of contracts with the New Jersey Prevention Network and Rutgers University School of Social Work

3. Does your state have a formal mechanism to assess community readiness to implement prevention strategies? (●) Yes ( ) No

If yes, please describe mechanism used

Various Instruments such as Community Prevention Readiness Index or Community Readiness Model

Narratve Question

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In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Planning

1. Does your state have a strategic plan that addresses substance use disorder prevention that was developed within the last five years? ○ Yes ◉ No

If yes, please attach the plan in BGAS by going to the **Attachments Page** and upload the plan

2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SABG? (N/A - no prevention strategic plan) ◉ Yes ○ No ○ N/A

3. Does your state's prevention strategic plan include the following components? (check all that apply):

- **a)** ☑ Based on needs assessment datasets the priorities that guide the allocation of SABG primary prevention funds
- **b)** ☑ Timelines
- **c)** ☑ Roles and responsibilities
- **d)** ☐ Process indicators
- **e)** ☑ Outcome indicators
- **f)** ☑ Cultural competence component
- **g)** ☑ Sustainability component
- **h)** ☑ Other (please list):

  Plan is Organized according to Five Steps of the SPF
- **i)** ☐ Not applicable/no prevention strategic plan

4. Does your state have an Advisory Council that provides input into decisions about the use of SABG primary prevention funds? ◉ Yes ○ No

5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SABG primary prevention funds? ◉ Yes ○ No

If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based

The SAMHSA Guidance Document on "Identifying and Selecting Evidence-Based Interventions" (January 2009)

Narratve Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder 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 requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

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In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Implementation

1. States distribute SABG primary prevention funds in a variety of different ways. Please check all that apply to your state:

- **a)** ☐ SSA staff directly implements primary prevention programs and strategies.
- **b)** ☑ The SSA has statewide contracts (e.g. statewide needs assessment contract, statewide workforce training contract, statewide media campaign contract).
- **c)** ☐ The SSA funds regional entities that are autonomous in that they issue and manage their own sub-contracts.
- **d)** ☑ The SSA funds regional entities that provide training and technical assistance.
- **e)** ☑ The SSA funds regional entities to provide prevention services.
- **f)** ☐ The SSA funds county, city, or tribal governments to provide prevention services.
- **g)** ☑ The SSA funds community coalitions to provide prevention services.
- **h)** ☑ The SSA funds individual programs that are not part of a larger community effort.
- **i)** ☐ The SSA directly funds other state agency prevention programs.
- **j)** ☐ Other (please describe)

2. Please list the specific primary prevention programs, practices, and strategies that are funded with SABG primary prevention dollars in each of the six prevention strategies. Please see the introduction above for definitions of the six strategies:

- **a)** Information Dissemination:

  Resource Directories, Health Fairs, Media Campaigns at County Level - Underage Drinking
- **b)** Education:

  Strengthening Families, Life Skills, WISE, Positive Parenting, etc.
- **c)** Alternatives:

  Drop-In Centers at the Mall, Drug/Alcohol Free Parties and Dances, Community Service Activities
- **d)** Problem Identification and Referral:

  Work in middle and high schools to provide education (in lieu of disciplinary action) to students who violate campus tobacco possession or use policies.
- **e)** Community-Based Processes:

  Recruitment and Training of Coalition Members, Collaboration with the Governor's Council on Alcoholism and Drug Abuse
- **f)** Environmental:

  Regional Coalitions: Work has led to 800+ Policy Changes in NJ, Cops in Shops, Sticker Shock, Server Training

3. Does your state have a process in place to ensure that SABG dollars are used only to fund primary prevention services not funded through other means?

(●) Yes ( ) No

If yes, please describe

Program Managers conduct quarterly reviews of each funded agency's programs.

Narratve Question

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In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Evaluation

1. Does your state have an evaluation plan for substance use disorder prevention that was developed within the last five years? (●) Yes ( ) No

If yes, please attach the plan in BGAS by going to the **Attachments Page** and upload the plan

2. Does your state's prevention evaluation plan include the following components? (check all that apply):

- **a)** [x] Establishes methods for monitoring progress towards outcomes, such as targeted benchmarks
- **b)** [x] Includes evaluation information from sub-recipients
- **c)** [x] Includes SAMHSA National Outcome Measurement (NOMs) requirements
- **d)** [x] Establishes a process for providing timely evaluation information to stakeholders
- **e)** [ ] Formalizes processes for incorporating evaluation findings into resource allocation and decision-making
- **f)** [ ] Other (please list:)
- **g)** [ ] Not applicable/no prevention evaluation plan

3. Please check those process measures listed below that your state collects on its SABG funded prevention services:

- **a)** [x] Numbers served
- **b)** [x] Implementation fidelity
- **c)** [x] Participant satisfaction
- **d)** [x] Number of evidence based programs/practices/policies implemented
- **e)** [x] Attendance
- **f)** [x] Demographic information
- **g)** [ ] Other (please describe):

4. Please check those outcome measures listed below that your state collects on its SABG funded prevention services:

- **a)** [x] 30-day use of alcohol, tobacco, prescription drugs, etc
- **b)** [x] Heavy use
- [x] Binge use
- [x] Perception of harm
- **c)** [x] Disapproval of use

d) ☑ Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)

e) ☐ Other (please describe):

Footnotes:

POMS (Prevention Outcomes Management System) is the web-based system (developed by DMHAS) to collect data from DMHAS-funded providers and coalitions. The system consists of three modules:

SPF-SIG: in which coalitions report on their activities as they related to the five steps of the Strategic Prevention Framework.

Environmental: in which coalitions report on environmental approaches they are using to address DMHAS' prevention priorities. Includes details about activities, dates, number of participants.

Curriculum-Based: collects demographic and process data about individual and family, curricular programs (i.e. Strengthening Families, LifeSkills) being delivered by DMHAS-funded prevention agencies throughout the state. These data are used when preparing the Block Grant reports and application.

Evaluation Plan
New Jersey's Partnerships for Success (NJPFS) Initiative
Division of Mental Health and Addiction Services (DMHAS)
School of Social Work, Rutgers University

PFS Evaluation Goals

The goals of the NJPFS Initiative are threefold: 1) to strengthen and enhance the work of 17 regional prevention coalitions; 2) to further develop the prevention data infrastructure and information systems capacity at the state level; and 3) in collaboration with state partners and community stakeholders, to continue work in developing a unified statewide prevention planning and service delivery system. The fundamental goal of NJPFS, however, is to address the prevention priorities identified by DMHAS' Prevention Strategic Planning Committee. These priorities are consistent with those specified by CSAP for the federal PFS initiative.

Two sets of evaluation goals have been developed for this evaluation. The first set of PFS evaluation goals for NJPFS involves our efforts to determine whether the interventions implemented by New Jersey's 17 regional prevention coalitions had an influence on the following:

1) Onset and reduction in the progression of underage drinking;
2) Reduction in the harmful consequences of underage drinking;
3) Reduction in the use of illegal substances, with a special focus on the use of opioids among young adults 18-25 years of age;
4) Reduction in the harmful consequences stemming from the use of illegal substances, with a special focus on the use of opioids among young adults 18-25 years of age;
5) Reduction in the prescription medication misuse across the lifespan;
6) Reduction in the harmful consequences of prescription medication misuse across the lifespan; and,
7) Reduction in the use of new and emerging drugs of abuse across the lifespan.

The second set of evaluation goals involves our work to examine the influence of NJPFS on the structure and functioning of the 17 regional coalitions as well as the state prevention system. Specifically, our goals are to determine whether the NJPFS had an influence on the following:

1) Strengthening the prevention capacity and infrastructure at the state and community levels; and
2) Leveraging, redirecting, and aligning statewide funding streams and resources for prevention.

Evaluation Questions

Our evaluation questions were developed to correspond directly with the two sets of evaluation goals. These questions ask about the ways in which regional coalitions implemented the SPF model and the influence of their interventions on targeted outcomes representing intervening variables, use and consequences. In addition, these questions ask about the ways in which the broader NJPFS initiative influenced the prevention systems at the state and local levels. Specifically, the evaluation questions are as follows:

1) What was the process through which regional coalitions implemented the Strategic Prevention Framework (SPF) model?
   a) Did coalitions implement the SPF model with a high degree of fidelity?

2) What was the process through which the NJPFS initiative was implemented?
   a) Was the NJPFS initiative implemented as planned?
   b) What deviations in NJPFS implementation occurred?
   c) What were the effects of those deviations on performance?
3) What were the effects of the interventions implemented by regional prevention coalitions on the targeted intervening variables?
4) What were the effects of the interventions implemented by regional prevention coalitions on the following outcomes?
   a) Onset and reduction in the progression of underage drinking;
   b) Reduction in the harmful consequences of underage drinking;
   c) Reduction in the use of illegal substances, with a special focus on the use of opioids among young adults 18-25 years of age;
   d) Reduction in the harmful consequences stemming from the use of illegal substances, with a special focus on the use of opioids among young adults 18-25 years of age;
   e) Reduction in the prescription medication misuse across the lifespan;
   f) Reduction in the harmful consequences of prescription medication misuse across the lifespan; and,
   g) Reduction in the use of new and emerging drugs of abuse across the lifespan.

Required Performance Measures

Our evaluation of the NJPFS initiative will utilize information from the existing DMHAS prevention information data collection system known as the Prevention Outcomes Management System (POMS). Data from POMS will be included in our reports so that SAMHSA can monitor the performance of NJPFS. POMS is critical to New Jersey's statewide prevention infrastructure and the planned evaluation because it provides an effective state and community-level data collection system that includes both process and outcomes data. All subrecipients of the NJPFS initiative, which include regional coalitions and providers of training and technical assistance (T/TA), will be mandated by DMHAS to use POMS.

As part of the Strategic Prevention Enhancement (SPE) grant DMHAS received in 2011, several modifications were made to POMS. One crucial modification involved integration of key items from the Community Level Instrument (CLI) into POMS. The CLI, an important component of the SPF-SIG Cross-Site Evaluation, had several strengths, including detailed data elements designed to capture information about sub-recipients' progress through the SPF model. In addition, the CLI was designed to collect information about the specific prevention interventions and strategies implemented by subrecipients. Elements from the CLI have been incorporated into POMS, and additional modifications will be made to track the provision of T/TA.

The SPE grant allowed us to conduct an inventory of all substance abuse prevention initiatives. This was the first inventory of all prevention initiatives ever conducted in New Jersey. The NJPFS initiative will allow us to replicate this inventory. Incorporating data from POMS and our new prevention inventory into our evaluation plan will allow us to report several measures of performance, including the following:

1) Number of T/TA activities provided through NJPFS to regional coalitions to support communities;
2) Reach (numbers served) of T/TA activities provided through NJPFS;

3) Percentage of communities targeted by regional coalitions that have increased the number or percentage of evidence-based programs, policies, and/or practices (EBPPPs);
4) Percentage of communities targeted by regional coalitions that report an increase in prevention activities supported by leveraging of resources; and,
5) Percentage of regional coalitions that submit data to the POMS data system.

POMS will be particularly useful for our evaluation since it follows the national model for the SPF SIG evaluation. Another vital modification to POMS included a new Strategic Prevention Framework (SPF) Module that tracks prevention providers' development of plans and progress in addressing the priorities that are specified by the State for particular funding awards. In addition, POMS now has an Environmental Module. Based on the CLI, the module collects information on activities related to policy enactment, enforcement and communication. These new modules will allow us to report several measures of performance, including the following:

1) Number of active partners supporting the local PFS initiative;
2) Number of people reached by Institute of Medicine (IOM) prevention category (universal, selected, indicated);
3) Number of people reached by demographic category;
4) Number of EBPPPs implemented by subrecipient communities; and,
5) Number of prevention activities at the subrecipient community level that are supported by leveraging of funding streams

Another component to be added to POMS, with support of this new funding, is a new Outcomes Module. It will incorporate the CSAP and PFS required national outcomes measures (NOMS), such as 30-day use, binge drinking, drug and/or alcohol-related crime, drug and/or alcohol-related car crashes and injuries, perceived risk/harm, and other targeted outcomes. This new Outcomes Module will allow us to report the following measures of performance:

1) Past-30-day alcohol use
2) Past-30-day prescription drug misuse
3) Binge drinking
4) Alcohol- and drug-related car crashes
5) Alcohol- and drug-related crime
6) Perception of parental of alcohol use
7) Perceived risk or harm or alcohol use
8) Alcohol and prescription drug-related emergency room visits

It is important to note that, at this time, we are specifying these NOMS in our evaluation plan only for the grantee. The regional coalitions have not yet developed their strategic plans to describe the nature of their particular intervention activities that will be conducted under the auspices of the NJPFS initiative.

Measurement

Our evaluation will use multiple methods, measures, and designs to assess process and outcome variables at state, coalition and community levels of analysis. As stated previously, our evaluation questions ask about the ways in which regional coalitions implemented the SPF model and the influence of their interventions on targeted outcomes representing intervening variables, use and consequences. In addition, these questions ask about the ways in which the broader NJPFS initiative influenced the prevention systems at the state and local levels. Our

process-related questions will be addressed using quantitative and qualitative methods in a multiple case study design. Data from web-based, self-report surveys, key informant interviews, participant observations, and analyses of documents (e.g., meeting minutes), along with data from the POMS, will be used to complete assessments of coalitions' fidelity to the SPF model and whether the NJPFS initiative was implemented as planned. A quantitative self-report survey will be administered online to all coalition members and qualitative, structured telephone interviews will be conducted with 2-3 coalition members and key DMHAS personnel. Participants in interviews will be drawn from a purposeful, nonrandom sampling strategy, which involved two levels of participants. The first group will involve state-level individuals, comprised of staff members within DMHAS and active members of the SEOW. The second group will involve individuals at the community level, consisting of participants within each of the regional coalitions. Together, these data will be used to assess coalitions' fidelity of implementation (FOI) to the SPF model. We will rely on the SPF FOI instrument developed by RMC Research, along with the SPF FOI User's Guide and Fidelity Assessment Rubric, to assess FOI in this evaluation. These surveys, interviews, and FOI assessment will be conducted annually.

To address our outcomes-related questions, variables at the state and community levels of analysis will be analyzed using interrupted time-series methodology to assess changes in outcomes in the targeted areas over time. Regarding outcome measures, below are the grantee-level measures that we have identified to date. Because regional coalitions have not yet developed their strategic plans to describe the nature of their particular intervention activities that will be conducted under the auspices of the NJPFS initiative, we are not identifying specific measures for coalitions at this time.

Grantee-Level Measures for Partnerships for Success

Measure	Source	Frequency Collected	Method of Collection	Level of Data
1. Past-30-day alcohol use	NJ Middle School Risk and Protective Factor Survey; NJ Health Survey of High School Students	Biennial Biennial	Middle schools (then classrooms) randomly selected throughout state; sample stratified by county, administered in classroom. Administered the survey in each randomly-selected classroom at sampled high schools	State, county State
2. Past-30-day prescription drug misuse	NJ Middle School Risk and Protective Factor Survey	Biennial	Middle schools (then classrooms) randomly selected throughout state; sample stratified by county, administered in classroom.	State
3. Binge drinking	NJ Middle School Risk and Protective Factor Survey	Biennial	Middle schools (then classrooms) randomly selected throughout state; sample stratified by county, administered in classroom.	State
4. Alcohol- and	Rutgers University	Annual	Administrative data	State,

drug-related car crashes	Center for Advanced Infrastructure and Transportation			county
5. Alcohol- and drug-related crime	Uniform Crime Report	Annual	Administrative data	State
6. Perception of parental disapproval of alcohol use	NJ Middle School Risk and Protective Factor Survey	Biennial	Middle schools (then classrooms) randomly selected throughout state; sample stratified by county, administered in classroom.	State
7. Perceived risk or harm of alcohol use	NJ Middle School Risk and Protective Factor Survey	Biennial	Middle schools (then classrooms) randomly selected throughout state; sample stratified by county, administered in classroom.	State
8. Alcohol and prescription drug-related emergency room visits	NJ Division of Mental Health and Addiction Services	Annual	Administrative data	State, county

Behavioral Health Disparities

Our evaluation plan includes procedures to assess the extent to which the 17 regional coalitions, as well as the broader NJPFS initiative, use data to identify subpopulations (i.e., racial, ethnic, sexual/gender minority groups) vulnerable to disparities and implement strategies to decrease the differences in access, service use, and outcomes among subpopulations.

Specifically, a case study design will be used to assess fidelity of implementation (FOI) to the SPF model at both the coalition and grantee/state levels. To assess coalitions' FOI to the SPF model, we will use the SPF FOI instrument developed by RMC Research. This instrument, along with the SPF FOI User's Guide and Fidelity Assessment Rubric, was developed to measure FOI to the SPF model, and it has specific criteria that can be sued by evaluators to assess the extent to which subrecipients' epidemiological workgroups use data to identify subpopulations vulnerable to disparities. Our evaluation team will use this instrument to assess whether regional coalitions used data to identify subpopulations vulnerable to disparities. Data from POMS will be used to determine the extent which coalitions implemented strategies to decrease the differences in access, service use, and outcomes among subpopulations.

Our evaluation also will measure access to culturally and linguistically appropriate services. Specifically, we will apply a modified version of a self-assessment tool developed by Michigan's Bureau of Substance Abuse and Addictive Services to assess the extent to which regional coalitions are implementing the SPF model and prevention strategies in ways that are culturally and linguistically appropriate. This self-assessment was designed to ensure that coalitions' members and staff were selected to bring diverse points of view and perspectives to the design and implementation of culturally-relevant practices. It also will assess whether cultural competence is permeated throughout the SPF process and whether cultural competence is considered as something more than racial and ethnic diversity.

Analysis Plan

Qualitative and quantitative analyses will be performed to examine data that will be used to address our process evaluation questions. Together, these qualitative and quantitative data will be used to complete the SPF FOI instrument. Qualitative data be gathered to describe implementation of the SPF model and the process through which the NJPFS initiative was implemented will be analyzed using a grounded theory approach. Our evaluation team will conduct the key informant interviews by telephone, using the structured schedule of questions. Recorded notes from the interviews will be entered into Atlas.ti version 6.1.17, qualitative data software, for analysis. One coder will assign in-vivo codes (line by line) to the transcripts of each of the interview questions separately. All codes will then be grouped into categories to explore patterns or themes. Themes will be identified and quantified within the data patterns.

The first step in the analysis of quantitative data from our self-report survey of coalition members will consist of data cleaning and verifying the accuracy of data entry and missing data. Frequency distributions will be tabulated for all variables and will be examined for normality in conjunction with skewness in the case of numerical variables. If there are extreme deviations, appropriate non-linear transformations (e.g., log) will be applied to the data. This is an initial, yet crucial, step to ensure the integrity of our data.

To test the validity of our quantitative measures in the self-report survey, we will conduct a series of confirmatory factor analyses (CFA) of the individual-level survey data. CFA will be performed to examine the underlying measurement models for survey scales. Although factor analysis represents a broad category of approaches and procedures for determining the latent structure of observed variables and assessing construct validity of an instrument, CFA will be used to impose substantively motivated constraints on the models and to perform statistical tests that will determine if the sample data obtained are consistent with the imposed constraints of the models. Prior to performing the CFA, exploratory data analysis will be conducted to inspect the univariate skewness and kurtosis values of the measured variables. In addition, the Kolmogorov-Smirnov test of normality will be performed to determine whether data are normally distributed. Mardia's coefficient of multivariate kurtosis provided by AMOS will also be examined to determine whether the assumption of multivariate normality is tenable. Based on these results, a decision will be made whether to use the frequently applied ML method of estimation or the asymptotically distribution-free (ADF) estimation procedure. The ML procedure requires the observed variables to be normally distributed whereas the ADF estimation does not. Researchers have suggested the use of ADF when the nature of the data could not justify the application of the ML. The overall fit of the data to the examined models will be initially based on the chi-square statistic. However, we recognize that the chi-square statistic is very sensitive to departures from normality. In an attempt to overcome this problem, our interpretation of model fit will be based on evaluating several fit indexes, parameter estimates, and residual error terms.

We also will analyze longitudinal data from our quantitative survey of coalition members to examine changes in coalitions' structure, functioning, and fidelity to the SPF model over time. We will perform these analyses with structural equation modeling (SEM) procedures on observed variables using AMOS 21. These analyses will be conducted to determine if significant overall changes in the variables occurred over time, if significant variability existed in individual change trajectories, and if relationships existed between baseline values and changes over time.

Regarding expected sample sizes, we anticipate approximately 400 responses to our quantitative self-report survey that will be administered online to all coalition members. In addition, we anticipate approximately 50 individuals to participate in our key informant

interviews. These qualitative, structured telephone interviews will be conducted with 2-3 members per regional coalition and key DMHAS personnel. Participants in interviews will be drawn from a purposeful, nonrandom sampling strategy, which involved two levels of participants. The first group will involve state-level individuals, comprised of staff members within DMHAS and active members of the SEOW. The second group will involve individuals at the community level, consisting of participants within each of the regional coalitions.

Graphic and statistical analyses will be performed to examine data that will be used to address our outcome evaluation questions. These data will be used to test the effects of the interventions implemented by regional prevention coalitions on the targeted intervening variables. It is important to recognize that the analyses presented here apply only to outcomes at the state level of analysis because regional coalitions have not yet developed their strategic plans to describe the nature of their particular intervention activities that will be conducted under the auspices of the NJPFS initiative. Although these analyses do not include a control or comparison group, they do allow for baseline and post-intervention comparisons, as well as procedures to measure change over time.

Participation in PFS National Cross-Site Evaluation

Our evaluation team will work closely with the national cross-site evaluators to provide data and other support as needed for this project. The evaluation team will comply with all requirements of the cross-site evaluation. Our evaluation also will integrate the cross-site evaluation instruments at the grantee and coalitions levels. We will ensure all data collection for the Grantee-Level Instrument and Community-Level Instrument.

Reporting Plan

The evaluation team will provide annual reports to the DMHAS' State Epidemiological Outcomes Workgroup (SEOW). The DMHAS epidemiologist, along with the SEOW Manager, will then develop electronic and hard copy data products for dissemination to policy makers, state agencies and local communities. Products will include Powerpoint projects to be presented locally to community organizations, county and state departments, and non-profit groups. Data fact sheets will be published and disseminated on an annual schedule.

Environmental Factors and Plan

9. Statutory Criterion for MHBG - Required for MHBG

Narrative Question

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental and substance use disorders. Describes available services and resources within a comprehensive system of care, provided with federal, state, and other public and private resources, in order to enable such individual to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Please respond to the following items

Criterion 1

1. Describe available services and resources in order to enable individuals with mental illness, including those with co-occuring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

SMHA funds four levels of service along the mental health continuum of care with Community Mental Health Block Grant, and other federal or state funds. They are: Prevention and Early Intervention Services, Acute Care Services, Intermediate and Rehabilitative Services, and Recovery Support including Consumer Operated Services. In addition, the SMHA partially funds four County Psychiatric Hospitals. The SMHA also engages in Olmstead Initiatives. The Department of Health has oversight for the four State Psychiatric Hospitals.

(1) Prevention and Early Intervention. The following are the SMHA's specific prevention initiatives: Executive Order #58 established the Governor's Council on Mental Health Stigma. Each year the Council presents Ambassador Awards to those who champion the mission to raise mental health awareness to combat stigma. Due to the restructuring of the Governor’s Council which is still in progress, the Ambassador Awards, did not occur in 2019. However, in the coming months, the Council will reconvene with renewed energy and enthusiasm and plan for their initiatives in Fiscal Year 2020.

First Episode Psychosis. New Jersey has utilized the MHBG 10% set-aside funds for providing service to individuals with first episode psychosis (FEP) since FY 2017 and will continue to provide the service in FY 2020-2021.

NJ PROMISE Program for Serving Youth and Young Adults at Clinical High Risk for Psychosis (CHR-P)
In FY 2019, the New Jersey Children’s System of Care (CSOC) was awarded a SAMHSA grant for establishing community programs for outreach and intervention with youth and young adults at clinical high risk for psychosis (CHR-P). DMHAS and CSOC co-lead the project. The project title is NJ PROMISE – Prevention, Resilience, Optimism, Mastery, Insight, Support, and Education. The NJ PROMISE program serves youths and young adults not more than 25 years of age who experience the prodromal symptoms of psychosis. This program provides evidence-based interventions to prevent and/or delay the onset of psychosis.

Moving on Maternal Depression (MOMD) Initiative: In August 2018, New Jersey received an award from the Center for Law and Social Policy (CLASP) through its Moving on Maternal Depression (MOMD) initiative. The 18-month grant provides technical assistance on promising practices toward serving populations with maternal depression. This initiative built a collaborative that focuses on improving the ability to serve mothers with maternal depression in New Jersey. The state agencies in the collaborate are the Division of Mental Health and Addiction Services, the Department of Health, the Division of Medical Assistance and Health Services, the Department of Children and Families, and three maternal health consortia.

Suicide Prevention. The SMHA funds the NJ Suicide Prevention Hopeline which accepts calls 24/7 from individuals seeking information or assistance for themselves or others at risk of suicide. If the caller is assessed as at risk for suicide, there is a warm transfer of the caller to the screener center. In addition, SMHA has scheduled to implement a statewide Zero Suicide approach in collaboration with the Zero Suicide Institute in fall of 2019.

(2) Acute Care Services. The SMHA funds and regulates a variety of acute mental health care programs for individuals with acute mental health needs and for those experiencing psychiatric crises. They include Designated Screening Centers (DSC), Affiliated Emergency Services (AES), Early Intervention Support Services (EISS), Involuntary Outpatient Commitment (IOC), Intensive Outpatient Treatment and Support Services (IOTSS), and Projects for Assistance in Transition from Homelessness (outreach to persons who are homeless) and Short Term Care Facility (STCF) beds.

(3) Intermediate and Rehabilitative Services. The SMHA contracts for Intermediate and Rehabilitative services including: Community

Support Services (CSS); Residential Services; Supported Employment (SE); Supported Education (SEd); Programs for Assertive Community Treatment (PACT); Intensive Family Support Services (IFSS), Illness Management and Recovery (IMR); Justice Involved Services (JIS); Integrated Case Management Services (ICMS); Outpatient Services (OP); Partial Care (PC); Statewide Clinical Outreach Program for the Elderly (S-COPE); and Legal Services.

(4) Extended/ongoing Recovery Supports: Consumer-operated Services including Self-help Centers and Wellness Recovery Centers. There are currently 33 Community Wellness Centers/Self-Help Centers/Recovery Centers throughout the 21 counties of the state funded by DMHAS, including 3 centers located on the grounds of the regional state hospitals.

2. Does your state coordinate the following services under comprehensive community-based mental health service systems?

a)	Physical Health	(•) Yes ( ) No
b)	Mental Health	(•) Yes ( ) No
c)	Rehabilitation services	(•) Yes ( ) No
d)	Employment services	(•) Yes ( ) No
e)	Housing services	(•) Yes ( ) No
f)	Educational Services	(•) Yes ( ) No
g)	Substance misuse prevention and SUD treatment services	(•) Yes ( ) No
h)	Medical and dental services	(•) Yes ( ) No
i)	Support services	(•) Yes ( ) No
j)	Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA)	(•) Yes ( ) No
k)	Services for persons with co-occuring M/SUDs	(•) Yes ( ) No

Please describe or clarify the services coordinated, as needed (for example, best practices, service needs, concerns, etc.)

3. Describe your state's case management services

Consumers are linked to Integrated Case Management Services (ICMS) upon discharge from a state hospital, county hospital or Short Term Care Facility (STCF) for 12 months post-discharge from the inpatient setting. ICMS services work collaboratively with the consumer, their family/significant others (as appropriate) and other collateral contacts to assesses the individual's strengths and needs, develop a service plan based on this assessment, refer and link individuals to needed services and monitor their engagement in services. ICMS services are available for a minimum of 12 months and can be extended beyond 12 months pursuant to the individual's specific needs.

In addition, PACT, PATH, and FEP programs also provide case management services. PACT is an evidence-based model of service delivery in which a multi-disciplinary, mobile, treatment team provides a comprehensive array of mental health and rehabilitative services to a targeted group of individuals with SMI. The program is designed to meet the needs of consumers, who are at high risk for hospitalization, are high service users and who have not been able to benefit from traditional mental health programs. In order to meet the unique needs of this targeted population, PACT teams offer highly individualized services, employ a low staff to consumer ratio, conduct the majority of their contacts in natural community settings (e.g. consumer's residence) and are available to help individuals address psychiatric crises 24 hours a day. Service intensity is flexible and regularly adjusted to consumer needs.

All New Jersey PATH programs provide outreach, screening and assessment, case management and referral services for community mental health and substance abuse treatment services, financial benefits, primary health services, job training/vocational and educational services and relevant housing services including; emergency housing, transitional housing and permanent housing services.

The New Jersey's CSC programs for individuals with FEP emphasize a team approach with the following components: outreach, low-dosage medications, cognitive and behavioral skills training, Individualized Placement and Support, Supported Employment and Supported Education, case management, and family psycho-education. Each CSC team is comprised of six team members of mostly masters' level trained clinicians. They include a team leader, a recovery coach, a supported employment and education specialist, a pharmacotherapist, an outreach and referral specialist; and a peer support specialist.

4. Describe activities intended to reduce hospitalizations and hospital stays.

The Division of Mental Health and Addiction Services (DMHAS) is in the process of revising Administrative Bulletin 5:11 in an effort to reduce hospital lengths of stay. Under this bulletin, consumers in state psychiatric hospitals are assigned to community service providers whom have the option of either accepting the consumer or requesting additional supports from DMHAS. In addition to community providers, state psychiatric hospitals have the option within their discharge planning process of requesting additional supports for the consumer in their potentially new living situations outside the institutions. Such requests and other efforts

toward successful discharge are to be documented within the Individual Needs for Discharge Assessment (INDA). Assignments are based on hospital treatment team recommendations as well as consumer choice, and the assigned provider is expected to participate in every treatment team meeting from the consumer's first to his/her last while in the hospital. The early involvement of community providers in the treatment planning process fosters familiarity between provider and consumer, allowing for immediate planning on the part of the provider to prepare to meet the individualized needs of each consumer upon discharge into their care. This preparation is critical to ensuring that the consumer is provided with necessary community supports and thereby maximizing his/her chances of sustained integration within the community.

As part of its Home to Recovery II Plan, DMHAS is focusing its efforts on enhancing the community-based resources available to its consumers. One such enhancement is the implementation of Community Support Services (CSS). A Medicaid-billable rehabilitative service, CSS offers education to consumers in the community on navigating daily activities, rather than performing these activities on their behalf. The goal of these services is to nurture independence and self-reliance on the part of the consumer, empowering them to thrive as functional and competent members of a community outside of an institutional setting.

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

Another area of focus for DMHAS's Home to Recovery II Plan is the examination of outcomes geared toward monitoring sustainability of the Division's community integration efforts. These outcomes include the completion of Medicaid applications within 30 days of determining the necessary level of care for consumers in state psychiatric hospitals; an increase in Peer Support Specialists across state psychiatric hospitals; expansion of the Behavioral Health Home initiative integrating primary and behavioral health care for mental health services consumers; enhanced utilization of Supportive Housing in the form of sustained tenure in Supportive Housing placements, expansion of Supportive Housing opportunities, and an increase in discharges to Supportive Housing as well as in the percentage of consumers served by Supportive Housing as compared to state psychiatric hospitals; and finally a decrease in hospitalizations in the form of lower census counts (for CEPP consumers and the total hospital population); fewer admissions to state hospitals; a reduction in length of stay on CEPP status and within the hospital overall; and a decrease in CEPP consumers as a proportion of the total hospital census.

There are the activities that SMHA would like to highlight:
1. The partnership with Vital Statistics continues. In October 2014, DMHAS established a partnership with Vital Statistics in the New Jersey Department of Health to allow DMHAS staff to routinely retrieve birth certificates prepared by Vital Statistics for New Jersey born consumers that were previously unable to produce them. This process has greatly improved the discharge process by helping to remove a significant barrier to discharge. In SFY2017, 471 birth certificates were obtained by way of this collaboration. The number of birth certificates obtained in SFY 2018 and SFY 2019 were 438 and 401 respectively.

2. The Bed Enrollment Data System (BEDS) was developed to help DMHAS manage and track vacancies. Utilization of a web-based system provides real-time access to vacancy information and helps facilitate assignments.

3. Enhancements to the Individual Needs for Discharge Assessment (INDA) were made. DMHAS has recently implemented INDA-specific canned reports, which provide hospital staff and central office users with immediate access to information contained within the assessment, including but not limited to provider assignments, attendance at treatment team meetings, functional needs of each hospital's census, and consumers refusing to be discharged. This information will be used at all levels of the Division and drive efforts geared toward quality improvement and planning for the allocation of resources and the implementation of new initiatives.

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

5. Utilization of Hospital Project Teams continues. Project Team meetings are higher-level meetings that occur immediately after ICRC and are typically chaired by the hospital CEO/DCEO or Medical Director. Policy and systems issues, as well as any issue that may involve collaboration with another Division or state Department, are discussed at these meetings and elevated to Olmstead leadership to address. In addition to policy and systems reviews, Project Team meetings also discuss newly-designated CEPP consumers to ensure that a discharge plan is in place. On an as-needed basis, teams also hear brief case presentations in the event that Olmstead resources are needed. Finally, Olmstead staff will also use these meetings to update the hospital leadership on any new administrative bulletins, requests for proposals, updates or changes to the vacancy tracking system, and/or trends

identified in the data.

6. Hospital Diversion Initiative continues. The Olmstead Office has partnered with Centralized Admissions within the state psychiatric hospitals on a process for redirecting would-be hospitalizations to less restrictive community settings. Regional Olmstead staff assist Centralized Admissions in securing additional supports needed for applicable consumers as a means of addressing their individualized circumstances and needs in the most integrated setting possible within their required level of care. This collaboration allows for reduced hospital census as well as enhanced community integration as mental health consumers are diverted from state or county hospitals and continue to live independently in the community.

Criterion 2: Mental Health System Data Epidemiology

Contains an estimate of the incidence and prevalence in the state of SMI among adults and SED among children; and have quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

Criterion 2

In order to complete column B of the table, please use the most recent SAMHSA prevalence estimate or other federal/state data that describes the populations of focus.

Column C requires that the state indicate the expected incidence rate of individuals with SMI/SED who may require services in the state's M/SUD system.

MHBG Estimate of statewide prevalence and incidence rates of individuals with SMI/SED

Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1.Adults with SMI	375,227	
2.Children with SED	122,296	

Describe the process by which your state calculates prevalence and incidence rates and provide an explanation as to how this information is used for planning purposes. If your state does not calculate these rates, but obtains them from another source, please describe. If your state does not use prevalence and incidence rates for planning purposes, indicate how system planning occurs in their absence.

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

Prevalence:
According to the Federal methodology proposed for estimating the prevalence of SMI, the proportion of adults within the state with a SMI is 5.4% (Federal Register, Volume 64, No. 121, p. 33890). According to figures released by the United States Census Bureau, the 2018 adult population of New Jersey was 6,948,646. The size of the New Jersey child population was 1,528,702. Using the SAMHSA's SMI prevalence rate among persons 18 and older (5.4%) the estimated number of adults with SMI in New Jersey in 2018 was 375,227. Using the SAMHSA's SED prevalence rate (8.0%), the estimated number of children with SED in New Jersey in 2018 was 122,296. New Jersey has not established a methodology to estimate statewide incidence rate of individuals with SMI/SED.

Criterion 3: Children's Services

Provides for a system of integrated services in order for children to receive care for their multiple needs.

Criterion 3

Provides for a system of integrated services in order for children to receive care for their multiple needs. Does your state integrate the following services into a comprehensive system of care?

a)	Social Services	(•) Yes ( ) No
b)	Educational services, including services provided under IDE	(•) Yes ( ) No
c)	Juvenile justice services	(•) Yes ( ) No
d)	Substance misuse preventiion and SUD treatment services	(•) Yes ( ) No
e)	Health and mental health services	(•) Yes ( ) No
f)	Establishes defined geographic area for the provision of services of such system	(•) Yes ( ) No

Criterion 4

a. Describe your state's targeted services to rural population.

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

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

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

During CCBHC Demonstration Year 1 which covered the period July 1, 2017 to June 30, 2018, NJ's seven CCBHCs cumulatively enrolled 17,851 consumers. Nineteen percent of the patient population were children and adolescents aged 0 to 17, three-quarters (73.3%) of patients were aged 18 to 64, and 8% were seniors aged 65 years and older.

Between July 1, 2017 and June 30, 2018, AtlantiCare enrolled 554 consumers. 91.0 percent of AtlantiCare CCBHC patients were aged 18 to 64 and 9% were seniors aged 65 years and older. By gender, three-fifths of patients were female. By race, 71.3% of consumers were white and 10% were black/African American, although race information was missing for 17% of consumers. Sixteen percent of consumers were of Hispanic ethnicity. Broken down by diagnostic subgroup, half (48.5%) of AtlantiCare CCBHC consumers had a primary diagnosis of Severe Mental Illness, two-fifths (37.7%) were members of the General population, and 14% had a primary diagnosis of Substance Use Disorder. Thirty-six percent of consumers were commercially insured, 12% had primary Medicare insurance, and 37% had Medicaid insurance as their primary insurer. An additional 6% of clients were dually Medicare/Medicaid insured for a total of 43.8% of AtlantiCare CCBHC consumers who had primary Medicaid insurance or were dually Medicare/Medicaid insured.

The CCBHC Demonstration Program is scheduled to end on September 13, 2019. The state is currently reviewing plans for sustainability.

b. Describe your state's targeted services to the homeless population.

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

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

The SMHA contracts with 25 non-profit agencies to operate PATH programs within the state's 21 counties. A small number of PATH programs use PATH funding to directly provide psychiatric assessment and outpatient mental health services. Many PATH providers are Community Mental Health Centers and link their consumers to mental health in their agency outpatient or partial care programs. All PATH programs link individuals to behavioral health and co-occurring services within their communities.

In SFY 2018, the PATH programs in New Jersey provided outreach to 4,284 individuals and served a total of 2,417 persons. 1,108 program participants were linked to mental health services, 289 to substance use treatment services, 410 to primary health/dental care, 623 to financial services, 467 to temporary housing/shelter, 527 to long term housing and 198 were linked to employment or vocational and educational services.

Services provided under the CCBHC initiative are available to all who meet programmatic criteria without regard for race, ethnicity, age, gender identity, sexual orientation, religious affiliation, or place of residence. Policies such as "no wrong door" allows any consumer access to CCBHC services regardless of insurance or pay status, place of residence, or lack of a permanent address. An average of three percent of CCBHC consumers at each CCBHC provider reported being homeless or living in a shelter during Demonstration Year 1. The two CCBHCs located in Trenton, Oaks Integrated and Catholic Charities, served the highest homeless populations at 10 percent and five percent, respectively.

In 2019, SMHA has created approximately 50 At-Risk Tenant Based Rental Subsidies for individuals with mental illness intended to promote: housing stability; engagement with mental health services and primary healthcare; community inclusion and wellness and recovery.

c. Describe your state's targeted services to the older adult population.

Statewide Clinical Outreach Program for the Elderly (S-COPE) provides a multidisciplinary treatment team approach to address the statewide crisis needs of older adults with SMI. In 2011, DMHAS saw a need to develop specialized services to assist screening centers and nursing homes to respond to an increasing number of older adults with behavioral problems. In 2012, DMHAS awarded a contract for the development of a program to provide specialized clinical consultation, assessment, treatment and intervention to older adults who were at risk for presentation to ERs for psychiatric hospitalization. Trinitas Regional Medical Center in Elizabeth, New Jersey was the recipient and has been administering this Statewide Clinical Outreach Program for the Elderly (S-COPE), which is fully funded by DMHAS and has been in operation since April 2012.

S-COPE provides crisis intervention and stabilization, consultation, and training for the management of mental health and behavioral health issues in older adults (55+) residing in nursing homes and State-funded residential care facilities. S-COPE functions as a multidisciplinary team consisting of a geriatric psychiatrist (consultant), a gero-psychologist, geriatric advanced practice nurse, and masters level clinicians. Outcomes are carefully monitored and reported to DMHAS on a monthly basis.

The S-COPE program is available 24 hours/7 day a week to offer face-to-face clinical consultative services. S-COPE staff also provide training and technical assistance to screeners, administrators, clinical staff, direct care staff and support staff, primarily in nursing facilities to improve staff's ability to assess, provide treatment, manage behavioral disturbances and stabilize crises for this population. The multidisciplinary clinical team advocates for acute care treatment of older adults who need psychiatric hospitalization and advocates within the facility for management of behavioral issues for individuals who would not benefit from inpatient psychiatric stays.

Prior to S-COPE's inception, individuals with dementia were more likely to be referred to mental health crisis screening centers and emergency rooms, and many were subsequently being admitted to inpatient psychiatric facilities, including state psychiatric hospitals. In 2018, there were 921 referrals to S-COPE and 189 were diverted from screening centers. There were 1,532 face to face visits conducted and 2,770 phone consultations. S-COPE continues to provide support in maintaining clients in facilities by closely working with nursing staff. With S-COPE involvement, at least 12 individuals have been diverted from state hospitals. S-COPE equips staff by sharing best practices and offering trainings. All trainings, assessments, and treatments offered are consistent with promising practices and/or evidence-based practices.

Trainings are delivered by S-COPE interdisciplinary team members consisting of Master level clinicians, Advanced Practice Nurse, Psychiatrist, Psychologist, and/or Licensed Clinical Social Workers. Trainings are conducted on-site at facilities, via ECHO on ZOOM platform, and at regional locations. In 2018, there were 177 trainings completed to over 2,300 people. There were 75 trainings completed in northern region, 47 trainings in the central region, and 55 trainings completed in the southern region. Trainings are open to all professionals including, but not limited to, Social Workers, Nurses, Psychiatrist, CNAs, and other professionals. In 2018, S-COPE exceeded the training contracted goals and it continues to find innovative ways to deliver evidence based trainings.

S-COPE ensures that the program is culturally and linguistically competent, accessible, and responsive to agencies, consumers and families. The older adult mental health service system in New Jersey does not discriminate with regard to diverse racial, ethnic and sexual /gender minorities.

Criterion 5: Management Systems

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

Criterion 5

Describe your state's management systems.

The DMHAS is dedicated to community--based mental health services and is advancing community supports for individuals no longer in need of hospital based psychiatric treatment and those at risk of hospitalization. The DMHAS coordinates with community based providers to administer behavioral health services, including prevention and early intervention, screening services, outpatient counseling, partial and day treatment services, case management, residential and supported housing, family support, self—help centers and supported employment. In SFY 2019, State appropriations for mental health community providers were $352 million. A significant source of the increase has been the State's investment in the Olmstead – Home to Recovery Initiative, which has primarily provided funding for supportive housing placements for clients discharged from state hospitals, as well as for clients at risk of hospitalization. Additionally, DMHAS is now over two years into the transition of moving select community based mental health services from cost-reimbursement contracts to fee-for-service contracts, also known as the Mental Health Fee-for-Service Program (MH-FFS Program). This transition, which began January 1, 2017, represented an historic transformation for the New Jersey public mental health system. The State has transitioned providers and clients to Fee for Service reimbursement, and away from fixed cost or overall cost reimbursement contracts. Concurrent with this, reimbursement rates were enhanced for many services and additional state funding (roughly $20 million) was appropriated for this purpose. DMHAS believes that the combination of more attractive Medicaid rates and the transition to a direct Fee for Service reimbursement approach for non-Medicaid services (with enhanced rates), will lead to greater access for clients and a more transparent, accountable and efficient behavioral health service delivery system.

As part of its remaining cost reimbursement contract base, DMHAS continues to fund training and technical assistance that many community providers are able to access. The total contracted amount for SFY 2019 was approximately $5.2 million. In addition, State staff are continuously organizing conferences, meetings and webinars that providers attend on many subjects of interest to them in their daily operations. Notably, in SFY 2019, and continuing into SFY 2020, State staff have been holding weekly webinars/information sessions to help providers adjust to the new Fee for Service billing system for non-Medicaid services.

Goals

While New Jersey currently has cost-based contracts and Fee for Service arrangements with approximately 117 unduplicated agencies that provide eligible Block Grant services, to facilitate reporting, administration and minimize the audit burden on our providers, DMHAS has allocated the available Block Grant funding to a selected group of approximately 26 provider agencies. This group of agencies and the amounts allocated to each have been revised over the years to reflect changes in Block Grant requirements, funding and service levels, changes in the agencies' service programs due to mergers, name changes, and other reasons. In order to ensure that we are in compliance with the requirement to expend such funds only for services to adults with SMI and children with SED, DMHAS first reviews data on consumers served by each of the selected agencies' contracts to identify the percentage of total consumers receiving services who are either adults with SMI or children with SED. Based on these results, we calculate the portion of each agency's total contract ceiling that represents Block Grant eligible costs. The result of this calculation yields a total pool of eligible costs, just for the above noted selected group of agencies, of about $94 million for state fiscal year 2020. Consequently, the Block Grant funding for contracted services is then allocated to each of the agencies in the selected group, based on the relative percentage of their eligible costs to the total eligible costs of all agencies in the group.

Footnotes:

Environmental Factors and Plan

10. Substance Use Disorder Treatment - Required SABG

Narrative Question

Criterion 1: Prevention and Treatment Services - Improving Access and Maintaining a Continuum of Services to Meet State Needs

Criterion 1

Improving access to treatment services

1. Does your state provide:

a) A full continuum of services

i)	Screening	(•) Yes ( ) No
ii)	Education	(•) Yes ( ) No
iii)	Brief Intervention	(•) Yes ( ) No
iv)	Assessment	(•) Yes ( ) No
v)	Detox (inpatient/social)	(•) Yes ( ) No
vi)	Outpatient	(•) Yes ( ) No
vii)	Intensive Outpatient	(•) Yes ( ) No
viii)	Inpatient/Residential	(•) Yes ( ) No
ix)	Aftercare; Recovery support	(•) Yes ( ) No

b) Services for special populations:

Targeted services for veterans?	(•) Yes ( ) No
Adolescents?	( ) Yes (•) No
Other Adults?	(•) Yes ( ) No
Medication-Assisted Treatment (MAT)?	(•) Yes ( ) No

Criterion 2: Improving Access and Addressing Primary Prevention -See Narrative 8. Primary Prevention-Required SABG.

Criterion 2

Criterion 3

1. Does your state meet the performance requirement to establish and/or maintain new programs or expand programs to ensure treatment availability? (●) Yes ( ) No

2. Does your state make prenatal care available to PWWDC receiving services, either directly or through an arrangement with public or private nonprofit entities? (●) Yes ( ) No

3. Have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care? (●) Yes ( ) No

4. Does your state have an arrangement for ensuring the provision of required supportive services? (●) Yes ( ) No

5 Has your state identified a need for any of the following:

a) Open assessment and intake scheduling (●) Yes ( ) No

b) Establishment of an electronic system to identify available treatment slots (●) Yes ( ) No

c) Expanded community network for supportive services and healthcare (●) Yes ( ) No

d) Inclusion of recovery support services (●) Yes ( ) No

e) Health navigators to assist clients with community linkages (●) Yes ( ) No

f) Expanded capability for family services, relationship restoration, and custody issues? (●) Yes ( ) No

g) Providing employment assistance (●) Yes ( ) No

h) Providing transportation to and from services (●) Yes ( ) No

i) Educational assistance (●) Yes ( ) No

6. States are required to monitor program compliance related to activities and services for PWWDC. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

The grants monitoring program at the Division of Mental Health and Addiction Services (DMHAS) includes Program Management Officers (PMO) and a supervisor who monitor SAPT Block Grant recipients. Onsite visits are made to each SAPT Block Grant recipient a minimum of one time per calendar year. More frequent reviews may be conducted on an as needed basis for agencies identified by the Department of Health, Certificate of Need and Licensing (CN&L) and or as needing additional technical assistance or monitoring because of violations, other deficiencies, or special grant requirements.

Site visits may be anywhere from one to five days in duration depending on the size and scope of the program. Once onsite, the PMO will meet with agency staff as a group and/or on an individual basis depending upon the need. The PMO will randomly select a representative sample of client records from the active client list (roster) which will be subject to individual chart reviews. The reviewer conducts chart reviews for the selected sample and completes an Annual Site Monitoring Report. The Annual Site Monitoring Report addresses at a minimum five core areas of performance: Facility, Staff, Treatment Records, Quality Assurance, Specialized Services, and Other contract requirements. 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, licensure, and supervision. Treatment questions pertain to the counselors' procedures and the availability and provision of medical and clinical services. Records questions pertain to the client roster and the maintenance of client files. Quality Assurance questions pertain to the agency's Quality Assurance plan and quality of care. Specialized Services questions pertain to child care, transportation and gender specific treatment. Other questions pertain to management and administrative matters. At the conclusion of the site review, the reviewers conduct an exit conference with sub-recipient representatives.

A copy of the Annual Site Monitoring Report is reviewed by the supervisor for approval. Serious and extreme violations of a requirement are reported up and violations reported to the CN&L for additional follow up with the agency. Site visit report is sent to the sub-recipient and sub-recipient is to reply with a plan of correction (PoC) for areas found to be in noncompliance. Sub-recipients are notified in writing of the acceptance or non-acceptance of the plan of correction and the monitoring staff continues to follow up until an acceptable plan of correction is submitted.

Criterion 4,5&6

Persons Who Inject Drugs (PWID)

1. Does your state fulfill the:

a)	90 percent capacity reporting requirement	(•) Yes ( ) No
b)	14-120 day performance requirement with provision of interim services	(•) Yes ( ) No
c)	Outreach activities	(•) Yes ( ) No
d)	Syringe services programs	(•) Yes ( ) No
e)	Monitoring requirements as outlined in the authorizing statute and implementing regulation	(•) Yes ( ) No

2. Has your state identified a need for any of the following:

a)	Electronic system with alert when 90 percent capacity is reached	( ) Yes (•) No
b)	Automatic reminder system associated with 14-120 day performance requirement	( ) Yes (•) No
c)	Use of peer recovery supports to maintain contact and support	(•) Yes ( ) No
d)	Service expansion to specific populations (e.g., military families, veterans, adolescents, older adults)?	(•) Yes ( ) No

3. States are required to monitor program compliance related to activites and services for PWID. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

DMHAS requires licensed SUD treatment agencies to submit their Interim Services Policies.

DMHAS requires licensed SUD treatment agencies to submit monthly rosters.

DMHAS requires that treatment agencies provide timely reporting on the Service Capacity Management System (SCMS) that is reported to Rutgers University Behavioral Health Care (UBHC), the entity that operates the Interim Managing Entity (IME) Addictions Access Center.

Tuberculosis (TB)

1. Does your state currently maintain an agreement, either directly or through arrangements with other public and nonprofit private entities to make available tuberculosis services to individuals receiving SUD treatment and to monitor the service delivery? (•) Yes ( ) No

2. Has your state identified a need for any of the following:

a)	Business agreement/MOU with primary healthcare providers	( ) Yes (•) No
b)	Cooperative agreement/MOU with public health entity for testing and treatment	( ) Yes (•) No
c)	Established co-located SUD professionals within FQHCs	(•) Yes ( ) No

3. States are required to monitor program compliance related to tuberculosis services made available to individuals receiving SUD treatment. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

The DMHAS Program Monitoring Unit conducts annual site visits to all licensed SUD treatment programs where compliance to TB Services are monitored.

TB Surveillance Procedures devised by the NJ Department of Health are incorporated into the residential and ambulatory regulations followed by all licensed SUD treatment agencies.

Early Intervention Services for HIV (for "Designated States" Only)

1. Does your state currently have an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIV in areas that have the greatest need for such services and monitoring the service delivery? ( ) Yes ( ) No

2. Has your state identified a need for any of the following:

a)	Establishment of EIS-HIV service hubs in rural areas	( ) Yes ( ) No

b)	Establishment or expansion of tele-health and social media support services	○ Yes	○ No
c)	Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS	○ Yes	○ No

Syringe Service Programs

1.	Does your state have in place an agreement to ensure that SABG funds are NOT expended to provide individuals with hypodermic needles or syringes(42 U.S.CÂ§ 300x-31(a)(1)F)?	◉ Yes	○ No
2.	Do any of the programs serving PWID have an existing relationship with a Syringe Services (Needle Exchange) Program?	◉ Yes	○ No
3.	Do any of the programs use SABG funds to support elements of a Syringe Services Program?	○ Yes	◉ No

If yes, plese provide a brief description of the elements and the arrangement

Criterion 8,9&10

Service System Needs

1. Does your state have in place an agreement to ensure that the state has conducted a statewide assessment of need, which defines prevention and treatment authorized services available, identified gaps in service, and outlines the state's approach for improvement — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

- **a)** Workforce development efforts to expand service access — (●) Yes ( ) No
- **b)** Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services — (●) Yes ( ) No
- **c)** Establish a peer recovery support network to assist in filling the gaps — (●) Yes ( ) No
- **d)** Incorporate input from special populations (military families, service memebers, veterans, tribal entities, older adults, sexual and gender minorities) — (●) Yes ( ) No
- **e)** Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, i.e. primary healthcare, public health, VA, community organizations — (●) Yes ( ) No
- **f)** Explore expansion of services for:
  - **i)** MAT — (●) Yes ( ) No
  - **ii)** Tele-Health — (●) Yes ( ) No
  - **iii)** Social Media Outreach — (●) Yes ( ) No

Service Coordination

1. Does your state have a current system of coordination and collaboration related to the provision of person -centered and person-directed care? — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

- **a)** Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services — ( ) Yes (●) No
- **b)** Establish a program to provide trauma-informed care — (●) Yes ( ) No
- **c)** Identify current and perspective partners to be included in building a system of care, such as FQHCs, primary healthcare, recovery community organizations, juvenile justice systems, adult criminal justice systems, and education — (●) Yes ( ) No

Charitable Choice

1. Does your state have in place an agreement to ensure the system can comply with the services provided by nongovernment organizations (42 U.S.C.§ 300x-65, 42 CF Part 54 (§54.8(b) and §54.8(c)(4)) and 68 FR 56430-56449)? — (●) Yes ( ) No

2. Does your state provide any of the following:

- **a)** Notice to Program Beneficiaries — (●) Yes ( ) No
- **b)** An organized referral system to identify alternative providers? — ( ) Yes (●) No
- **c)** A system to maintain a list of referrals made by religious organizations? — (●) Yes ( ) No

Referrals

1. Does your state have an agreement to improve the process for referring individuals to the treatment modality that is most appropriate for their needs? — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

- **a)** Review and update of screening and assessment instruments — (●) Yes ( ) No
- **b)** Review of current levels of care to determine changes or additions — (●) Yes ( ) No
- **c)** Identify workforce needs to expand service capabilities — (●) Yes ( ) No

d) Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background — (●) Yes ( ) No

Patient Records

1. Does your state have an agreement to ensure the protection of client records? — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

a) Training staff and community partners on confidentiality requirements — (●) Yes ( ) No

b) Training on responding to requests asking for acknowledgement of the presence of clients — (●) Yes ( ) No

c) Updating written procedures which regulate and control access to records — (●) Yes ( ) No

d) Review and update of the procedure by which clients are notified of the confidentiality of their records include the exceptions for disclosure — (●) Yes ( ) No

Independent Peer Review

1. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers? — (●) Yes ( ) No

2. Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C.§ 300x-52(a)) and 45 § CFR 96.136 require states to conduct independent peer review of not fewer than 5 percent of the block grant sub-recipients providing services under the program involved.

Please provide an estimate of the number of block grant sub-recipients identified to undergo such a review during the fiscal year(s) involved.

FFY 2020: 3
FFY 2021: 3

3. Has your state identified a need for any of the following:

a) Development of a quality improvement plan — ( ) Yes (●) No

b) Establishment of policies and procedures related to independent peer review — (●) Yes ( ) No

c) Development of long-term planning for service revision and expansion to meet the needs of specific populations — ( ) Yes (●) No

4. Does your state require a block grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, such as the Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for block grant funds? — ( ) Yes (●) No

If Yes, please identify the accreditation organization(s)

i) ☐ Commission on the Accreditation of Rehabilitation Facilities

ii) ☐ The Joint Commission

iii) ☐ Other (please specify)

Criterion 7&11

Group Homes

1. Does your state have an agreement to provide for and encourage the development of group homes for persons in recovery through a revolving loan program? (●) Yes ( ) No

2. Has your state identified a need for any of the following:

a) Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service ( ) Yes (●) No

b) Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing ( ) Yes (●) No

Professional Development

1. Does your state have an agreement to ensure that prevention, treatment and recovery personnel operating in the state's substance use disorder prevention, treatment and recovery systems have an opertunity to receive training on an ongoing basis, concerning:

a) Recent trends in substance use disorders in the state (●) Yes ( ) No

b) Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services (●) Yes ( ) No

c) Preformance-based accountability (●) Yes ( ) No

d) Data collection and reporting requirements (●) Yes ( ) No

2. Has your state identified a need for any of the following:

a) A comprehensive review of the current training schedule and identification of additional training needs (●) Yes ( ) No

b) Addition of training sessions designed to increase employee understanding of recovery support services (●) Yes ( ) No

c) Collaborative training sessions for employees and community agencies' staff to coordinate and increase integrated services (●) Yes ( ) No

d) State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort (●) Yes ( ) No

3. Has your state utilized the Regional Prevention, Treatment and/or Mental Health Training and Technical Assistance Centers (TTCs)?

a) Prevention TTC? (●) Yes ( ) No

b) Mental Health TTC? ( ) Yes (●) No

c) Addiction TTC? (●) Yes ( ) No

d) State Targeted Response TTC? ( ) Yes (●) No

Waivers

Upon the request of a state, the Secretary may waive the requirements of all or part of the sections 1922(c), 1923, 1924. and 1928 (42 U.S.C.§ 300x-32 (f)).

1. Is your state considering requesting a waiver of any requirements related to:

a) Allocations regarding women ( ) Yes (●) No

2. Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus:

a) Tuberculosis ( ) Yes (●) No

b) Early Intervention Services Regarding HIV ( ) Yes (●) No

3. Additional Agreements

a) Improvement of Process for Appropriate Referrals for Treatment (●) Yes ( ) No

b) Professional Development ( ) Yes (●) No

c) Coordination of Various Activities and Services ○ Yes ◉ No

Please provide a link to the state administrative regulations that govern the Mental Health and Substance Use Disorder Programs.

http://www.state.nj.us/humanservices/providers/rulefees/regs/

Footnotes:

Criterion 1: Services for adolescents are provided by the Department of Children and Families' Children's System of Care (CSOC).

Criterion 8, 9 and 10 Patient Records: There are statutes, regulations and policies as well as contractual requirements that protect client information.

Criterion 7 and 11 Group Homes: The Division of Mental Health and Addiction Services (DMHAS) is expanding recovery homes through grant funding rather than through the revolving loan fund.

Environmental Factors and Plan

11. Quality Improvement Plan- Requested

Narrative Question

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2018-FFY 2019? (●) Yes ( ) No

Please indicate areas of technical assistance needed related to this section.

The Division of Mental Health and Addiction Services (DMHAS) is in the process of updating its Quality Improvement Plan from 2016-2017 to include performance measures that are in the Olmstead Home to Recovery Plan, Community Mental Health Block Grant Plan, Substance Abuse Prevention and Treatment Block Grant, as well as current Performance Improvement initiatives that are occurring throughout the Division. DMHAS would benefit from an exchange with other states to see how they have incorporated these areas in their QI Plans.

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Footnotes:

The Division of Mental Health and Addiction Services (DMHAS) did not modify its CQI plan. The Children's System of Care (CSOC) modified its CQI plan from FFY 2018 - FFY 2019.

New Jersey Division of Mental Health and Addiction Services
Quality Improvement Plan
FY 2016 – FY 2017

"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

The Division of Mental Health and Addiction Services is committed to continuously improve the quality and safety of services and supports delivered to adults in New Jersey's behavioral health

system. This commitment is incorporated into all aspects of the Division's activities: Strategic Planning, Resource Allocation and Performance Improvement Activities.

The Quality Improvement Plan describes the approaches, processes and mechanisms used to ensure New Jersey's mental health and addiction system is meeting its goals. We do this based upon the principles of continuous quality assurance/performance improvement. Many of our approaches to improved service delivery are data-driven; meaning, we rely on valid and reliable data to identify and track critical outcomes and performance measures to ensure their effectiveness.

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 Strategic Planning activities. Division-wide priorities have stakeholder input with continuous communication regarding our status. 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.

The Quality Improvement 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, Strategic Plan and special initiatives. The following criteria are used to base priority for measurement:

- High risk
- High-volume
- Problem prone
- Sentinel events
- Processes related to consumer needs, expectations, and satisfaction
- Strategic goals
- Special Initiatives
- Resource availability, The Operating Budget
- Regulatory Compliance
- Staff and Staffing Issues

DMHAS has processes which are tracked at the state psychiatric hospital level and several clinical initiatives which are being done in collaboration with the state psychiatric hospitals and the community. Each state psychiatric hospital has a Quality Improvement Plan and all community agencies licensed by DHS are required to have a Quality Improvement Plan.

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

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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

The primary goal of the Quality Improvement Program is to continually and systematically plan, design, measure and assess and improve the performance of key functions and processes involved with the delivery of services and supports to adult behavioral health consumers and patients. The Quality Improvement Plan provides 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.

To achieve this goal, the Quality Improvement Plan strives to:

- Assess the needs of consumers, patients and other key stakeholders;
- Incorporate quality planning throughout the state psychiatric hospitals and provider agencies and;
- Provide a systematic mechanism for state hospitals, provider agencies, individuals, Division Offices, committees and workgroups to function collaboratively in their efforts toward performance improvement

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

THE QUALITY MODEL

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 PDC(S)A cycle: Plan, Do, Check/Study, Act which is described below pictorially and in a narrative.

Plan–Do–Check/Study–Act Process

1. **Plan** - Recognize an opportunity and plan a change.
2. **Do** - Test the change. Carry out a small-scale study.
3. **Check/Study** - Review the test, analyze the results and identify what you've learned (how do they compare with the predictions).
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.

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
- consumer surveys

Examples of techniques include:

- benchmarking
- cost of quality
- quality function deployment
- failure mode effects analysis
- design of experiments

SCOPE OF THE PERFORMANCE IMPROVEMENT PROGRAM

The National Behavioral Health Quality Framework was used as a guide in the development of the Division's Performance Improvement Program. By doing so, this ensures consistency with Federal efforts. The scope of the Quality Improvement Plan covers all aspects of the organization which provide services and supports. In addition to quantitative data, the Division tracks qualitative data including programmatic improvements using stakeholder input, inclusive of individuals in treatment and recovery and their families. 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 the Behavioral Health Planning Council (includes family members, consumers, providers, and representatives from the Division and other Departments), Quarterly Stakeholder meeting, Quarterly Addictions Medical Directors meetings, Citizens Advisory Council, and the Addictions Professional Advisory Committee (meets every other month).

Specific monitoring activities are listed below and will be described in more detail in this section. The Performance Measures that were selected to be monitored will be listed at the end of the applicable section.

- Strategic Plan Performance Measures
- Suicide Prevention
- Addictions Treatment and Services
- Contracted Agency Performance
- Critical Incidents
- Sentinel and Adverse Clinical Events
- Mortality
- Response to Emergencies
- Complaints and Grievances

- Consumer Satisfaction
- Hospital-Based Inpatient Psychiatric Services (HBIPS)

STRATEGIC PLANNING

Key areas were assessed as critical for the Division's Strategic Plan and are reported on quarterly to Senior Leadership. Performance Measures have been developed for each of the key areas:

Development of an Interim Management Entity (IME) for Addiction Services

Performance Measures:

- 90% of Members score their satisfaction with IME at average or above average
- 50% of IME Providers score their satisfaction with IME at average or above average

Community Support Services

Performance Measure:

- 90% of individuals retain their supportive housing placement 1 year or longer

Community Re-Integration

Performance Measures:

- The percent of state hospital CEPP census will decline for all 3 regional hospitals (APH – 30%, TPH – 20%, GPPH – 20%)

Community/Clinical Services and Processes-the measurement of this strategic initiative for this plan year is specifically focused on decreasing the morbidity and mortality of consumers with severe and persistent mental illness and substance use and measurement will begin in year 2

Performance Measures:

- Increase by 20% above baseline the number of mental health consumers in the community screened for tobacco use, diabetes and metabolic syndrome
- Increase by 20% above baseline the number of substance use consumers screened for tobacco use
- Increase the number of treatment plans by 20% above baseline that address tobacco use, diabetes and/or metabolic syndrome for mental health consumers in the community who screened positive

Competency and Training

Performance Measure:

- Increase the number of individuals trained as behavioral health peer providers

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SUICIDE PREVENTION

Using 2012 National Strategy for Suicide Prevention: Goals and Objectives for Action as a guide, the DMHAS finalized the NJ Adult Suicide Prevention Plan in 2014. There are four specific objectives that are the current focus:

Goal #5: Strengthen, develop, implement, and monitor effective suicide prevention programs that promote wellness and prevent suicide and related behaviors.
Goal #7: Provide training to community and clinical service providers on the prevention of suicide and related behaviors.
Goal #8: Promote suicide prevention as a core component of health care services.
Goal #9: Promote and implement effective clinical and professional practices for assessing and treating those identified as being at risk for suicide and suicidal behaviors.

Performance Measures:

- Reduce the Number of Suicide Attempts in NJ
- Reduce the Number of Suicides in NJ

ADDICTIONS TREATMENT AND SERVICES

Addictions treatment and services performance measures relate to prevention of adverse outcomes.

Performance Measures:

- Reduce the number of opioid-related deaths
- Reduce the number of opioid overdoses
- Reduce the percentage of addictions' consumers who smoke
- Increase the number of people on medication assisted treatment

CONTRACTED AGENCY PERFORMANCE

Contract monitoring/utilization review occurs both in addictions and mental health programs.

Addictions

Contracted addictions agencies have one formal contract site visit each calendar year. More frequent reviews are conducted on 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.

Provider Performance Reports (Substance Abuse)

Provider Performance Reports are made available to all addiction treatment provider agencies. These reports were first produced in 2006 and are issued twice a year for the fiscal and calendar year. The reports were emailed to over 300 providers; however, in 2014 they were programmed to be generated automatically by the SSA's IT system, NJSAMS. Providers can download their reports upon sign-in.

The provider report includes: 1) statewide admission and discharge treatment data and agency specific treatment data for key variables, 2) admission and discharge data by level of care for each specific agency, and 3) State Outcomes Measures (SOMs) for each level of care an agency provides in comparison to statewide averages and peers. In order for agencies to compare their performance relative to other agencies, percentile scores are computed for each outcome measure. They compare 1) the change in performance between discharge and admission and 2) the level of performance at discharge. Statewide outcome data are also presented so an agency can compare its performance to the state.

The outcomes in these reports include: abstinence from alcohol, abstinence from drugs, employment, enrollment in school/job training, criminal justice involvement, homelessness, and retention in substance abuse treatment. A measure on the percentage of clients successfully completing their treatment plan is also included. 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.

These performance reports are one strategy that DMHAS has adopted in its continuous quality improvement efforts to help improve services to clients. The SOMs are one way to monitor client outcomes, help direct system improvements and achieve better accountability. These reports are also used by the provider to inform their continuous quality improvement efforts.

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 are 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. By conducting triennial reviews with the Department of Human Services' Mental Health Licensing Unit.

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.

Systems Review Committee Dataset(s)

The Systems Review Committee (SRC) Datasets are a series of linked MS-Excel documents submitted to the SMHA on monthly basis from 32 Short Term Care Facilities (STCF) and 23 Designated Screening Centers (DSC). The Systems Review Committee was created by legislative mandate[1] in 2010 which requires the division (among other tasks) to: monitor the acute care system, conduct utilization management, identify gaps, and conduct data analysis.

For analytical and administrative purposes, DSC dataset is handled separately from the STCF dataset, although both share great similarities in reporting protocol, functionality, and purpose (hence, we refer to both sets of information collectively as the SRC dataset). The SRC data is compiled monthly by providers on a one-page monthly MS-Excel spreadsheet that is submitted electronically to the SMHA. The SRC dataset provides program/agency-specific data that is the aggregate of each program's consumers served within a given month.

Due to the large number of data points (>50) found on each datasheet, the comprehensiveness of the data, and the geographic coverage of the information , this dataset provided the Division and stakeholders with a range of valuable information on a regular basis. In addition to being the "go to" resource for monitoring the acute care system across the state and within each county's System Review Committee, the SRC is also used regularly ad-hoc reporting on a regular basis.

Provider Performance Reports (Mental Health)

Provider Performance Reports (PPRs) for mental health agencies are designed to be 'data dashboards' that display how key variables of a given agency compare to statewide and regional measures of central tendency. Currently mental health PPRs have been developed for a small number of program elements, specifically Supportive Housing and Designated Screening. For each program element, the PPR contains approximately 20 data elements and calculations drawn from different datasets including the QCMR, the SRC, the Annex A and the Annex B. These data elements are organized into the domains of "Volume", "Quality" and "Cost". By having a single dashboard that pulls data from several distinct data sources, the reader can gain a quick and comprehensive summary of how a given provider's program element compares to statewide

[1] NJAC 10:31-5.1 "Acute Care System Review" , NJAC 10:31-5.2 "Composition of the systems review committee", and NJAC 10:31-5.3 (a)

measures of central tendency, each region of the state (i.e., North, Central, South), and how that agency compares to others. The SMHA is in the process of acquiring additional human resources needed to expand provider performance reporting.

CRITICAL INCIDENTS

The addictions' community may call the Department of Human Services, Office of Licensing-Special Operations/Addiction Services to report incidents and these are entered into the Department of Human Services' (DHS) Unusual Incident Reporting Management System (UIRMS). 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.

Community mental health agencies directly report incidents to the Division's Unusual Incident Coordinators for their respective county. These incidents are entered into the DHS' Unusual Incident Reporting Management System. Aggregate data reports are shared with the community agencies. Specific demographic and other detailed information related to deaths is kept in an Access database for trending and analysis purposes.

All incidents require an investigative follow-up report. Some incidents are also referred to other DHS units for further investigation; these include allegations of abuse, neglect, exploitation, operational issues and other incidents as deemed by the Department of Human Services.

SENTINEL and ADVERSE CLINICAL EVENTS

All state psychiatric hospitals are required to conduct root cause analyses for any hospital sentinel event that falls under The Patient Safety Act or The Joint Commission sentinel event policy. The Division of Mental Health and Addiction Services' 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 assessed for thoroughness and credibility.

MORTALITY

The Division collects data related to deaths which occur with mental health 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.

RESPONSE TO EMERGENCIES

Response to emergencies is dependent upon the type of emergency:
DMHAS has a Disaster and Terrorism Branch 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.

Assistant Division Director for Community Services, 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 consumers receiving methadone treatment, there is a system called Guest and Emergency Medication System (GEMS), which will allow consumers 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 COOP Continuity of Operations Plan (COOP) and provides support using GEMS, if needed.

COMPLAINTS AND GRIEVANCES

Community Addictions Agencies

For purposes of this section, term complaints and grievances is used interchangeably. The addictions' community may call the Department of Human Services, Office of Licensing-Special Operations/Addiction Services to report any complaints or grievances and these are handled through the DHS Office of Program Integrity and Accountability Unit (OPIA).

Mental Health Agencies

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.

Each consumer is made aware of the existence of a complaint procedure and second, non-emergency contacts. Under all circumstances, consumers not accepted for services are informed immediately of the State-wide advocacy services available to them. Agency Directors designate a staff person to function as Agency Ombudsperson on as needed basis. The responsibilities of the Agency Ombudsperson:

- 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.

CONSUMER SATISFACTION

State Psychiatric Hospitals

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 Division of Mental Health and Addictions Services' 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 obtaining input from patients is through an Inpatient Consumer Survey developed by National Association of State Mental Health Program Directors (NASMHPD)/ Research Institute, Inc. (NRI).

Survey Domains

- Clients Perception of Outcomes
- Clients Perception of Dignity
- Clients Perception of Rights
- Clients Perception of Participation
- Clients Perception of Environment
- Clients Perception of Empowerment

Dissemination of Surveys

The survey is disseminated to 100% of the patients just prior to discharged or mailed to them with a self-addressed stamped envelope after discharge as well as to all patients remaining in the hospital at their annual review. Patients are assisted with completion of the 27 question survey only if they ask for assistance. Completion of the survey is voluntary and anonymous.

Survey Results

Survey data is used for performance improvement. Quarterly reports are received from NRI and each hospital reviews and assessed the aggregate data in each domain and takes corrective action to improve performance.

Mental Health Community

Consumer satisfaction with the services provided by DMHAS contracted mental health agencies is measured via the Annual *Consumer Perception of Care Surveys* which provides consumers with an avenue in which to report their reactions to the services that they are receiving, and a mechanism through which DMHAS may evaluate itself and its contracted providers.

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 DMHAS Annual Consumer Perception of 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*[2]--used it in its entirety (48 questions), supplemented by ten questions related to primary health, from the Behavioral Risk Factor Surveillance System (BRFSS) survey[3] . These tools are recommended for use by the National Association of State Mental Health Program Directors (NASMHPD) Research Institute, Inc. (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?
*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?

Survey Domains

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 (effectiveness of services received), Functioning Outcomes (overall social skills and symptom reduction), Social Connectedness and Legal Challenges (response to clinical justice programs in NJ).

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 optional and anonymous survey questionnaire.

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 Behavioral 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

[2] See http://www.nri-inc.org/#!urs-forms--info/c1xvm
[3] See http://www.cdc.gov/brfss/questionnaires/pdf-ques/2011brfss.pdf

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.

Since 2011, the Annual Consumer Perception of Care Survey of Mental Health Services has been distributed to a stratified random sample of consumers in all non-acute, community-based settings. (Prior to 2011, this survey was distributed annual to the entire population of consumers receiving services from one specific program element.) Going into its fifth year of data collection on this cross-program basis, the SMHA is excited that this dataset can be now looked at from a historical perspective, allowing to SMHA to look at how consumer attitudes on program elements, providers and the system-at-large have changed over time.

HOSPITAL CORE MEASURE DATA SET (HBIPS)

Specific to state psychiatric hospitals, the Division collects data from the hospitals on Core Measures for the NRI Behavioral Healthcare Performance Measurement System (BHPMS) which are sent to NRI and then to The Joint Commission and then some of the measurement data is sent to The Centers for Medicare and Medicaid Services (CMS). These core measure sets fulfill the ORYX reporting requirements for The Joint Commission. HBIPS core measures that describe five areas from the initial admission screening process, four content areas from the continuing care plan and antipsychotic medications post-discharge. These measures include:

- HBIPS 1: Screening for Violence Risk to self or others, Substance Use, Psychological Trauma History, and Strengths
- HBIPS 2: Hours of Physical Restraint Use
- HBIPS 3: Hours of Seclusion Use
- HBIPS 4: Patients Discharge on Multiple Antipsychotic Medications
- HBIPS 5: Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification
- HBIPS 6: Post Discharge Continuum of Care Plan Created
- HBIPS 7: Post Discharge Continuum of Care Plan Transmitted to Next Level of Care Provider upon Discharge

The hospitals also collect data regarding Comfort Care to indicate if the patient is on comfort measures only as this population is excluded from the data collection.

GLOBAL POPULATION MEASURES

Specific to state psychiatric hospitals, the Division collects additional data from the hospitals for the NRI Behavioral Healthcare Performance Measurement System (BHPMS) which are sent to NRI and then to The Centers for Medicare and Medicaid Services. The data collected is related

to substance use screening and tobacco use screening and treatment. Also collected is data related to patient influenza immunization status. These measures include:

- SUB-1: Alcohol Use Status Screening
- TOB-1: Tobacco Use Status Screening
- TOB-2: Tobacco Use Treatment Practical Counseling
- TOB-2a: Tobacco Use Treatment FDA-Approved Cessation Medication Provided or Offered
- IMM-2: Influenza Immunization

EVALUATION and CONTINUOUS IMPROVEMENT

Performance measurement data is reported at Senior Staff Meetings once a quarter by data owners. Senior Leaders have an opportunity at this time to discuss opportunities for improvement. For data which is outside of our expected performance standards and an action plan is devised and implemented by the data or process owner and measurement continuously occurs. If the action plan has resulted in improvement then 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.

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.

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Children's System of Care (CSOC) Quality Improvement

The Department of Children and Families (DCF) Quality Improvement Plan is available here:
https://www.nj.gov/dcf/about/divisions/opma/Continuous.Quality.Improvement.pdf

Performance Management and Accountability

The Office of Performance Management and Accountability (PMA) is responsible for all quality assurance and program evaluation activities, data analysis and reporting, and child fatality and near fatality case practice reviews. PMA manages the department's organization-wide continuous quality improvement effort and prepares annual reports on the department's work and progress.

PMA provides quantitative and qualitative information for the department to measure and support organizational performance. This information is used to report on the outcomes of service delivery to children and families and to comply with state and federal requirements. PMA strives to produce information useful to front-line staff, management, administration, and stakeholders.

PMA oversees the Office of Quality, the Office of Research, Evaluation and Reporting, the Fatality and Executive Review Unit, the Federal Reporting Unit, and the Child and Family Service Review (CFSR) Unit.

Office of Quality

The Office of Quality supports and promotes the department's commitment to continuous quality improvement (CQI). It assesses the overall quality of case practice and services by identifying strengths and areas that need improvement. The Office of Quality examines performance and, by applying CQI processes, conducts Qualitative Reviews, monthly ChildStat reviews, and case record reviews. It provides data analysis and interpretation support and assists development and implementation of county-level program improvement plans. The Office of Quality monitors CQI results and evaluates interventions.

Qualitative Review

The Qualitative Review process assesses system performance and identifies strengths and areas for improvement.

- Qualitative Review Protocol and Instrument
- QR Overview
- New Jersey Quality Review

ChildStat

Encourages self-assessment and self-diagnostic processes through a case conferencing model.

Office of Research Evaluation and Reporting

The Office of Research, Evaluation and Reporting (RER) provides DCF quantitative and qualitative data to measure and support organizational performance, comply with state and federal requirements, and to report on outcomes of services for children and families. RER strives to

produce information that can be used by front-line staff, management, administration, and stakeholders.
RER conducts CQI activities and collaborates with leadership throughout DCF to ensure the reliability and validity of data used to inform decision making and understand the impact of our work with NJ's children and families.

RER spearheads the department's Manage by Data Fellows program. This nationally recognized program develops agency staff, teaching them to use data to improve outcomes for children and families. The Fellows use data to tell the story of the children and families DCF serves. They also build analytical and presentation skills and they design targeted solutions to local challenges. It is at the center of our department-wide commitment to operate as a data-driven, learning organization. Hundreds of staff members have graduated from the program. DCF views every Fellows graduate as a department mentor and ambassador. After graduating from the program, Fellows coach and mentor others as part of their daily work with colleagues, communities, and families.

SafeMeasures
Used throughout the department, SafeMeasures is a case management reporting tool for monitoring performance and tracking staff caseloads. The comprehensive child welfare reporting package includes analytical capabilities; expertise geared to front-line staff and supervisors; training and implementation support; and ongoing on-line support.

Office of Research Evaluation and Reporting Related Links
The *Commissioner's Monthly Report* contains selected data points on who we are serving and how well we are serving them. Reflecting our work across the department, the Commissioner's Monthly Report helps guide our efforts.

The *New Jersey Child Welfare Data Hub* is a collaborative effort between the New Jersey Department of Children and Families and the Institute for Families at the Rutgers University School of Social Work. The Data Hub seeks to improve the lives of children and families by disseminating New Jersey child welfare data.

- DCF Commissioner's Monthly Report
- NJ Child Welfare Data Hub
- CP&P Monthly Screening and Investigation Report
- Child Welfare Outcomes Report
- Adoption Report

Fatality and Executive Review Unit

The Fatality and Executive Review Unit is responsible for unusual incident reports, Executive Directed Case Reviews, and Child Abuse Prevention and Treatment Act (CAPTA) reports. It ensures child fatalities, fatalities from domestic violence, and unusual incidents involving children in residential facilities are reviewed and any systemic issues or trends are discovered and addressed.

The **New Jersey Child Fatality and Near Fatality Review Board** reviews fatalities and near fatalities of children in order to identify their causes, relationship to governmental support systems, and methods of prevention.

The **New Jersey Domestic Violence Fatality and Near Fatality Review Board** allows the community to honor victims of domestic violence-related fatalities and learn from their deaths in an effort to improve systemic and community responses to domestic violence.

Federal Reporting Unit

The Federal Reporting Unit is tasked with reporting on the state's child welfare system to the federal government. This unit also serves as the liaison between the Center for the Study of Social Policy and DCF for reporting Sustainability and Exit Plan measures. The Federal Reporting Unit partners with the Child and Family Services Review Unit to coordinate New Jersey's CFSR process as well as the Child and Family Services Plan and the Annual Progress and Services Report. Additionally, this unit coordinates the Staffing and Oversight Review Subcommittee, which is a subcommittee of the New Jersey Task Force on Child Abuse and Neglect.

The Federal Reporting Unit coordinates New Jersey's **Child and Family Services Plan** and **Annual Progress and Services Report** submissions.

The **Staffing and Oversight Review Subcommittee** reviews and makes recommendations on CP&P staffing levels and staff recruitment, hiring, and retention.

Child and Family Service Review Unit

The Child and Family Service Review (CFSR) Unit coordinates New Jersey's 2017 CFSR. The CFSR ensures conformity with federal child welfare requirements and helps states identify strengths and areas needing improvement within their agencies and programs. The CFSR unit serves as the primary liaison between New Jersey and the Children's Bureau for the CFSR. The unit is responsible for submission of the Statewide Assessment, coordinating training and conducting round three of the CFSR. Following the review, the unit, in collaboration with the Federal Reporting Unit and the Children's Bureau coordinates the formation of the Department's, two year, Program Improvement Plan, and ensures New Jersey completes all action steps and benchmarks, and achieves improvement in all measures specified in the federal government's performance improvement plan.

The Child and Family Services Review (CFSR) is an evaluation of a state's child welfare system to determine how well the system performs in promoting outcomes for the safety, permanency, and well-being for children. Additional information is available at https://www.nj.gov/dcf/childdata/njfederal/index.html .

New Jersey Child Welfare Data Hub

New Jersey child data is available through the **data portal**.

Environmental Factors and Plan

12. Trauma - Requested

Narrative Question

Trauma [57] is a widespread, harmful, and costly public health problem. It occurs because of violence, abuse, neglect, loss, disaster, war and other emotionally harmful and/or life threatening experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective M/SUD service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in M/SUD services. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated M/SUD problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions. Schools are now recognizing that the impact of exposure to trauma and violence among their students makes it difficult to learn and meet academic goals. Communities and neighborhoods experience trauma and violence. For some these are rare events and for others these are daily events that children and families are forced to live with. These children and families remain especially vulnerable to trauma-related problems, often are in resource poor areas, and rarely seek or receive M/SUD care. States should work with these communities to identify interventions that best meet the needs of these residents.

In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink doing ?business as usual.? These public institutions and service settings are increasingly adopting a trauma-informed approach. A trauma-informed approach is distinct from trauma-specific assessments and treatments. Rather, trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma in clients and staff, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to these appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma[58] paper.

57 Definition of Trauma: *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.*
58 *Ibid*

Please consider the following items as a guide when preparing the description of the state's system:

1. Does the state have a plan or policy for M/SUD providers that guide how they will address individuals with trauma-related issues? (●) Yes ( ) No

2. Does the state provide information on trauma-specific assessment tools and interventions for M/SUD providers? (●) Yes ( ) No

3. Does the state have a plan to build the capacity of M/SUD providers and organizations to implement a trauma-informed approach to care? (●) Yes ( ) No

4. Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations? ( ) Yes (●) No

5. Does the state have any activities related to this section that you would like to highlight.

See attached.

Please indicate areas of technical assistance needed related to this section.

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Footnotes:

12. Trauma -requested

5) Does the state have any activities related to this section that you would like to highlight.

Division of Mental Health and Addiction Services (DMHAS)

The Division of Mental Health and Addiction Services (DMHAS) contract language for licensed substance use disorder treatment providers receiving women's set aside block grant funds requires the providers to be trauma informed with trauma specific services. All women must be screened for trauma with one of the DMHAS recommended evidence based screening tools, and providers are required to use the "Seeking Safety" curriculum. The DMHAS Monitoring Unit conducts annual site visits to the women's set aside providers. The monitoring review form has a module for specialized services that lists all requirements for gender specific treatment including "Seeking Safety" curriculum.

DMHAS recognizes the national statistics that indicate that 43%-81% of adults in psychiatric hospitals and up to 2/3 of individuals in substance abuse treatment have experienced trauma. As DMHAS embarked on becoming Trauma-Informed, we identified work groups comprised of providers, administrators, and individuals with lived experience to advise us as we adapt the materials from the National level to needs in New Jersey. DMHAS includes trauma awareness as a governing principle in addressing policy making, service system design and implementation, workforce development, and professional practice. We advocate for all of our agencies to adopt similar practices using the five values of Trauma-Informed Care (TIC) as developed through the efforts at a national level:

1. Safety, meaning: "Do no harm." Trauma sensitive and compassionate care is given from initial contact.
2. Trustworthiness, meaning: The system provides care with the least amount of risk for re-traumatization.
3. Choice, meaning: Individuals have input into decisions made in treatment, and that input is taken seriously.
4. Collaboration, meaning: Recognize that trauma-related symptoms and behaviors originate from adaptation to traumatic experiences
5. Empowerment, meaning: Promoting resilience; providing opportunities and understanding that all of us are competent and capable to grow and heal.

Department of Children and Families/ Children's System of Care (DCF/CSOC)

The mission of the Department of Children and Families (DCF) is 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 Children's System of Care (CSOC) to understand, prevent and mitigate the impact of trauma that children, youth and young adults and their families experience.

In 2015, DCF was awarded a $12 million grant by the Substance Abuse and Mental Health Services Administration (SAMHSA) to expand mental health services for children with complex behavioral health challenges. Entitled *Promising Path to Success*, the project was funded to run four years, from September 2015 to September 2019, to help CSOC achieve the following goals:

- Reduce the percentage of youth in the system of care who require multiple episodes of out-of-home treatment;
- Reduce the percentage of youth who re-enter treatment after discharge from an initial treatment episode;
- Reduce the average length of stay for youth in out-of-home treatment from 11.5 to 9 months; and
- Analyze and understand the impact of each type of system investment to make future resource allocation decisions.

The project's main components include two trauma-informed interventions, *Six Core Strategies for Reducing Seclusion and Restraint Use* (an evidenced-based practice) and *The Nurtured Heart Approach*. These interventions have been introduced system-wide through CSOC's training partner, Rutgers University Behavioral Health Care (UBHC), to approximately 146 out-of-home treatment programs as well as all of CSOC's other System Partners (Care Management Organization [CMO], Family Support Organization [FSO], Mobile Response and Stabilization Services [MRSS], and County Interagency Coordinating Council [CIACC]). Another key component of the project is a return on investment (ROI) study being conducted by Rutgers University's Center for State Health Policy. The ROI study will enable CSOC to determine the relative success of the project in achieving its identified goals and help DCF make future decisions concerning resource allocation.

The milestones CSOC was able to reach in the project's third full year include the following:

- Hosted two *Nurtured Heart* Certified Trainers' Institutes that certified 117 new trainers.
- Hosted one *Six Core Strategies* two-day training for over 300 partners around the state.
- Provided *Nurtured Heart* training to over 5400 individuals in year 3 with a total of 16,536 individuals trained since the grant's inception. Groups that received this training include NJ CSOC funded programs and system partners as well as other entities outside the original scope of the grant, such as Juvenile Detention Centers, Division of Child Protection and Permanency (DCP&P), Office of Education (OOE), ARC NJ, and County Interagency Coordinating Council (CIACC) Education Partnerships.
- NJ CSOC's first youth ambassador was hired and is providing a youth voice and perspective to the grant's goals and training initiatives.

Although the grant is scheduled to end on September 30, 2019, a no cost extension is being requested to ensure Phase 5 providers receive the same coaching support provided to Phase 1-4

participants. In addition, an extension will allow Rutgers ample time to complete the Return on Investment.

Brief Descriptions of the Two Approaches

Six Core Strategies To Prevent Conflict and Violence: Reducing the Use of Seclusion and Restraint

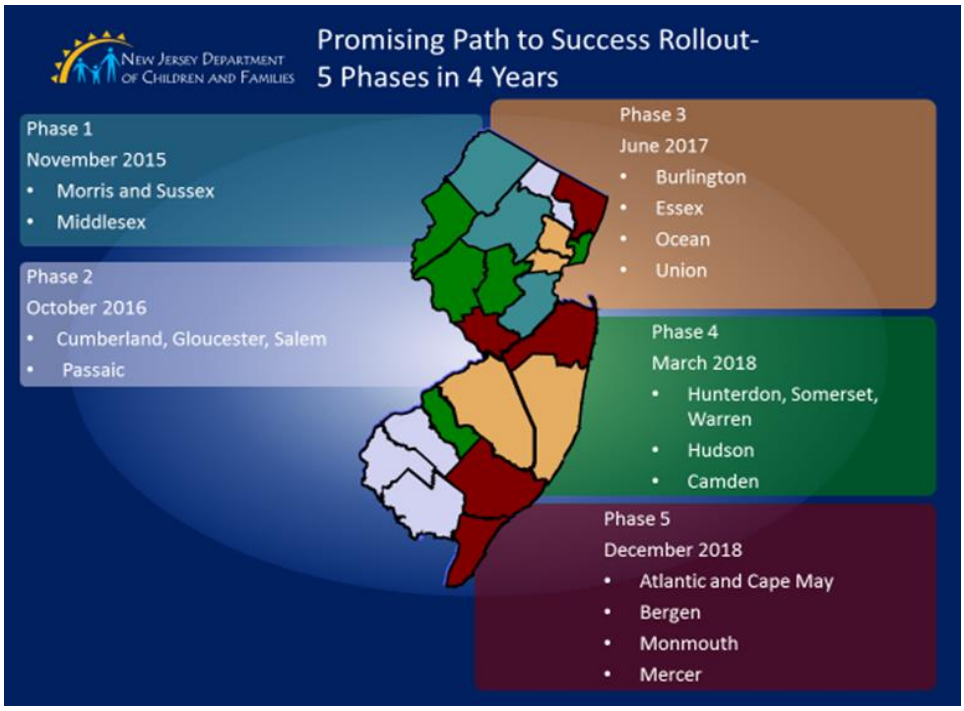
1. Leadership toward organizational change
2. The use of data to inform practice
3. Workforce development
4. Full inclusion of individuals and families
5. The use of seclusion and restraint reduction tools, which include the environment of care and use of sensory modulation
6. Rigorous debriefing after events in which seclusion and restraint might have been used

Nurtured Heart Approach

"The Nurtured Heart Approach® is a relationship-focused methodology founded strategically in The 3 Stands™ for helping children (and adults) build their Inner Wealth® and use their intensity in successful ways. It has become a powerful way of awakening the inherent greatness in all children while facilitating parenting and classroom success.

The essence of the Approach is a set of core methodologies originally developed for working with the most difficult children. It has a proven impact on every child, including those who are challenged behaviorally, socially and academically. The Nurtured Heart Approach has been shown to create transformative changes in children diagnosed with ADHD, Oppositional Defiant Disorder, Reactive Attachment Disorder and other behavioral, emotional and anxiety related symptoms – almost always without the need for long-term mental health treatment. Even children experiencing social cognitive challenges, like Autism Spectrum Disorder and Asperger Syndrome greatly benefit from the Approach, reducing the need for traditional mental health and medical interventions.

Traditional approaches often fall short of promoting the Inner Wealth essential for children to build successful relationships. This method has helped thousands of families, educators, and child advocates channel a child's intensity in beautifully creative and constructive ways – helping children achieve new emotional portfolios of confidence and enduring levels of competency." http://childrenssuccessfoundation.com/about-nurtured-heart-approach/



CSOC continues to support the need for high quality, timely and focused assessments as a part of the continuum of care available to children, youth and young adults and their families in New Jersey. Biopsychosocial assessments provide critical information from the child, youth or young adult and 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 CSOC as possessing the capacity to complete the Information Management Decision Support Needs Assessment, which has been revised to incorporate a trauma-specific module.

CSOC 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 Cognitive Behavioral Therapy (CBT) and Trauma Focused-Cognitive Behavioral Therapy (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.

CSOC 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 (TF-CBT), Cognitive Behavioral Therapy (CBT), Post Traumatic Stress Management (PTSM) Training and Psychological First Aid (PFA) with Ethnocultural, Gender, and Developmental Specificity ; Advanced PTSM: Response Protocols to Suicide; and, Classroom Based Psychosocial Intervention (CBI) and Traumatic Incident Intervention (TII)

The following trauma-specific workshops are available through the Traumatic Loss Coalitions for Youth program sponsored by CSOC:

- 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

Environmental Factors and Plan

13. Criminal and Juvenile Justice - Requested

Narrative Question

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one-third meet criteria for having co-occurring mental and substance use problems. Youth 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 use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.[59]

Successful diversion of adults and youth from incarceration or re-entering the community from detention is often dependent on engaging in appropriate M/SUD treatment. Some states have implemented such efforts as mental health, veteran and drug courts, Crisis Intervention Training (CIT) and re-entry programs to help reduce arrests, imprisonment and recidivism.[60]
A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with M/SUD from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment Medicaid and/or the Health Insurance Marketplace; loss of eligibility for Medicaid 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.

The MHBG and SABG 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.

[59] 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 Ren?e L. Binder. **OJJDP Model Programs Guide**

[60] **http://csgjusticecenter.org/mental-health/**

Please respond to the following items

1. Does the state (SMHA and SSA) have a plan for coordinating with the criminal and juvenile justice systems on diversion of individuals with mental and/or substance use disorders from incarceration to community treatment, and for those incarcerated, a plan for re-entry into the community that includes connecting to M/SUD services? (●) Yes ( ) No

2. Does the state have a plan for working with law enforcement to deploy emerging strategies (e.g. civil citations, mobile crisis intervention, M/SUD provider ride-along, CIT, linkage with treatment services, etc.) to reduce the number of individuals with mental and/or substance use problems in jails and emergency rooms? (●) Yes ( ) No

3. Does the state provide cross-trainings for M/SUD providers and criminal/juvenile justice personnel to increase capacity for working with individuals with M/SUD issues involved in the justice system? (●) Yes ( ) No

4. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address M/SUD and other essential domains such as employment, education, and finances? (●) Yes ( ) No

5. Does the state have any activities related to this section that you would like to highlight?

The SMHA is involved in very active collaborations with the Judiciary, Office of the Attorney General, local law enforcement, State Parole Board and Department of Corrections, and funds 15 JIS services and several other criminal justice initiatives. JIS is provided to a diverse mix of consumers, male and female as well as individuals of Caucasian, African American, Hispanic, Asian and Asian Indian backgrounds and from many different countries.

The SMHA funds a CIT Center of Excellence through the Mental Health Association of Southwest New Jersey. The Center facilitated the development of new county CIT efforts. Presently sixteen of twenty-one counties as well as the NJSP provide training to law enforcement, dispatcher and mental health staff in CIT. These counties offer the training to other counties and municipalities as well as their own. As of May 2019, 276 of 565 municipalities have at least one certified CIT officer. As of February 2019, 4,643 law enforcement and mental health provider staffs have been trained.

Juvenile Justice Highlights
Reducing the number of Juvenile Justice commitments

The Children's System of Care (CSOC) is fully accessible to youth involved with the juvenile justice system and the services coordinated by care managers help to keep youth out of detention centers. There has been a significant decrease in the number of detention center admissions resulting in the reduction of the number of county detention centers from seventeen to seven in the past few years (Union County detention center closed in February 2019).

In 2004 there were approximately 200 youth, statewide, in detention awaiting residential treatment post disposition. The term disposition is utilized in Juvenile Court versus the term sentence when the outcome of charges yields the Court determination that a youth needs out of home treatment through CSOC not incarceration; and the youth remain in Detention while waiting for admission to a treatment bed. In 2019, there are typically about three youth awaiting residential treatment post disposition.

The average waiting time to be admitted to a residential program is approximately 52 days (an increase from 40 days last year) across all levels of intensity for behavioral health. The waiting time increased this year due to increased demand for two co-occurring residential programs and specialty programs for girls. For youth in detention centers in need of out of home treatment, there are detention alternative beds that can be accessed on an emergent basis.

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

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

Protocol for Court-Ordered Assessment of Children with Emotional and Behavioral Health Needs (14 Day Plan Protocol) between DCF/Children's System of Care and the New Jersey Judiciary, Family Division.
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 protocol exists

Biopsychosocial Assessments
The Juvenile Justice Commission requires, in the Manual of Standards, that all youth entering Detention receive the MAYSI (Massachusetts Youth Screening Instrument) within 24-48 hours of admission. CSOC has implemented an easily accessed clinical assessment process for any youth in a county juvenile detention center that may score on the MAYSI regarding possible mental health concerns or need for substance use treatment. This assessment is also utilized to expedite out of home treatment.

When a court-involved youth held in a county juvenile detention facility is ordered by a Family Court judge to be assessed for an out-of-home treatment facility in lieu of incarceration, the youth should be transitioned from the juvenile detention center as quickly as possible. issues. The biopsychosocial evaluation, which has a turn-around time of five business days, can be requested by the Social Services staff at the detention center. To accomplish this, CSOC developed a tracking system for children in county detention centers for whom a congregate care treatment program is being considered. The contracted system administrator's (CSA) management information system was also modified to incorporate information about legal status for system-involved children. The information in the CSA management information system identifies children for whom proactive treatment is initiated.

CSOC is represented on the New Jersey Council for Juvenile Justice Improvement. Diversion and the Reentry processes are discussed by the Access to Treatment and Racial Disparities sub-committees of the Council. Formal recommendations are presented to the full Council by the individual sub-committees.

DCF has established cooperative relationships with the Juvenile Justice Commission (JJC). In December 2004, the Department with the JJC signed a Memorandum of Understanding that outlines a distinct process by which youth in the JJC can be referred directly to what is now known as the Children's System of Care for services that will be implemented upon the youth's release from a JJC facility. Representation from both DCP&P and CSOC participate in the JJC and Annie E. Casey Foundation driven JDAI (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 Juvenile Justice Commission is responsible for operating state services and sanctions for juveniles and for developing a statewide plan for the effective provision of juvenile justice services and sanctions at the state, county and local levels. To emphasize New Jersey's commitment to provide coordinated quality services and appropriate sanctions for youthful offenders while ensuring the public's safety, the JJC established the State/Community Partnership Grant Program. These Partnership Grants provide funding to 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/CSOC.

The Office of Special Needs oversees the SCRC, in terms of intra- and inter-agency planning. It is chaired by the Special Needs Assistant. Members include representatives from DCP&P, Office of Adolescent Services, Children's System of Care, the JJC Juvenile Parole and Transitional Services (JP & TS) Pre-Release Teams, Regional Court Liaisons/designees, the JJC Child Study Teams, JJC community residential homes, and 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, DCF maintains an existing Memoranda of Understanding (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 juveniles in a JJC facility have permanency and treatment needs that require the intervention of DCF, the JJC Special Needs Review Committee will work with CSOC and DCP&P to make appropriate referrals prior to time of discharge. In circumstances where CSOC is unable to access a timely treatment plan in accordance with mandatory release dates, 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.

CSOC developed two out of home Detention Alternative Programs (DAP) with a total of 14 beds. The priority population is youth in DCF DCP&P custody awaiting DCF placement once their charges have been disposed. The CSOC liaison also refers youth in detention centers with mental health needs.

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

DCF/CSOC funds the Technical Assistance Center through University Behavioral Health Care Rutgers, the State University to provide training statewide. CSOC, through the UMDNJ Training contract, offers training to all children's system of care providers free of charge. 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
- Human Trafficking
- Substance Use and Abuse: Youth with Co-Occurring Developmental and Mental Health Challenges
- Substance Abuse 2: A Closer Look – Family and Addiction

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

Please indicate areas of technical assistance needed related to this section.

Footnotes:

Environmental Factors and Plan

14. Medication Assisted Treatment - Requested (SABG only)

Narrative Question

There is a voluminous literature on the efficacy of medication-assisted treatment (MAT); the use of FDA approved medication; counseling; behavioral therapy; and social support services, in the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for MAT for SUDs is described in SAMHSA TIPs 40[1], 43[2], 45[3], and 49[4].

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with substance use disorders demonstrate that they both have the capacity and staff expertise to use MAT or have collaborative relationships with other providers that can provide the appropriate MAT services clinically needed.

Individuals with substance use disorders who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments based upon each individual patient's needs.

In addition, SAMHSA also encourages states to require the use of MAT for substance use disorders for opioid use, alcohol use, and tobacco use disorders where clinically appropriate.

SAMHSA is asking for input from states to inform SAMHSA's activities.

Please respond to the following items:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding MAT for substance use disorders? (●) Yes ( ) No

2. Has the state implemented a plan to educate and raise awareness of the use of MAT within special target audiences, particularly pregnant women? (●) Yes ( ) No

3. Does the state purchase any of the following medication with block grant funds? (●) Yes ( ) No

- **a)** [x] Methadone
- **b)** [x] Buprenophine, Buprenorphine/naloxone
- **c)** [ ] Disulfiram
- **d)** [ ] Acamprosate
- **e)** [x] Naltrexone (oral, IM)
- **f)** [ ] Naloxone

4. Does the state have an implemented education or quality assurance program to assure that evidence-based MAT with the use of FDA-approved medications for treatment of substance abuse use disorders are used appropriately*? (●) Yes ( ) No

5. Does the state have any activities related to this section that you would like to highlight?

With the State Targeted Response (STR) award from SAMHSA, the SSA developed a fee-for-service initiative known as the State Targeted Opioid Response Initiative (STORI). The initiative includes the use of methadone, buprenorphine and Vivitrol for which providers can bill, if they are an Opioid Treatment Program (OTP) or outpatient provider that has been approved as a provider for the Vivitrol Enhancement Network. As of May 1, 2019, State Opioid Response (SOR) no-cost extension grant funds were used to continue this initiative through part of SFY 2020.

The Division of Mental Health and Addiction Services (DMHAS), with SAMHSA funding, plans to hold an Opioid Summit on September 20, 2019 which will focus on addressing Medication Assisted Treatment (MAT) and discrimination/stigma. The goal is to include medical professionals, clinicians and criminal justice professionals at this event.

DMHAS mandates trainings on medication assisted treatment for licensed substance use disorder treatment providers, incorporates language requiring acceptance of clients on all forms of medication assisted treatment into contract requirements as well as all applications for new funding.

DMHAS has a Memorandum of Agreement (MOA) with Rutgers University and Rowan University to coordinate buprenorphine DATA waiver training in CY 2019 for eligible statewide practitioners (i.e. physicians, APNs). The goal is to have a minimum of 1,000 prescribers trained and receive their Buprenorphine Waiver, in an effort to have more individuals with the ability to prescribe

buprenorphine.

Through use of State Opioid Response (SOR) grant funds, a Request for Proposal (RFP) was issued in February 2019 for the development of a Low Threshold Buprenorphine Induction program. This program is designed to make buprenorphine easily accessible to participants who utilize services at Harm Reduction Centers (HRC), also commonly known as Syringe Access Programs (SAP). The program is scheduled to commence in Spring 2019.

DMHAS issued a Request for Letters of Intent in 2019 to all 19 county correctional facilities for plans to establish MAT programs or enhance existing MAT services for inmates with an OUD. Funding will be made available to promote clinical stability and effective recovery processes for inmates prior to release from incarceration.

DMHAS, in partnership with the Department Human Services (DHS), Office of Public Relations, has awarded a contract to a vendor to deliver a campaign to help eliminate stigma and discrimination around the use of MAT. Various forms of messaging will be utilized including social media targeted to different audiences.

DMHAS, in partnership with the Department of Human Services (DHS) and other State Departments held a Naloxone Distribution Day on June 18, 2019, in which participating pharmacies in NJ distributed free naloxone throughout the State. There were 16,251 kits distributed.

**Appropriate use is defined as use of medication for the treatment of a substance use disorder, combining psychological treatments with approved medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, and advocacy with state payers.*

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Footnotes:

Other federal funding as well as state funding support the purchase of Naloxone.

Environmental Factors and Plan

15. Crisis Services - Requested

Narrative Question

In the on-going development of efforts to build an robust system of evidence-based care for persons diagnosed with SMI, SED and SUD and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from M/SUD crises. SAMHSA has recently released a publication, Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies that states may find helpful.[61] SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with M/SUD conditions and their families. According to SAMHSA's publication, **Practice Guidelines: Core Elements for Responding to Mental Health Crises**[62],

"Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination, and victimization."

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The following are an array of services and supports used to address crisis response.

[61] **http://store.samhsa.gov/product/Crisis-Services-Effective-Cost-Effectiveness-and-Funding-Strategies/SMA14-4848**

[62] Practice Guidelines: Core Elements for Responding to Mental Health Crises. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009. **http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427**

Please check those that are used in your state:

1. Crisis Prevention and Early Intervention

- **a)** ☑ Wellness Recovery Action Plan (WRAP) Crisis Planning
- **b)** ☑ Psychiatric Advance Directives
- **c)** ☑ Family Engagement
- **d)** ☑ Safety Planning
- **e)** ☑ Peer-Operated Warm Lines
- **f)** ☑ Peer-Run Crisis Respite Programs
- **g)** ☑ Suicide Prevention

2. Crisis Intervention/Stabilization

- **a)** ☑ Assessment/Triage (Living Room Model)
- **b)** ☐ Open Dialogue
- **c)** ☑ Crisis Residential/Respite
- **d)** ☑ Crisis Intervention Team/Law Enforcement
- **e)** ☑ Mobile Crisis Outreach
- **f)** ☑ Collaboration with Hospital Emergency Departments and Urgent Care Systems

3. Post Crisis Intervention/Support

- **a)** ☑ Peer Support/Peer Bridgers
- **b)** ☑ Follow-up Outreach and Support
- **c)** ☑ Family-to-Family Engagement
- **d)** ☑ Connection to care coordination and follow-up clinical care for individuals in crisis
- **e)** ☑ Follow-up crisis engagement with families and involved community members

f) ☑ Recovery community coaches/peer recovery coaches

g) ☐ Recovery community organization

4. Does the state have any activities related to this section that you would like to highlight?

During SFY 2018, the state's 23 Designated Screening service programs provided 91,542 episodes of emergency mental health care to screening centers. The state's 12 Affiliated Emergency Service Programs delivered 28,954 episodes of crisis care. The Early Intervention Support Service (EISS) programs (offering urgent mental health care) delivered 13,505 episodes of care during SFY 2018, with episodes generally ranging from one contact with immediate referral to four-six weeks of short term out-based crisis stabilization.

DMHAS continues to support consumers' development of Psychiatric Advance Directives (PADs) to express their wishes about their mental health care and other assistance during a personal mental health crisis. In SFY 2019, DMHAS implemented an electronic registry of PADs, so that providers and consumers can retrieve PADs during episodes of crisis care. Early 2019, the PAD Registry went live at http://www.state.nj.us/humanservices/dmhas/resources/mental/pad/. Both providers and peers were invited to meet at a training provided by DMHAS and were provided with information not only on how to "upload documents" in to the Registry, but were also provided with informational supplements on the laws surrounding PADs; what should be included in a PAD; and the actual technical demo for the upload as well as the accessing of the Registry by the provider. Peers were also provided with regional trainings on what constitutes a legally acceptable PAD, how to assist someone in preparing/writing their own PAD, and how the self-help/community wellness centers can assist their members with uploading their documents in to the Registry. Persons with PADs also receive wallet cards with information as to how to access their PADs once they have completed the process.

The Division staff are planning to work with their community partners to continue to raise awareness about the self-empowering nature of having a PAD in the Registry, and offering support in instances where individuals need some guidance or technical assistance downloading their document in to the Registry.

A description of the CSOC Crisis Services is provided:
New Jersey Suicide Prevention Hopeline at 1-855-654-6735 & www.njhopeline.com. It is staffed by mental health professionals and peer support specialists 24 hours a day, seven days a week. The service is available to all ages for confidential telephone support (except when a suicide attempt is in progress), assessment, and referral. Crisis chat is available through the website and the service can be reached by texting njhopeline@ubhc.rutgers.edu.
2ND Floor Youth Helpline. Accredited by the American Association of Suicidology, 2ND Floor confidentially serves youth and young adults (ages 10-24). Youth who call are assisted with their daily life challenges by professional staff and trained volunteers. The 2nd Floor website can be accessed at http://www.2ndfloor.org/
Screening and Screening Outreach Programs. Available in each county 24-hours a day, seven-days a week to individuals in emotional crisis who require immediate attention. An individual may be seen without an appointment or be brought to the screening center by a parent, friend, spouse, law enforcement official, mental health worker, or any other concerned individual.

Crisis Text Line. Children's System of Care has developed an agreement with Crisis Text Line in New Jersey to provide another tool for constituents. Crisis Text Line is a free 24/7 support that connects anyone experiencing a self-defined crisis with a trained counselor. Crisis counselors are trained to bring texters from "a hot moment to a cool calm" using empathic listening techniques. They collaboratively problem-solve to help the texter come up with a plan to stay safe. Calls are anonymous and confidential, unless referral to emergency services is absolutely necessary. Additional information about Crisis Text Line can be found at crisistextline.org.

Mobile Response and Stabilization Services (MRSS). Mobile Response and Stabilization Services (MRSS) provides rapid response to youth and families experiencing family-defined crisis, 24 hours per day, 7 days per week, 365 days per year, that focuses on crisis intervention and stabilization that is intensive, therapeutic and rehabilitative.

Traumatic Loss Coalitions for Youth (TLC) – Rutgers UBHC Suicide Prevention. Suicide is the third leading cause of death for New Jersey's youth. CSOC is dedicated to the prevention of youth suicide. New Jersey's primary youth suicide prevention program is the Traumatic Loss Coalitions for Youth funded by CSOC. The Traumatic Loss Coalitions for Youth Program at Rutgers-University Behavioral HealthCare is an interactive, statewide network that offers collaboration and support to professionals working with school-age youth. This is accomplished through county, regional and statewide conferences, training, consultation, onsite traumatic loss response, and technical assistance. Since its inception, the TLC has trained thousands of individuals throughout the state with the purpose of saving lives and promoting post trauma healing and resiliency for the youth of New Jersey. The TLC website can be accessed at http://ubhc.rutgers.edu/tlc/

Functional Family Therapy for Foster Care (FFT-FC). CSOC in partnership with the Division of Child Protection and Permanency (CP&P) and a local provider offer access to and service delivery of Functional Family Therapy – Foster Care (FFT-FC) through the CSOC Mobile Response and Stabilization Service and Intensive In-Community service lines. FFT is a relationally focused, trauma informed, evidence-based treatment model for youth in resource care that increases the likelihood of successful adjustment for youth in their resource placements as well as positive permanency outcomes. This treatment model is targeted toward youth aged 12-18 who are demonstrating behaviors that place them at risk of disruption in their resource care placement and are in the legal

custody of the CP&P and have the intellectual capacity to benefit from the treatment intervention. The model uses the relationally focused techniques of Functional Family Therapy (FFT) in a comprehensive and systemic approach adapted to helping youth and families involved with DCP&P to overcome individual and relational trauma to promote placement stability, increase youths' lifelong connections and improve youths' permanency outcomes.

Children's Crisis Intervention Services (CCIS). Psychiatric inpatient hospital services, located in community hospitals, provide acute inpatient treatment, stabilization, assessment and short-term intensive treatment. The units are licensed by the Department of Health, following yearly designation by CSOC. The Children's Crisis Intervention Service (CCIS) designation process ensures that CCIS units, established to meet the intent of the 1987 Children's Regional Plan, are following both the intent and spirit of the plan and comply with the Certificate of Need criteria for CCIS units (N.J.A.C. 8:33) and Hospital Licensing Standards (N.J.A.C. 8:43G). Nine CCIS units are located around the state and provide services to all 21 counties. There are currently 164 beds. They are funded through Medicaid and private insurance. Seven of the nine CCIS' receive additional support through a mental health subsidy ($15, 056 annual per bed) from the Division of Mental Health and Addiction Services. Youth receive educational services in the acute care setting as clinically appropriate. Therapeutic services include the child's family as an integral element in planning for a return home or to a lower intensity of service.

Please indicate areas of technical assistance needed related to this section.

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Footnotes:

Environmental Factors and Plan

16. Recovery - Required

Narrative Question

The implementation of recovery supports and services are imperative for providing comprehensive, quality M/SUD care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of: health (access to quality health and M/SUD treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder. Because mental and substance use disorders are chronic conditions, systems and services are necessary to facilitate the initiation, stabilization, and management of long-term recovery.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life to the greatest extent possible, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see **SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders.**

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Technical assistance and training on a variety of such services are available through the SAMHSA supported Technical Assistance and Training Centers in each region. SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

Please respond to the following:

1. Does the state support recovery through any of the following:

a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care? (●) Yes ( ) No

b) Required peer accreditation or certification? (●) Yes ( ) No

c) Block grant funding of recovery support services. (●) Yes ( ) No

d) Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system? (●) Yes ( ) No

2. Does the state measure the impact of your consumer and recovery community outreach activity? (●) Yes ( ) No

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

See attached.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state.

The Division of Mental Health and Addiction Services (DMHAS) supports the role of peers through several new and existing recovery support initiatives. These programs assist individuals with opioid use disorders or those who are at risk of an opioid overdose through supportive services, case management, education, resources, and advocacy for families and individuals. The Opioid Overdose Recovery Program (OORP), which is now in all 21 counties, provides support services to individuals reversed from opioid overdoes treated at hospital emergency departments. Peers working in OORP programs meet with individuals at bedside where they share their stories of hope and recovery. These peers are instrumental in engaging individuals in the emergency department and beyond and letting them know that they are not alone and that recovery is available to them in whatever pathway they choose.

Support Teams for Addiction Recovery (STAR) program provide case management and recovery support services for individuals with opioid use disorders (OUD). The STAR initiative is comprised of one team, each consisting of a program supervisor, two case managers and two recovery specialists. The team is to maintain a caseload of 40 individuals. STAR case managers work with individuals to assist with issues that often occur concurrently with an OUD, such as homelessness, incarceration, legal issues, employment, education, transportation, need for social services, health care, child welfare involvement, child care, health insurance, documentation, etc. The STAR recovery specialists provide non-clinical assistance and recovery supports services. The overall goal of STAR is to help maintain individuals with an OUD in the Recovery Zone for as long as possible, help to reduce the risk of recurring episodes of opioid related problems, and prevent future overdose. The STR grant funded the STAR program in 10 counties. The SOR grant and SOR supplemental grant funds have expanded program to the remaining 11 counties, making the program statewide.

Maternal Wrap Around Services (M-WRAP) combines intensive case management and peer recovery support series for opioid dependent women during pregnancy and up to one year after giving birth. Intensive case management focused on developing a single, coordinated care plan for pregnant/postpartum women, their children and families.

DMHAS funds two comprehensive centers and three smaller scale recovery centers (Community Peer Recovery Centers [CPRC]) for persons in recovery from substance use disorders. Recovery centers are a place that those in recovery can find help, fellowship, and a safe haven. Peer workers provide mentoring, coaching, care coordination, social and recreation activities, life skills, vocational training, support groups, wellness classes, workshops and other assistance. DMHAS will issue a Request for Proposals (RFP) in early Summer 2019 using State Opioid Response (SOR) grant funds to fund seven additional CPRCs. Providers are required to provide peer-to-peer recovery support services that are responsive to community needs. All activities and services are led and drive by “peers”, individuals who have experienced addiction and recovery, either directly or indirectly as a family member or friend. The overall goal of the CPRC is to provide a safe place for recovering individuals to gather in support of one another and experience sober living in a community setting. The CPRC will be a place where those in recovery can have the opportunity to give back to their community thereby fostering senses of empowerment and independence.

Two public colleges and universities receive funds to support students in recovery. Recovery support and housing agreements are in place with Rutgers University, New Brunswick and Newark campuses and The College of New Jersey. Recovery supports include screening and intervention services for at risk students; self-help, mentoring, peer and academic support; crisis management and relapse prevention; community education; and alcohol-free/alternative programming and community service opportunities. Capital agreements are in process with The College of New Jersey, and Ramapo College of New Jersey to either develop designated recovery housing and/or enhance existing recovery communities on campus. An additional five programs will be added.

Telephone Recovery Support (TRS) is a confidential peer-to-peer check-in type service. Peers provide weekly telephone recovery support calls to people seeking recovery from opioid addiction. Staff help provide information about local recovery supports, including information about local resources such as self-help meetings, food pantries, and sober living, if needed. To date, 618 individuals have been served by TRS.

The Prison Intensive Recovery Treatment Support (PIRTS) program is a collaboration with the NJ Department of Corrections (DOC) providing peer services that expands pre- and post- release recovery support services to individuals within DOC with an opioid use disorder and facilitates continuity of care and treatment that includes comprehensive medical, substance use treatment and social services. Eligible Offenders being released from DOC custody who are receiving FDA approved medication assisted

treatment for an OUD and who will continue to receive medication assisted treatment after their release from prison, and those Eligible Offenders, with an OUD, being released from custody who choose not to receive medication assisted treatment while incarcerated are participants in the PIRTS program. This program was developed through a Memorandum of Agreement (MOA) with Rutgers University Behavioral Health Care and in close collaboration with DOC. A key feature of this program is that the provider will begin working with offenders six months prior to release.

DMHAS supports the advancement and professionalism of peers by increasing and enhancing its peer workforce. All peers working in DMHAS initiatives attend a 3-day Ethics training, where they learn about themselves, others, cultural diversity, motivation interviewing, outreach, and engagement techniques. In addition, peers attend the 5-day Connecticut Community for Addiction Recovery (CCAR) which leads to peer certification. DMHAS supports two pathways to peer certification. The International Reciprocity and Credentialing Consortium (IC&RC) NJ affiliate, the Addiction Professionals Certification Board, grants the Certified Peer Recovery Specialist (CPRS) and NAADAC, the Association for Addiction Professionals grants the National Certified Peer Recovery Support Specialist (NCPRS). Over 150 peers have receiving training through the Division's Addiction and Training Workforce Development initiative and half have obtained certification as recovery support specialists.

5. Does the state have any activities that it would like to highlight?

The Division of Mental Health and Addiction Services (DMHAS) has worked with the Division of Medical Assistance and Health Services (DMAHS) to develop a bundled rate for Opioid Overdose Recovery Program (OORP) services so it is now Medicaid reimbursable. DMAHS has also developed an individual rate for addiction peers. DMAHS is working now on developing a reimbursable rate for substance use disorder (SUD) case management services for its new supportive housing program.

Please indicate areas of technical assistance needed related to this section.

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Footnotes:

16. Recovery - Required

3) Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

Division of Mental Health and Addiction Services (DMHAS)

Consumer-Operated Services in New Jersey
Consumer-operated Services continue to expand the availability of resources, as well as having a strong commitment from the Division of Mental Health and Addiction Services (DMHAS) toward building a recovery-based system-of-care. DMHAS strongly emphasizes the participation of the mental health, addiction and co-occurring consumer population and the families of those consumers into the development of its programs; the planning procedures for those programs; the careful monitoring of such programs; as well as consumer and family inclusion into the evaluation process for nearly all programs provided.

33 Community Wellness Centers, Self-help Centers and/or Recovery Centers
There are 33 Centers throughout the 21 counties of the state that are funded by the Division of Mental Health and Addiction Services and these centers are all consumer-run community-based or State hospital on-grounds centers that strive to provide support services to individuals experiencing mental health and/or substance use issues, with available resources and structure to foster their personal recovery and wellness. The Center members are supported through self-help, socialization, peer support, employment and education opportunities, and recovery-based activities. Some Community Wellness/Self-help Centers/ Recovery Centers are leaders in delivering support services to the members. Many of the Wellness Centers that were originally conceived and set up to provide mental health support to the surrounding communities are seeing considerable changes in their membership structure and most are now servicing not only individuals with mental health challenges, but also welcoming more members who need co-occurring support services, as well as servicing many behavioral health consumers who are homeless, have criminal justice involvement and more people with language barriers, particularly Spanish speaking members. This shift in membership demands, has had a huge impact on the availability/use of financial resources and has caused a lot of adjustment necessities and an increase in training needs of Wellness Center peer staff and a need to have long-term center members understand and accept the demands that are resulting in changes to the structure of the services that are provided/needed.

Wellness Centers/Self-help Centers continue to have access to the Recovery Library by Pat Deegan, which is an evidence-based practice that provides an opportunity to an array of online supports, group ideas, videos, and interactive exercises that focus on issues relevant to recovery, including addiction issues, wellness issues, parenting, advocacy, relationship building and developing natural supports in ones' community of choice.

This year, DMHAS reallocated some of its' already existing funding dollars under the auspice of Consumer-operated Services and created a competitive opportunity for Wellness Centers/Self-help Centers to apply for additional **"Wellness Dollars."** Through an application process in which the managers had to explain how they would use these particular funds to address the memberships

needs surrounding specific dimensions from SAMHSA's Eight Dimensions of Wellness, and how that additional funding would assist to enhance services in dimensions that were important to the members of each Center.

Journey to Wellness (JTW) Self-help Center in Toms River, NJ and **Brighter Days Wellness Center** in Jackson, NJ are both in Ocean County and the leadership staff has been active in working collaboratively in their respective communities. They have worked with the Ocean County Department of Human Services, local police departments, county social service agencies, and the NJ Department of Community Affairs. Those Self-help Center/Wellness Center managers have been at the forefront of what has resulted in a tremendous
legal shift and helped to change individual rights for Residential Health Care (RHC) residents throughout NJ.

Advocates/Managers from these two centers have directly assisted in developing new State legislature that provides *Due Process* to the RHC/Boarding Home residents in New Jersey, particularly around new State regulated eviction procedures. These residents can also now have community visitors at their homes between 8 AM and 8 PM, 7 days a week. The RHC/Boarding Home residents have the liberty to access Wellness Center transportation services and participate in activities at their local Wellness Centers/Self-help Centers if they choose to take advantage of that new opportunity. This type of resource was previously unavailable to many RHC/BH residents and when they weren't in a program, they had limited options to their ability to engage in consumer-based services. Many people at these homes had little family support and were not engaged in outside activities at night or on the weekends. DMHAS Wellness Centers/Self-help Centers are now able to offer their many services to the residents, many who previously were restricted from attending, by the RHC/BH management/leadership. The Wellness Centers/Self-help Centers state-wide assist these residents with socialization skill development, offer them a supportive environment in which they can focus on developing their recovery skills, provide assistance to empower them with ways to make positive changes in their lives, while helping them understand how to manage their behavioral health needs. Wellness Center staff are helping these RHC/boarding home residents learn computer skills so that they can find phone numbers that they need and locate addresses for agencies that they wish to contact. Many centers have also been doing some groups specifically for the Boarding Homes residents, such as: Budgeting their money and assisting them to develop independent living skills.

Journey to Wellness offers diverse, innovative, and purposeful groups to all of their members, that are delivered by a well-trained peer staff, who either have their CRSP credential or CPRS credential, many of which hold dual certifications, holding both credentials. Groups offer a variety of evidence-based strategies and coping skills to obtain and retain your personal wellness and recovery. Examples of the groups are: IMR, WRAP, Creative Expressions, Your Wellness Counts, Yoga, Mindfulness & Meditation, Anger Management, and Weekend Wellness. JTW focused its' Wellness Dollars on social wellness and enhanced its' Saturday Socialization activities. That center also updated their community garden to promote environmental wellness, so that the members would have access to fresh fruits and vegetables. And lastly, JTW added a small community library at the center, for intellectual wellness, which the members enjoy greatly.

Brighter Days is starting up a NJ Connect Recovery Group. The focus is to educate parents and

partners the skills to deal with substance use that are affecting their families and their personal relationships. This is a 13-week workshop where family members/partners will learn how to: Understand Behaviors, Communicate Effectively, Practicing Self-Care and most of all, that they are not alone. NJ Connect for Recovery Workshops provide a safe, nonjudgmental place for family members of the Center members who have co-occurring or addiction difficulties to get immediate support, counseling and assistance from professional staff on substance use issues. There is a NARCAN training at the close of the workshop and a NARCAN kit is provided to the attendees who complete the 13-week program. Brighter Days has also become a "Quit Center" for smoking cessation and will work with professional representatives from Robert Wood Johnson University Hospital. As for the Wellness Dollars, Brighter Days is going to be doing a raised garden this year with a variety of vegetables. The members will be looking at different ways to incorporate these fresh home-grown vegetables into everyday meals to make them healthier. They have also planned a Sunflower Garden around the property.

Hudson County Integrated Services (HCIS) Wellness Center is a heavily attended urban-based center in the heart of Jersey City. The center is truly a life-line for many people. For many people struggling to recover from mental illnesses and/or addictions as well as homelessness, this Wellness Center proudly offers safety, assistance, encouragement, constructive criticism, caring and most importantly, hope with the message, "You Matter" and "YOU ARE WORTH THE EFFORT." It is absolutely a source of refuge and often times a life saver.

The HCIS Center Wellness Center provides hope and inspiration for the staff and a realization of how grateful we should be for all that we have but usually take for granted. HCIS, as well as all the other centers in New Jersey that offer un-countable and un-measurable gifts of hope. The Wellness Centers offer consumers with mental health and/or co-occurring issues, opportunities for recovery that often, the rest of society generally believe these incredible people don't even deserve. Activities at this center include: Helping individuals learn to access resources and tools available in the community, extensive housing services, assistance getting Birth Certificates, ID and SS cards, 3 meals a day, meetings important to members' recovery; including a Methadone Support group. The center also offers its' members groups that focus on Stress/anger management, Resume writing, computer access and assistance. They maintain a dedicated fitness area and an art room. The center provides its' community members an opportunity to spend time enjoying Holiday meals, on the day of the actual Holiday.

The MHANJ's **Esperanza Wellness Center** was welcomed into the Elizabeth community in November 2017. They have witnessed over the past 1 ½ years an under-funded community with multicultural people that have tremendous character, values, and history. Homelessness and malnutrition are some of the daily challenges for the community. Esperanza Wellness Center has become a haven and a positive beacon of hope for many. Many of the residence suffer from addiction and are biased towards seeking treatment for undiagnosed mental illnesses. It has always been our motto to meet people where they're at; to empower by providing education, information, and resources. They provide Wellness Groups in Spanish and English with linkages to other bilingual resources. Esperanza has partnered with Make the Road New Jersey which has helped many Dreamers enter College and get citizenship. Esperanza has partnered with the over 100 other community providers like the Union County Office of LGBTQ Affairs, Union County College

Youth Corp, Gateway YMCA, Elizabeth Public Library, Stop & Shop, Bridgeway, and Trinitas Regional Hospital.

They are a member of Shaping Elizabeth Coalition which focuses on the health and nutrition needs of the community. Esperanza's wellness dollars are being used for a 3-month physical wellness workshop. Also, in making members aware that May is Stroke Awareness Month they have formed weekly walk groups over the summer months. Esperanza is proud of its' partnership with the LGBTQ community. Many suffer from mental illness and substance abuse early in life. Forty percent of homeless young adults are transgender or gay. Fifty percent have reported alcohol and substance abuse. Many of those members have been referred to treatment facilities or helped to reconnect with family members and loved ones. Esperanza Wellness Center has been and will continue working with the Union County Office of LGBTQ Affairs to make Esperanza a safe and empowering environment for all. Several members who identify as LGBTQ have shared they feel safe and even shared some of their struggles. In February 2019, Esperanza was invited to Union County's LGBTQ Networking Roundtable that was put together by Freeholders and Union County Office of LGBTQ Affairs. In April 2019, Esperanza members had access to Union County Parent and Adoption Recruitment Info session geared towards decreasing homelessness among the LGBTQ. Esperanza members have access to GLAAD media institute training being held in May, and every June there is the Union County Teen Pride Prom. Esperanza will continue to be a strong supporter of Union County Office of LGBTQ initiatives. Union has a richly diverse community and many needs; the center is deeply proud be a part of that community.

Collaborative Support Programs of New Jersey (CSPNJ) Community Wellness Centers' (CWC) mission is to create a warm welcoming place where people can gain skills and motivation to set and achieve wellness goals necessary for recovery. Center peer staff strive to offer opportunities to access education, support and provide resources to help people in recovery realize a lifestyle centered on wellness in all dimensions (physical, emotional, spiritual, intellectual, social, occupational, environmental, and financial). The Center's provide a place where you can feel respected and accepted. They provide stepping stones to personal growth and help individuals learn to access resources and tools available in their community. They are a place where you can gain support from other people who have similar life experiences and help prevent loneliness and isolation.

Peer Management focuses their efforts on integrated services to eliminate the silos between all levels of community services. Peer Recovery Support Specialists have been added to the consumer management staffing, to provide training and recovery focused groups at those Centers. The Peer Recovery Specialist is also working to assist members with their engagement to services. There has also been the addition of a Community Integration Specialist to work with breaking down barriers to full integration to the community for members. CSPNJ operated Wellness Centers offer active peer support, innovative groups, linkage to community advocacy and a welcoming atmosphere. Each center plans and schedules activities based on the feedback of the membership and the needs of the local community. This is a list of some of the many groups offered in a CSP Community Wellness Center: Access to Peer Resources (Recovery Library and Common Ground), DBSA, Dual Recovery Anonymous, GROW, Hearing Voices Network, Decision Making, Men and Woman's groups, Meditation, Diet and Nutrition, Advocacy and Political Science, Diabetes, Thrifty Shopper, Dance, Cultural Heritage, Computer Skills, Peer Employment

Support, Compassion and Spiritual Wellness, Leadership Trainings, Physical Wellness, Walking Clubs, Methadone Support Groups, Anger Management, Zumba, Yoga, Resilience, Healthy Boundaries, and AA/NA.

Collaborative Support Programs of New Jersey's CWCs offer groups that represent the eight dimensions of wellness. They also provide a link to other CSPNJ services such as Supportive Housing, Respite Centers and Financial Services based on each member's needs. All center's offer groups and or programs using the Wellness Dollars to enhance their ability to meet membership needs. There is a major focus on this year's programs on addressing physical wellness and integrated care. State-wide the CWCs have also been working to meet the changing needs of their members, as there has been an increase of those who are experiencing homelessness, criminal justice involvement and co-occurring disorders.

The Reach-out/Speak Out (RO/SO) Community Wellness Center in Mercer County (Hamilton, NJ) facilitates a weekly group that is attended by consumers from **Trenton Psychiatric Hospital (TPH).** The RO/SO manager also works at the Trenton Psychiatric Hospital's On-grounds Wellness Center. Through this dual role, the center manager assists all attending members by offering GED assistance, computer training groups, GROW, Kung Fu, Spirituality Groups, Hearing Voices Network, and individual peer support. The members suggest activities, food, etc. which is then coordinated (and the calendar set) at the business meetings. Reach Out/Speak Out Community Wellness Center provides transportation to a local soup kitchen and plans shopping trips for members. The group stresses cultural competency and diversity and has activities focused on this, such as trips to local cultural events. RO/SO Wellness Center used their Wellness Dollars to have a nutritionist come to the center weekly and to attend the center's Diabetes group. They are a certified nutritionist who specializes in working with individuals who have diabetes and want support with weight management. These areas of physical health are very important to this center, as they focus a lot on exercise and wellness. They currently offer exercise groups, walking groups, cooking groups and nutritional groups. Listening to the needs of the membership, the center has been able to offer a well-rounded approach to improving ones' physical well-being. RO/SO strives to provide the best services and opportunities for their membership.

Three of New Jersey's Wellness Centers are directly On the Grounds of three State Psychiatric Hospitals found at Ancora, Trenton, and Greystone Psychiatric Hospitals. The **On-grounds Wellness Centers** provide self-help and mutual-aid activities, offer peer support, provide socialization opportunities and share information and offer daily living skills training to individuals who are receiving services at those hospital sites.

The On-grounds Centers use material from the Recovery Library to develop groups, they support work done with individuals and provide prep time and support for the center staff. All on-ground centers use "Welcome to Community Cards." These cards were developed by staff and membership to provide information and offer resources to consumers being discharge into the community. These cards are a way to engage members and help link people to available Community Wellness Centers. Members use on-line services to apply for jobs, do housing searches, and link with friends and family. TPH does "12-step Yoga for Sobriety" and "Living your Wellness" groups. Ancora On-grounds Wellness Center does WRAP groups and several

groups that focus on the 8 Dimension of Wellness. Greystone offers "Living your Wellness" groups.

The Trenton Psychiatric hospital-based center has also been serving the Ann Klein forensic state hospital since the beginning of the center eight years ago. Originally the staff provided groups to the TAP program which stood for transitional alternative programming. Ann Klein has recently changed their rehab groups and no longer has TAP on the Rehab link, so groups are now provided to their standard rehab programming. Examples of the groups at the forensic site are groups focusing on the materials found on the Recovery library, as well as; Wrap topics, 8 dimensions of Wellness groups, shared Recovery stories, using Community resources, Coping, in a locked in environment, and other topics as requested by group members.

One on one groups do not happen all the time, although sometimes they are requested by staff or membership, and are provided upon request. In the one on one groups, members have sometimes expressed their interest to become peer specialists when they get back into the community. In fact, one of our original members is currently working as a manager in the Peer field.

The Camden Wellness Center (Camden WC) is designed to empower consumers who are living with Mental Health and/or co-occurring issues to realize a lifestyle centered on Wellness. They provide support groups such as: spirituality, exercise, current events, employment and unemployment. They use guest speakers to discuss topics such as: money management, networking, public transportation services and much more.

Camden Wellness Center has used its' Wellness Dollars on a "practical approach" to Wellness. The center calls this new service; "The Enterprise." They purchased new computers to replace the outdated and seldom working computers that existed. The center upgraded the Wi Fi system to a more effective and operational system that allows members to fill out applications and upload resumes to send to potential employers. The members utilize the computers to better understand agency requirements for obtaining identification, such as: Birth Certificates, Social Security cards and Medicaid cards. They create resumes and send them to prospective employers for job opportunities. The members can create Psychiatric Advance Directives (PAD) and will soon be able to upload them electronically to the PAD website, which is scheduled to go live in NJ on June 27, 2019. Homeless members are now able to utilize social media to reconnect and then stay in contact with their family members. Many of the Center's membership has lost contact with their families over the years, due to the lack of resources to contact them.

The Camden WC has made extensive efforts to visit other centers and agencies for resources and training. Recently the center members visited the Rite Center in Burlington County and saw the Mental Health Players perform. This center has received donations that allowed members to attend the Camden Salvation Army KROC (Ray and Joan Kroc) Center, which provides the community with Play Care, a Fitness Center, a pool, group fitness rooms, and a gym. Members also attend the KROC Center to find spiritual, physical and mental enrichment. The Camden Wellness Center has partnered with the Center for Family Services (CFS), and through CFS community outreach efforts, they have enrolled several members in their STAR (Support Team for Addiction Recovery) Program, centered on people living with opioid addiction. Several individuals who have completed the STAR program have been able to finish the program and are

in recovery. With support from STAR they received housing vouchers. The STAR "graduates" continue to attend the Camden Center and now volunteer as coaches and mentors for other consumers who struggle with co-occurring disorders.

The Riverbank Self-Help Center (RBSHC) is dedicated to promoting the Wellness and Recovery of mental health consumers by providing information and support to adult members with mental health and co-occurring issues. The RBSHC provides their members with the opportunity to learn coping strategies for symptom management and stress management, as well as, social skills and recreational activities, including outings into the larger community. Most recently, with the help of the Wellness Dollars, RBSHC have taken on the goal of providing more groups centered around movement and nutrition. Several new groups and outings have been added to the program designed to promote exercise and better educate consumers about nutrition. The Nutrition and Exercise Accountability group participants were provided with individual notebooks, to track their food intake and their exercises, as well as, being directed to Smart Phone apps members can use. This is currently being supported by talking with interested individuals for one on one support and goal setting. RBSHC also started a new group called "Artz in Action" which includes active theater games and improv skills. The center also offers dance groups, nature walks, healthy cooking, recreational therapy, yoga and tai chi groups.

Roads to Recovery is a consumer operated service that provides transportation four days weekly to and from AA, NA, DT, Suicide Anonymous, GA meetings/groups within Burlington County for consumers with co-occurring disorders who have been unable to get services. The driver is available to respond to geographic locations within a 10-mile radius of Westampton. "Roads to Recovery" is a free service that was developed by the Riverbank Self Help Center under the auspices of Burlington Behavioral Health Services, a program of Catholic Charities.

The Riverbank Transportation program is a consumer run service that offers available transportation to mental health and co-occurring consumers to and from work in Burlington County. It is a dependable, affordable service that has been in continuous service for 19 years. The service is for mental health consumers who would like to return to work, but lack the transportation. Drivers are able to respond to individual work schedules and geographic locations that are not serviced by public transportation. Rides must be scheduled in advance with the transportation dispatcher. The cost for this door to door service is $2.00 and is billed monthly. The hours are 8:00am-9:00pm, Monday through Friday.

Realizing Independence Through Empowerment (The RITE Center) Self Help Center offers a Monthly Trauma Recovery Group- Oaks Integrated Care is a recognized Trauma Informed Care behavioral health agency and the group focuses on a peer support trauma focused topic. They also have recently started a "Come Learn The RITE Way" monthly community outreach dinner takes places on the 3rd Wednesday monthly from 4pm - 8pm. Each month the center hosts a dinner for the community and a has a presentation on a wellness and recovery focused topic. Presentations have included medication education and a presentation by the NJ Mental Health Players. Future presentations will be focused on nutrition, spirituality, financial planning/budgeting (including overview of SSI/SSDI and an open mic night. The goal of having monthly outreach dinner is to provide opportunities to those in Burlington County to experience the support of the center outside its regularly scheduled hours of support.

Individuals in Concerted Effort (ICE) **Peer Center** was founded over 35 years ago. Its focus to integrate peer support across Atlantic County via strong collaborations and partnerships with providers, community organizations, churches and Stockton University of NJ, to create a community focus on proactive outreach and self-care for persons in recovery. Services are offered through the county, with groups focusing wellness, skill building, and community integration.

The ICE Center provides extensive peer-focused case management. Their support groups take place throughout the county and they offer boarding home outreach services. Multiple centers employ a trained Wellness Recovery Action Plan-certified facilitator that enable them to offer the Evidence Based Practice level of WRAP to all of their members and also support Peer Outreach Support Teams (POST) providing peer case management and outreach serving hundreds of consumers each year with WRAP-based recovery services.

The Mental Health Association in NJ (MHANJ) operates Peer Outreach Support Teams (POST) in four New Jersey counties that provide proactive peer to peer case management in the community (serving over 150 clients per year). POST create and operate a wide scope of support groups designed to assist peers in the community, work as educators/trainer with first responders (CIT), schools, libraries and facilitate collaborations across healthcare systems to meet the needs of consumers in recovery. All staff are credential peer-staff, volunteers, and student interns. POST offers non-clinical peer delivered case-management to individuals, living with mental health and/or co-occurring disorders, who share their lived experience to motivate others, offering inspiration and a foundational mutual respect.

Evidence-based methods are embedded in case management and include Motivational Interviewing, the Intentional Peer Support Model, and an Illness Management and Recovery approach. Goals are organized in the Specific, Measurable, Achievable, Relevant, and Time-Bound (SMART) format and based off the eight dimensions of wellness. Transportation is available to and from the one-to-one meetings, and Peers can assist consumers with transportation to and from doctor appointments, food banks, social service agencies, job interviews, etc. Peer Outreach Support Teams do a lot of community outreach (groups, training, and meetings). POST Team members sometimes support consumers with hospital discharge planning. POST works in partnership with other providers to offer guidance and support to mental health consumers who transition out of hospital care or re-enter the community from the correctional system. POST workers help people "bridge the gap" to be ready for life back in the community.

Here are three new county initiatives:

- **Atlantic County POST** has started new groups in 2019 which include a grief and loss group for those who have lost someone due to a substance use disorder, a Veteran's support group, a men's support group and pet therapy. Atlantic County POST also provides in-home hoarding interventions that are unique in the state.
- **Ocean County POST** offers non-clinical case-management, transportation, and educational/engagement outreach to Ocean County residents living with mental health and/or co-occurring disorders. Launched a full evening of innovative support groups

focusing on addiction, co-occurring for individuals and families from needs identified by POST clients.

- **Union County POST** developed a new initiative this year to focus on physical wellness. Many community agencies have partnered with the POST team and are participating in this project to provide health screenings, nutrition and healthy cooking education, and physical trainings at the local YMCA. The Union County staff have formed walking groups with POST clients and community volunteers and they are walking together for their health once a week throughout the year.

The NJ Suicide Prevention Hopeline is funded by the New Jersey Division of Mental Health and Addiction Services and is operated by Rutgers University Behavioral Health Care. Since its inception in May of 2013, call volume has steadily risen from Fiscal Year 2014's total of 19,876 incoming calls to Fiscal Year 2018's total incoming call volume of 42,827. Fiscal Year 2019 is expected to total nearly 48,000 incoming calls. The Hopeline employs one full time peer support specialist and two part-time peer support specialists. Peer support specialists are fully integrated into the Hopeline's call answering system and their expertise and experience in wellness and recovery are utilized to engage callers, help build rapport, and elicit motivation from callers with high degrees of ambivalence towards or distrust in the system of care.

Wellness Respite Services-Receiving a psychiatric diagnosis can often be a disempowering experience wherein one's autonomy is usurped by a mental health system imbedded in settings that foster dependency and segregation. Hospitalization can contribute to this sense of disempowerment, and often leads to a decrease in social and vocational functioning, loss of housing and jobs, dependence on professional staff, loss of contact with natural supports, and, potentially, increase in trauma and stigmatization. Yet, hospitalization is often the only resource available to individuals experiencing a psychiatric crisis (Burns-Lynch, Murphy, Gill, & Brice, 2015). Thus, Wellness Respite Services were created as a community based alternative to hospitalization which offers comprehensive and individualized mental health services.

There are a total of 4 Peer-operated Respite Center's currently available in NJ. Three of the Respite programs run by CSPNJ and there is another Respite-crisis program in Ocean County, NJ, run by Legacy Treatment Services. All Respite centers are doing extremely well. Historically, the Middlesex County Respite has had the highest occupancy rates out of all the CSPNJ respites. More recently, respites have had high occupancy rates. For the month of March, the (CSPNJ) Middlesex County Respite had a 94% occupancy rate, (CSPNJ) Passaic County had a 97% occupancy rate and the newest Respite in Essex County had a 103% occupancy rate. An occupancy rate in the 100's took years for the Middlesex County Respite to reach whereas, the Essex County Respite reached this rate in its six months of operation. This is a testament, not only to the tremendous need in this area, but also to the marketing plan that the Respite teams have carried forward.

Contributing to the increased occupancy rates at all CSPNJ Respite programs is evidence that the marketing plan is working. The Respite staff created and advanced a strategic marketing plan in which each staff person has a target group and is required to reach out to 2 contacts per week. This includes sending the contact an overview of Respite services along with their respective brochure

and flyer. Examples of target groups include Intensive Outpatient Programs, Supportive Housing programs and agencies, private therapists, primary care physicians, and partial care programs, etc.

Additionally, Respite supervisory staff attend local county PAC (provider advisory committees) and SRC (systems review committee) meetings in order to network with local providers and exchange information and resources. Additional meetings and committees include the CIT (Crisis Intervention Team) training planning committee, the Behavioral Health Justice Involved Task Force and the Campaign to End Stigma in Middlesex County Committee. Also, in particular, the Middlesex County Respite, celebrated its 5-year anniversary last month and has had over 700 guest stays since its opening in April 2014. Recently, the Middlesex County Respite program manager, has attended several events on the topic of opioid overdose prevention in an attempt to further the substance use services provided at the Respite. In fact, Respite staff from all of the Respite houses have recently become NARCAN trained as a response to the opioid epidemic. Lastly, the Middlesex Respite staff also continue to maintain a strong working relationship with the Community Wellness Center in Middlesex County, combining their marketing efforts and strategies.

Moreover, the Passaic County Respite's occupancy rates have seen a steady increase since July of 2018 wherein a new Program Manager, was hired. This key leadership change has had a positive impact on team morale as well as guest occupancy rates. In fact, Haledon Respite reached its highest occupancy rate to date; 99% in December 2018. To date, the Passaic County Respite has served over 530 guests since its opening in July 2014. Highlights for the Passaic County Respite include the ability to offer services in Spanish. The leadership team at Haledon is bi-lingual which ensures that there are staff in 7 days a week that speak and write in both Spanish and English. This has opened a door to many individuals that previously was not available.

Additionally, it should be highlighted that the Essex County Respite is in a unique situation in that the Essex County Respite is a part of CSPNJ's Essex County Integrated Services Wellness Center. The Respite in Essex County is located within the Better Life building that houses the Better Life Community Wellness Center. All guests at the Respite are linked to the Better Life Community Wellness center wherein guests report enjoying the center's support groups, daily activities, meals, and working with the center's resource specialist who can provide linkages to housing resources. The Essex County Respite offers, in addition to daily support from staff, a weekly substance abuse group and weekly art group. The respite team and guests are currently working collaboratively with the Better Life Wellness Center staff and membership to create a Better Life garden for all members and guests to enjoy over the summer. During the first quarter of 2019, the three CSPNJ respites had their licensing inspections. The respites were found to be very clean, orderly, and tranquil. Overall, the reviewers appeared to be impressed with the services offered at those Respite programs.

Furthermore, the Better Life Community Wellness Center will provide support services for 12 – 14 individuals living in housing units on the second floor of the Better Life (housing subsidies are managed by the Newark Public Housing). Most of the supports will be provided by peers and the residents will be encouraged to take advantage of the Engagement Center, which is totally peer-operated, on the first floor for support and resources to help them in their wellness and recovery as well as making important linkages to their local community.

Legacy Treatment Services operates a Peer Crisis Respite (Crosswinds) in Toms River, NJ. The Legacy Respite is peer-operated, with clinical staff providing over-sight. Crosswinds recently adapted their recreation room to now become a wellness room. In the wellness room they have incorporated SMART TV to stream in videos among other information for purposes of enhancing daily psycho-education groups. It has yoga mats and the floor is outlined with mesh tile that offers space to run yoga groups. The room is equipped for meditation services with meditation cushions and a chair. Materials have been purchased to run CD's and DVD's through the SMART TV for purposes of running yoga and meditation groups. There were items purchased to enhance the respite ambience with essential oil diffuser and running water. Crosswinds has a garden on the grounds for consumers to utilize as a therapeutic intervention and provide home grown food for menu preparation.

Crosswinds staff help link consumers to community-based programs, such as: Wellness Centers, re-entry programs, medication management and counseling, and in particular housing placements. Roughly 90% of consumers admitted to the Crosswinds respite are experiencing some form of acute mental health issue that is concurrent and often attached to their housing circumstances. The Legacy's Crosswinds Peer Respite has an 85% success rate linking homeless consumers to stable housing upon discharge.

Legacy Treatment Services Psychiatric Screening Services implemented employing peers on its emergency Psychiatric Crisis Screening unit in 2005**,** Legacy Treatment Services Behavioral Health Advocates have proven to be an essential part of the screening process. Behavioral Health Advocates provide support to those on the unit from a shared perspective of having a diagnosis themselves and their personal learned insights on what is needed to live life based on the principles of wellness and recovery. It is this shared mutuality that enables advocate staff to connect to those on the crisis unit in ways that a clinician can't. Screening and Crisis Intervention Program (SCIP) advocates primary role is to be to consumers the example that moving on from crisis is possible and that living life in wellness and recovery is an attainable goal, this happens by having advocate staff scheduled 24 hours a day 7 days a week. SCIP advocate staff further support consumers on the unit by assisting them with coming up with a Wellness Recovery Action Plan (WRAP) based post crisis plan which allows a consumer to gain insight on specific action steps that are needed to be in place while they embark on their wellness and recovery journey. Legacy Treatment Services Screening Program distinguishes itself as one of the few crisis screening programs in New Jersey that has peer staff.

Since 2005, the consumer-driven **CHOICES** team has been providing tobacco education to mental health and/or co-occurring consumers receiving services across the state of New Jersey. The services are delivered by a team of peer providers who do not use tobacco and are highly educated about the consequences of tobacco use and evidence-based treatments for tobacco use disorder. The team travels throughout the state to provide onsite tobacco educational presentations and feedback sessions to consumers at outpatient mental health programs, conferences, health fairs, & other events. The team also provides these sessions for Community Wellness Centers, and work collaboratively with center directors to provide engaging activities for consumers who are coming into the centers.

The goal of the **CHOICES** Program is to motivate tobacco users to consider quitting and link them to appropriate support services. The services are highly sought after by community providers and CHOICES has presented at statewide events like the annual COMHCO conference, for the past 10 years. Staff also participate in the MHANJ Consumer Connections training two to three times per year, to provide tobacco education for mental health consumers working toward becoming certified peer specialists. This is a vitally important session for the individuals attending the Consumer Connections program, as many of them are smokers themselves, and find the information learned inspiring in their own quest to become tobacco free, as well as the work they will be doing with their peers.

CHOICES peer counselors, called Consumer Tobacco Advocates (CTAs) are paid, part-time positions and there is a part time Program Director who provides supervision and oversight to the team. CHOICES also disseminates a program newsletter twice yearly which is posted to their website. The CHOICES newsletter is almost entirely made up of contributions from mental health consumers who share their stories. These contributions include personal smoking and quit smoking stories, poetry, artwork, and puzzles. Consumers who have contributed to the newsletter find it extremely validating to see their work in print. Each issue of this newsletter reaches between 3,000-4,000 consumers annually.

Additionally, the CHOICES program has received national attention and has been presented with awards in Innovative Programming by Mental Health America in 2007, the Silver Achievement Award in 2009 from American Psychiatric Association, the Community Innovations Award presented by Healthy People 2020 in 2011, as well as the 2016 Excellence in Wellness Award, presented by SAMHSA's Programs to Achieve Wellness. The CHOICES team was also invited to present at the 2018 CDC – Interagency Committee on Smoking and Health, and met with U.S. Surgeon General, Jerome Adams, who was very supportive of the CHOICES message. Additionally, CHOICES was invited to Washington DC in June 2018 to participate in the stakeholder meeting "Smoke Free at Home" hosted by Mental Health America and the American Lung Association to discuss approaches to addressing the smoking ban instituted at public housing facilities nationwide, which took effect on July 31, 2018. CHOICES has been featured in radio, video, webinars, and print campaigns presented by the Truth Initiative, the National Council for Behavioral Health, the Legacy Foundation, Mental Health Weekly, among others.

Since 2005, the CHOICES team has completed nearly 1,600 presentations for over 49,000 consumers, and has delivered individual personalized feedback sessions for over 12,000 consumers to help them to discover resources available to help address their tobacco use.

Financial Services

In 2002, Collaborative Support Programs of New Jersey, Inc. (CSPNJ) and Community Enterprises Corporation (CEC) broadened its mission to address the financial issues of living in the community, the situational poverty and resulting disempowerment faced by many very low income persons, especially people with psychiatric disabilities and people with special needs. In response, CSPNJ and CEC developed a Financial Services Program and now offer many financial products and services aimed at promoting financial literacy, responsibility for money management, and development of long-term savings skills and habits leading to asset building opportunities.

Financial Service products and services include: Financial Management Accounts, Savings Incentive Initiatives Accounts, Credit Building and Repair, Micro-loan Program, Financial Literacy Education, and
Vacation Clubs.

Given access to economic opportunities, people in recovery with psychiatric disabilities living in poverty will achieve financial stability, security and independence through increasing financial knowledge and net worth. Poverty is one of the key barriers to recovery and this service seeks to promote systems transformation that promotes asset building and economic prosperity.

CSPNJ's economic development mission today is "to promote self-determination, self-sufficiency, community integration and personal responsibility by offering products and services that increase a person's wealth through financial education, personal assets and employment. This is done through a wellness and recovery approach".

CSPNJ endorses the belief that individuals, including people living with psychiatric disabilities and/or special needs, have a right to housing and economic opportunities to maintain and improve their quality of life. With these rights come responsibilities to learn, to grow, and to fulfill a valued role in society by managing money, paying taxes and filing their tax return, building assets with savings, maintaining a good credit rating, and becoming financially fit and independent.

Financial education and access to economic opportunities will change people's attitudes toward money, allowing them to improve their standard of living and to get out of poverty. They believe that quality products and services provided to these individuals will contribute to personal wellness and recovery, community integration, financial stability, security, independence and overall financial health.

Consumer Connections (Mental Health Association of NJ)
Consumer Connections continues to be NJ's prime trainer of consumers seeking to work as recovery peers in the NJ behavioral health system, as the sole provider of the Certified Recovery Support Practitioner (CRSP) Medicaid approved certification. The program added the capacity to provide the new addiction peer certification the Certified Peer Recovery Specialists (CPRS) to mental health peers to expand the capacity to service the growing co-occurring population in NJ. In February 2019 Consumer Connections sponsored its first statewide Peer Career Fair, attracting over 30 behavioral health providers, and over 100 peer job seekers- this will become an annual event. Collaboration with the growing addiction peer movement in the areas of self-care and sharpening peer to peer communication training will be a major goal for the future to help build a stronger peer workforce.

Certified Recovery Support Practitioner (CRSP)
The CRSP remains one of the most comprehensive peer training programs in the nation with 126 required hours of training and 500 hours of supervised peer work experience. This certification provides NJ's mental health community with a uniquely qualified and stable peer workforce, and services as the cornerstone to build a larger and stronger peer workforce to engage the most chronic and those with the complexities of co-occurring disorders.

Peer Recovery Warmline
The Mental Health Association in New Jersey's Peer Recovery Warm Line (PRW) is a consumer-run service providing ongoing telephone support to mental health consumers as they work towards their recovery. All calls are answered by peers who are trained, supportive mental health consumers. PRW is open 365 days per year. In 2018, over 40,000 calls came into the PRW) The staff of the PRW has grown to include 1 full-time Coordinator, 17 part-time Peer Specialists and volunteers. Peer Specialists are hired after receiving peer certifications and receive additional training in the Intentional Peer Support model. The Peer Recovery Warmline effectively support callers with outcome data demonstrating callers; developing social and coping skills, avoiding emergency rooms and other restrictive environments, and making significant positive changes regarding wellness, socialization, work, housing, and self-esteem.

Self-Help Clearinghouse
The New Jersey Self-help Clearinghouse is a program comprised of a database of over 8,700 support groups in the State of New Jersey. The program also provides a wide variety of services including assistance in starting self-help groups as well as ongoing consultation, free workshops/trainings, the first newsletter highlighted the need for suicide support groups. The newsletter was distributed to the County Mental Health Administrators with goal of seeding new groups in their counties. The growing peer movements in mental health and addiction highlight the need to integrate self-help bases across behavioral and physical health.

Wellness Recovery Action Plan (WRAP) Initiative
MHANJ is the leader in the State of New Jersey around WRAP by being one of the few agencies in the state to provide WRAP as per the evidence-based practice guidelines initially recognized in 2012. MHANJ has created a partnership with the Copeland Center, the organization that promotes WRAP as an evidence-base practice through training, research and education, to ensure New Jersey uses WRAP as it is intended. WRAP is a personalized wellness philosophy rooted in self-determination. MHANJ has the largest group of trained Facilitators and Advanced Level facilitators in the state. MHANJ has seen the power WRAP creates when the evidence-based practice is followed. MHANJ provides the most WRAP seminar I and seminar II workshops in the State of New Jersey, and is always looking to increase the amount of individuals impacted. MHANJ recently trained 13 new WRAP facilitators to support efforts across NJ. The agency has also offered WRAP for Addictions to support the recovery from substances use disorders for individuals and family members in recovery.

Psychiatric Advance Directives (PADs) promote the empowerment of consumers to direct their own care regarding 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. Currently, PADs are submitted to the SMHA and available on a 24-hour basis. Training is provided to both clinical staff and consumers, as an online registry for completed PAD's is scheduled to go live on June 27, 2019.

The Coalition of Mental Health Consumer Organizations (COMHCO) is a state-wide membership organization whose purpose is education, empowerment and advocacy on behalf of Mental Health Consumers in New Jersey. The organization began in 1986 with a handful of consumers and presently has a membership of over 4,000. Membership is open to all

Mental Health Consumers as individuals or as representatives of a consumer organization. COMHCO also offers a supporting membership for non-consumers who have no voting rights. There are 21 Board of Trustee Members, one representing each county in the state. Each trustee also serves as a County Liaison who is responsible for not only distributing information to county consumers and agencies from membership and committee meetings, but who is also responsible for completing the chain of local connection by reporting back to the COMHCO board with any local issues and concerns. The Community Wellness Centers are an integral part of the organization which provides a valuable source of communication and integration into the local support structure for the local Mental Health Community. Monthly membership meetings, quarterly trustee meetings, and several standing committees make up an effective information network to ensure that all consumer views are represented.

COMHCO has strong working relationships with other organizations and agencies that provide support, information and advocacy on behalf of Mental Health Consumers throughout the state. The trustees and members also represent the consumer perspective on boards, councils and advisory committees such as the NJ State Behavioral Health Advisory Board & Council, CSPNJ, Mental Health Association of NJ, Disability Rights New Jersey Inc., PAIMI Council, State Consumer Advisory Council, NAMI-NJ, and county mental health boards.

The Annual COMHCO New Jersey Consumer Conference has an average attendance of 230 people with the lived experience of mental illness. It provides an opportunity for Consumers to make connections with support groups from their local communities, as well as providing 12 workshops on various topics like receiving benefits, healthy living, and returning to work and school that can strengthen an individual's abilities as they develop and sustain their Recovery. COMHCO maintains an email Alert list which provides consumers, Community Wellness Centers and individuals with meeting announcements and information on state and federal issues concerning Mental Health Recovery. In addition to advocacy alerts that generate support for issues of local, state, and national importance, the COMHCO email alert list ensures that the Consumer Voice is able to impact legislative issues in a timely manner.

GROW is an international community mental health movement organized and led by people recovering from mental illness. This 12-step program assists those individuals who want to take responsibility for their health issues by providing them with a group method to assist them in making positive choices while receiving support from a caring and sharing community. The weekly GROW groups meet for two hours followed by a half hour period of socialization; also education and discussion groups meet monthly. All members have the opportunity to participate in a monthly social activity held on the weekend. GROW workers conduct workshops on specific features of the program and training courses for group organizers and recorders. A leadership workshop is conducted at least annually and presentations are offered for professionals and consumers in the community by GROW leaders and field workers. GROW groups are located throughout the three regions of the state. There are currently 18 groups meeting on a weekly basis. GROW provided on average 752 monthly hours of group and social support monthly with staff attending the majority of meetings and social events. Grow averaged serving 179 distinct individuals monthly with 2.5 FTE staff. For 2020 it is anticipated that GROW will serve 205 distinct individuals from throughout New Jersey.

The Wildwood Recovery Retreat
The Wildwood Recovery Retreat also known as Leadership Training Academy (LTA) is a program developed in 2001 to provide a training/networking site for consumers who participate in the Learning Recovery Community Wellness Center, for members of the statewide peer/consumer movement and for center members and residents who are part of the statewide support services program and the local community of Cape May County. The Retreat last year provided service to over 450 individuals, primarily members of both CSP-sponsored and non-CSP wellness centers and residents from CSP Support Services, The Wildwood Learning Retreat offers various events including trainings, networking, mini-conferences, meetings and recreational activities with an increasing emphasis on Wellness. The Wildwood Learning Retreat site is a relaxed atmosphere that allows consumers to meet and discuss issues, receive technical assistance, and learn techniques in handling operational challenges associated with managing wellness centers. Other popular trainings have focused on alternative therapies, such as Reiki and meditation that complement other treatment choices. The Wildwood Learning Retreat has also been a source of opportunity for individuals providing community service through the Cape May County Probation Department and the Community Work Experience Program (CWEP). We also assist individuals experiencing budgetary challenges with washing of personal laundry and provide laundry detergent with donations received from Acme Market and Community Food Bank of Southern Jersey. This allows staff the opportunity to teach individuals about proper loading of the washer, using proper amounts of soap and bleach, separating linens from darks.

There have also been many discussions on WRAP, Diabetes self-management, Pain management issues, maintaining a budget, benefits of physical activity, respectful and fiscally responsible use of resources, and sharing of resources with other groups who share use of the retreat. There are a total of 13 trainings scheduled for the summer season with 10 participants at each training. We continue to outreach to Rutgers for NARCAN trainings which have enabled attendees to save the life of a loved one, a friend, or even a stranger.

The Recovery Network Project provides opportunities for individuals with a lived experience to reach out to state institutions to educate both individuals dealing with mental health issues or dual issues and staff about recovery and wellness principles and resources. This project was initially funded through Substance Abuse and Mental Health Administration (SAMHSA). The Recovery Network Project offers on-site weekly groups at three of the four State Hospitals: Trenton Psychiatric Hospital, Ancora Psychiatric Hospital and Ann Klein Forensic Center (AKFC) by staff from the hospital on-grounds centers. Currently the fourth State Hospital, Greystone Psychiatric Hospital holds its' groups at their On-Grounds Center, as space is an issue within the hospital building itself. The content of the group presentations provides the consumer with a clear message of hope and present an array of self-help, wellness, and recovery resources. The purpose is to share experiences and introduce resources so that persons with a mental illness currently living at the state hospitals can access recovery and wellness resources in their present environment and when they return to the community. In addition to these weekly groups they also provide a Peer-to–Peer project at Ann Klein Forensic. The weekly group has been more challenging in Fiscal year 2019 due to the rehab department at AKFC being down for about two and a half months. This Project has Peer Educators meeting with individuals who are unable to participate in programming outside of their unit.

The groups are delivered by people who have entered a recovery journey and therefore can provide proof that recovery is possible. Presenters themselves, share their process of accepting their mental health diagnosis and the ways they have learned to move forward into a full life keeping their diagnosis in perspective. Presenters share their stories, highlighting what has worked for them and what might help consumers who are currently in the state hospitals helping them look into themselves to find their own personal strengths and talents so that they can learn to manage their illness and move toward a path of recovery and wellness.

The project is designed to empower consumers to affect changes in their own recovery so they move back into the community and maintain a strong connection to a greater array of natural community supports and self-help resources. Group materials emphasize how consumers can assume personal responsibility for recovery and improve their quality of life and successful integration into the community.

Life Coaching

Life Coaching is a support offered by CSPNJ that assists peer staff, peer facilitator volunteers from Wellness Center and at times Wellness Center members throughout the agency helping them deal with a number of stresses connected to or returning to work. The Life Coach assists staff who are either referred by supervisors or self-referred. The Life Coach assists "coaches" in being better able to handle job stress and life stress leading to better job performance and tenure. The sessions are time limited but the Coach is always available for consultation and support. Over time the goals of coaching have expanded to include assisting individuals with quitting smoking, getting more exercise, improving sleep habits and building career skills. The Coach also assists individuals with issues concerning health related and/or job related problems including time management, personality conflicts, and staying focused. We feel that Life Coaching has proved effective for most who participate as the turnover in peer positions is significantly lower than that of other staff both at CSPNJ and throughout the mental health community. Peer staff also has reported being highly satisfied with their jobs in staff surveys with concerns surrounding salaries.

Most referrals continue to come through the Community Outreach Department. Coaching continues to be offered to Peer Managers and Mentors of the Community Wellness Centers and the On-the-Grounds hospital centers although peers throughout the agency have used coaching services during the past year.

Proud To Be Well is a peer health engagement service to strengthen the capacity of the CSPNJ peer workforce (Peer Mentors, Center Managers, Regional Coordinators) to serve individuals through the Community Wellness Centers (CWCs). The purpose of Proud to be Well Peer Health Engagement Services is to improve access to health and wellness support to adults with serious mental illness served by CSPNJ CWCs statewide. Participants include persons with or at risk of co-occurring substance and medical challenges who face gaps in terms of access to accessible health care services for long term and acute health care conditions. The Centers trained peer health engagement services staff will market and outreach to local communities raising awareness for individuals not attending a Center to participate in the program and receive services. Proud to be Well will address the health disparities and wellness needs by building the capacity of the statewide peer workforce by training over 60 leaders over 3 years in using a Peer Health and Wellness Toolkit

who will serve over 1,500 over the 3-year project period. By training and developing an ongoing technical support and learning collaborative model the peer workforce can strengthen their health and wellness competencies including health literacy and engagement, so they will be able to offer targeted individuals support and also create a center environment built on principles of health literacy and health engagement.

Hearing Voices Network
For the past 5 years CSPNJ has sponsored Hearing Voices Network (HVN) Groups. These groups are held at Community Wellness Centers and made up of people who are voice hearers, see visions, or experience other phenomena. HVN is committed to helping people who hear voices. Psychiatry traditionally refers to hearing voices as "auditory hallucinations" but research shows there are many explanations for hearing voices. The aims of the network are: To raise awareness of voice hearing, visions and tactile sensations and other sensory experiences, to give people who have these experiences an opportunity to talk freely about this together, to support anyone with these experiences seeking to understand, learn and grow from them in their own way.

The Emotional Freedom Technique (EFT) program purpose is to train peers in the use of an acupressure technique to assist people to reduce anxiety. The practice often referred to as "tapping" has become part of the practice of psychotherapists and used by individuals to reduce the intensity of panic attacks and anticipatory as well as generalized anxiety. This technique has been introduced to Support Services, Respite and Wellness Center staff. Quarterly trainings will be held for Centers and support staff to keep the Emotional Freedom Techniques fresh.

Children's System of Care (CSOC)

The Department of Children and Families' (DCF) Children's System of Care (CSOC) 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.
- assures 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, CSOC 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.

CSOC views youth and their families as full partners in the development of their individualized service plans and in assessing progress toward their own outcomes. CSOC 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. CSOC services are coordinated through one entity and are based on a single, strength-based Individual Service Plan (ISP) developed with the family for the child, young adult and their family.

Within the children's system of care Family Support Organizations (FSO) are system partners within the NJ Children's System of Care. 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 Contracted System Administrator, 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 Children's System of Care are upheld. FSOs are directly funded through CSOC. Meetings between CSOC management and FSO Executive Directors are held on a monthly basis. CSOC staff serves as the liaison to the FSOs. Additional information regarding Family Support Organizations can be accessed here: http://nj.gov/dcf/families/support/support/.

Located within each county, Children's 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. Based on needs assessments that have been conducted within the county as well as CSOC/CIACC data reports, each CIACC determines how CSOC community development funds should be allocated within that county. Additional information regarding the CIACCs can be accessed here: http://www.state.nj.us/dcf/providers/resources/interagency/

Environmental Factors and Plan

17. Community Living and the Implementation of Olmstead - Requested

Narrative Question

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in **Olmstead v. L.C., 527 U.S. 581 (1999)**, provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of M/SUD on America's communities. Being an active member of a community is an important part of recovery for persons with M/SUD conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated setting appropriate to the individual and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with M/SUD needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office for Civil Rights **(OCR)** cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other settings that have institutional characteristics to serve persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain evidenced-based supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

Please respond to the following items

1. Does the state's Olmstead plan include :

Housing services provided.	(•) Yes ( ) No
Home and community based services.	(•) Yes ( ) No
Peer support services.	(•) Yes ( ) No
Employment services.	(•) Yes ( ) No

2. Does the state have a plan to transition individuals from hospital to community settings? (•) Yes ( ) No

3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?

The Division of Mental Health and Addiction Services (DMHAS) is in the process of revising Administrative Bulletin 5:11 in an effort to reduce hospital length of stay. Under this bulletin, consumers in state psychiatric hospitals are assigned to community service providers whom have the option of either accepting the consumer or requesting additional supports from DMHAS. In addition to community providers, state psychiatric hospitals have the option within their discharge planning process of requesting additional supports for the consumer in their potentially new living situations outside the institutions. Such requests and other efforts toward successful discharge are to be documented within the Individual Needs for Discharge Assessment (INDA). Assignments are based on hospital treatment team recommendations as well as consumer choice, and the assigned provider is expected to participate in every treatment team meeting from the consumer's first to his/her last while in the hospital. The early involvement of community providers in the treatment planning process fosters familiarity between provider and consumer, allowing for immediate planning on the part of the provider to prepare to meet the individualized needs of each consumer upon discharge into their care. This preparation is critical to ensuring that the consumer is provided with necessary community supports and thereby maximizing his/her chances of sustained integration within the community.

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

As part of its Home to Recovery II Plan, DMHAS is focusing its efforts on enhancing the community-based resources available to its consumers. One such enhancement is the implementation of Community Support Services (CSS). A rehabilitative service billable by Medicaid, CSS offers education to consumers in the community on navigating daily activities, rather than performing these activities on their behalf. The goal of these services is to nurture independence and self-reliance on the part of the consumer, empowering them to thrive as functional and competent members of a community outside of an institutional setting.

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

Another area of focus for DMHAS's Home to Recovery II Plan is the examination of outcomes geared toward monitoring sustainability of the Division's community integration efforts. These outcomes include the completion of Medicaid applications within 30 days of determining the necessary level of care for consumers in state psychiatric hospitals; an increase in Peer Support Specialists across state psychiatric hospitals; expansion of the Behavioral Health Home initiative integrating primary and behavioral health care for mental health services consumers; enhanced utilization of Supportive Housing in the form of sustained tenure in Supportive Housing placements, expansion of Supportive Housing opportunities, and an increase in discharges to Supportive Housing as well as in the percentage of consumers served by Supportive Housing as compared to state psychiatric hospitals; and finally a decrease in hospitalizations in the form of lower census counts (for CEPP consumers and the total hospital population); fewer admissions to state hospitals; a reduction in length of stay on CEPP status and within the hospital overall; and a decrease in CEPP consumers as a proportion of the total hospital census. Here are some Highlights:

1. Partnership with Vital Statistics. In October 2014, DMHAS issued Administrative Bulletin 4:27 in response to delays in hospital discharges resulting from missing patient identification documents. With the collaborative efforts between DMHAS and Vital Statistics, and subsequent development of the AB 4:27, a new process was implemented whereby DMHAS staff routinely retrieve birth certificates prepared by Vital Statistics for New Jersey born consumers that were previously unable to produce them for discharge planning. This process has greatly improved the discharge process by helping to remove a significant barrier to discharge. In SFY2017, 471 birth certificates were obtained by way of this collaboration. The number of birth certificates obtained in SFY 2018 and SFY 2019 were 438 and 401 respectively.

2. Validation of Vacancy Tracking Systems. The Bed Enrollment Data System (BEDS) was developed to help DMHAS manage and track vacancies. The Olmstead and Housing Offices within DMHAS are currently collaborating on reconciling the subsidy list maintained by the Housing Office with the vacancies tracked by BEDS. Utilization of a web-based system provides real-time access to vacancy information and helps facilitate assignments and avoid outdated spreadsheets. Analysis of the utilization of independent (e.g. Community Support Services) vs. supervised settings (e.g. group homes and supervised apartments) allows for assessment of the Division's progress toward community integration. The system also enables planning at both the individual consumer level for placement purposes and system-wide for purposes of enhancements in community resources. In addition to Community Support Services and residential (i.e. group home and supervised apartment) living arrangements, DMHAS is in the process of adding short-term care facility (STCF) placements to BEDS. This will allow for analysis and quality improvement measures geared toward improved wait times in STCF beds prior to discharge to long-term housing.

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

4. Enhancements to the Individual Needs for Discharge Assessment (INDA). DMHAS has recently implemented INDA-specific canned reports, which provide hospital staff and central office users with immediate access to information contained within the assessment, including but not limited to provider assignments, attendance at treatment team meetings, functional needs of each hospital's census, and consumers refusing to be discharged. This information will be used at all levels of the Division and drive efforts geared toward quality improvement and planning for the allocation of resources and the implementation of new initiatives.

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

6. Continued Utilization of Hospital Project Teams. Project Team meetings are higher-level meetings that occur immediately after ICRC and are typically chaired by the hospital CEO/DCEO or Medical Director. Policy and systems issues as well as any issue that may involve collaboration with another Division or state Department, are discussed at these meetings and elevated to Olmstead leadership to address. In addition to policy and systems reviews, Project Team meetings also discuss newly-designated CEPP consumers to ensure that a discharge plan is in place. On an as-needed basis, teams also hear brief case presentations in the event that Olmstead resources are needed. Finally, Olmstead staff will also use these meetings to update the hospital leadership on any new administrative bulletins, requests for proposals, updates or changes to the vacancy tracking system, and/or trends identified in the data.

7. Hospital Diversion Initiative. The Olmstead Office has partnered with Centralized Admissions within the state psychiatric hospitals on a process for redirecting would-be hospitalizations to less restrictive community settings. Regional Olmstead staff assist Centralized Admissions in securing additional supports needed for applicable consumers as a means of addressing their individualized circumstances and needs in the most integrated setting possible within their required level of care. This collaboration allows for reduced hospital census as well as enhanced community integration as mental health consumers otherwise on track for admission to state or county hospitals are able to continue to live independently.

Please indicate areas of technical assistance needed related to this section.

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Footnotes:

Environmental Factors and Plan

18. Children and Adolescents M/SUD Services - Required MHBG, Requested SABG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community.[63]. Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.[64]. For youth between the ages of 10 and 24, suicide is the third leading cause of death and for children between 12 and 17, the second leading cause of death.[65].

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21.[66]. Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on financing, workforce development and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs.[67].

According to data from the 2015 Report to Congress[68] on systems of care, services:

1. reach many children and youth typically underserved by the mental health system;
2. improve emotional and behavioral outcomes for children and youth;
3. enhance family outcomes, such as decreased caregiver stress;
4. decrease suicidal ideation and gestures;
5. expand the availability of effective supports and services; and
6. save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious M/SUD needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

- non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and employment); and

- residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

[63]Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2).

[64]Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

[65]Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

[66]The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

[67]Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from **https://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings-Executive-Summary/PEP12-CMHI0608SUM**

[68] **http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf**

Please respond to the following items:

1. Does the state utilize a system of care approach to support:

a) The recovery and resilience of children and youth with SED? (●) Yes ( ) No

b) The recovery and resilience of children and youth with SUD? (●) Yes ( ) No

2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address M/SUD needs:

a) Child welfare? (●) Yes ( ) No

b) Juvenile justice? (●) Yes ( ) No

c) Education? (●) Yes ( ) No

3. Does the state monitor its progress and effectiveness, around:

a) Service utilization? (●) Yes ( ) No

b) Costs? (●) Yes ( ) No

c) Outcomes for children and youth services? (●) Yes ( ) No

4. Does the state provide training in evidence-based:

a) Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families? (●) Yes ( ) No

b) Mental health treatment and recovery services for children/adolescents and their families? (●) Yes ( ) No

5. Does the state have plans for transitioning children and youth receiving services:

a) to the adult M/SUD system? (●) Yes ( ) No

b) for youth in foster care? (●) Yes ( ) No

6. Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

see uploaded file

7. Does the state have any activities related to this section that you would like to highlight?

see uploaded file

Please indicate areas of technical assistance needed related to this section.

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Footnotes:

18. Children and Adolescents MSUD Services

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

The goal of DCF's CSOC is to enable the youth to remain at home, in school, and within their community. Therefore, through an organized system of care approach, CSOC is committed to providing services that are:

A. Clinically appropriate and accessible;
B. Individualized, reflecting a continuum of services and/ or supports, both formal and informal, based on the unique strengths of each youth and his or her family/ caregivers;
C. Provided in the least restrictive, most natural setting appropriate to meet the needs of the youth and his or her family/ caregivers;
D. Family-guided, with families engaged as active participants at all levels of planning, organization, and service delivery;
E. Community-based, coordinated, and integrated with the focus of having services, decision-making responsibility, and management resting at the community level;
F. Culturally competent, with agencies, programs, services, and supports that are reflective of and responsive to the cultural, racial, and ethnic differences of the populations they serve;
G. Protective of the rights of youth and their family/caregivers; and
H. Collaborative across child-serving systems, involving; child protection, juvenile justice, and other system partners who are responsible for providing services and supports to the target populations.

The NJ Children's System of Care is founded on the following Core Values and Principles:

- **Family Driven and Youth Guided**– Families are engaged as active participants at all levels of planning, organization, and service delivery.
- **Culturally and Linguistically Competent** – learning and incorporating the youth and family's culture, values, preferences, and interests into the planning process, including the identified language of the family.
- **Community Based** – identifying and utilizing supports that are least restrictive, accessible, and sustainable to maintain and strengthen the family's existing community relationships.

In the years since 2006, the mission of CSOC has expanded. On January 1, 2013 CSOC began coordinating services for youth with developmental disabilities and their families. Coordination of services for youth with substance use challenges and their families began on July 1, 2013.

Implementation of the Department of Children and Families (DCF) Strategic Plan

In keeping with Governor Murphy's platform of a stronger, fairer NJ, DCF is undergoing a transformation that is guided by best practice, national trends, staff and consumer voice.

Our vision is that all NJ residents are (or become) safe, healthy and connected.

Our values are what we hold to be true of our work for the department. It is the core of our operations and interactions. It is the professional compass that guides us.

- Collaboration is about our willingness and intention to work in teams, **in comfortable and uncomfortable ways**.
- Equity means making sure we do what is needed to support each person we serve to be safe, healthy and connected.
- Evidence means using evidence-based, or promising practices, data and outcomes as our basis for advancing - or ending – certain programs and services.
- Family means all that we do should be in the interest of family and should be determined, as much as possible, by listening to their needs and providing appropriate supports.
- Integrity means that we're honest, reliable and respectful in all that we do.

DCF has also embraced five core approaches or practices that we will embed in all our work.

- Race equity – DCF is committed to integrating policies that advance racial equity in the work that we do.
- Healing Centered Practice – DCF will strengthen practice models, customer service, physical spaces and services that we purchase, so that they promote healing.
- Protective Factors Framework – DCF will structure practice models and purchased services to assess for and to promote the 5 protective factors: parental resilience, social connections, concrete support in times of need, knowledge of parenting and child development, and social and emotional competence for children.
- Family Voice – DCF's new Office of Family Voice will provide us with staff and families with lived experience to ensure that we're attentive to their ideas and input.
- Collaborative Safety – DCF will incorporate safety science into child and family services so that we do not merely respond to adverse events, but learn from them in such a way that we can reliably prevent future adverse events from happening

DCF's strategic focus represents an effort to identify the major areas in need of attention to maintain service excellence while simultaneously achieving significant transformation of the systems

Four (4) major Departmental priorities have been identified:

- Primary prevention of maltreatment and maltreatment related fatalities. This includes child maltreatment, domestic violence and sexual assault prevention.
- Preserving kinship connections
- Staff health and wellness

- CSOC - In order to best align the priorities of the CSOC with the DCF vision and values, DCF is forming an external advisory group to collaborate with us to identify the specific goals for innovation and change that will sustain and grow the children's system of care in the years to come. DCF anticipates framing the recommendations of the advisory group within these three priorities:
    - Promote integrated health and behavioral health
    - Build capacity to deliver evidence-based interventions and services
    - Enhance CSOC capacity to ensure equitable access

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

Currently CSOC serves **over 59,000** youth per year through a complement of needs-driven supports and services within a system of care approach: family driven, youth-guided, strengths-based, individualized care. The primary goals of CSOC are to ensure youth receive quality care in the most appropriate, community-based setting whenever possible to maintain connections to family and communities for sustainable relationships and planning. CSOC also has a continuum of out-of-home treatment settings of varying degrees of intensity of service accessible based on youths' individual needs.

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

There is generally one CSOC staff member assigned to manage each of the key services available through CSOC (i.e. CMO, MRSS, IIC/BA, FSO).

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

- Mental Health Rehabilitation Services Behavioral Assistance (01-04);
- Mental Health Rehabilitative Services Intensive In-Community (01-06);
- Reimbursement for Mental Health Rehabilitation Services Children's Mobile Response (01-10);
- Reimbursement for Mental Health Rehabilitation Services Residential Care Facilities, Children's Group Home, and Community Psychiatric Residences for Youth and Other Programs for Children Licensed/Certified by New Jersey Government Agencies (02-8, 02-09 and 02-14) and;
- Behavioral Health Homes (16-0002) and;

2. CSOC also receives funding through the NJ FamilyCare Comprehensive Demonstration (1115 Waiver) approved by the Centers for Medicare and Medicaid Services (CMS) in 2017.

3. Services are provided based on medical necessity.

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

Care Management Organization (CMO) - CMOs are county-based, nonprofit organizations that combine face-to-face care management and comprehensive service planning for high and moderate need youth and their families into a single, integrated system of care. Youth are enrolled with a CMO when independent CSOC CSA review of clinical and need based information about the youth meets the threshold of clinical criteria and the youth and family can benefit from services. CMOs facilitate the Child/Family Team (CFT) meetings and implement Individual Service Plans (ISP) for each youth and their family. The CMO provides a single point of accountability for the organization, the delivery of services and the supports needed to maintain stability for each youth.

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

CFT members include, but are not limited to, the following individuals:

- Child/Youth/Young Adult
- Family Support Partner
- Parent(s)/Legal Guardian
- Care Management Organization
- Natural supports as identified and selected by youth and family
- Treating Providers (in-home, out-of-home, etc.)
- Educational Professionals
- Physical Health Providers (pediatrician, specialist)
- Probation Officer (if applicable)
- Child Protection & Permanency (CP&P) (if applicable)

Behavioral Health Homes - Each Behavioral Health Home (BHH) is a designated Care Management Organization (CMO) with enhanced care management teams that include medical

expertise and health/wellness education for purposes of providing fully integrated and coordinated care for youth remaining in their home and who have chronic medical conditions.

BHH services are a "bridge" that connects prevention, primary care, and specialty care. Medical and wellness staff are integrated into the existing CMO CFT structure responsible for care coordination and comprehensive treatment planning for youth and their families which includes planning for the holistic needs of the youth. The CFT structure and approach (CMO, FSO, Family, Youth and other designated service providers and supports) enhanced with BHH RN, Health/Wellness Coach staffing plans for the holistic needs of a youth with both behavioral health and medical needs (inclusive of substance use and developmental and intellectual challenges). Nurse Manager and Health/Wellness staff communicate with youth's medical providers (primary care specialty providers, urgent or emergent medical care) and connect the medical domain and planning with the existing CFT process.

New Jersey is among the first states using Targeted Case Management (TCM) to deliver BHH for youth only. NJ's BHHs are operational in Bergen, Mercer, Cape/Atlantic, and Monmouth counties. During SFY 2018, 484 youth were enrolled in BHH services. To be eligible, youth must meet the criteria for CMO and have a qualifying medical condition which is inclusive of intellectual and developmental challenges as well as substance use.

Family Support Organizations (FSOs) - FSOs are operated by 15 agencies under contract with CSOC to: ensure that service plans developed for families are child-centered and family-focused; provide support to families through peer counseling, family training and workshops; advocate for families at the local level with other system partners; and cultivate and empower youth development consistent with the wellness and recovery model. The FSOs offer support to families of youth with behavioral health needs, substance use needs, and intellectual and developmental challenges. Family Support Partners within the FSOs are assigned to each family of youth enrolled in CMOs to offer and provide individual family peer-to-peer support. Additionally, the FSOs offer community-based supports to all youth and families in their service area. They provide community outreach and education on peer support and CSOC, family and youth support groups, youth partnership structure and activities, and telephonic support for families. FSO NJ Alliance is contracted to provide training and technical assistance to FSOs.

Mobile Response and Stabilization Services (MRSS) - MRSS provides rapid response to youth and families experiencing family-defined crisis, 24 hours per day, 7 days per week, 365 days per year, that focuses on crisis intervention and stabilization that is intensive, therapeutic and rehabilitative. MRSS approach is engagement focused, strengths based, collaborative with youth and families, culturally sensitive and based on individual needs. The purpose of MRSS is to provide crisis intervention, assessment, and planning services designed to stabilize escalating behaviors and/or emotional challenges, maintain children and youth in their home environment and community, and avoid unnecessary psychiatric hospitalization, out of home care and legal involvement. Features of the MRSS program include:

- Face to Face, on site, one-hour response time from initial service request.

- 72-hour crisis intervention period which includes assessment of youth behaviors and family patterns, individualized and strategic crisis and care planning, skill building and resource identification with youth and families.
- Up to an eight-week stabilization service which includes family support and collaboration, crisis plan oversight, management of service providers within a developed stabilization network, and progress monitoring. Services managed and monitored are implemented based on youth and family need and include formal services such as Intensive In-Community and Behavioral Assistance services, partial care, outpatient, in addition to community supports and informal resources. Mobile Response is required to connect with families, service providers and supports minimally once a week to ensure families are connected with providers, to assess progress and ensure the plan is being implemented or make changes when necessary, including evaluation of a need for higher intensity of support or intervention.
- Standard Crisis Assessment Tool is employed and reflects youth risk behaviors, emotional/behavioral challenges, life domain functioning, and caregiver needs and strengths.
- 97% of children/youth served remain in their current living arrangement.

Intensive In-Community/Behavioral Assistance (IIC/BA) services - Intensive In-Community/Behavioral Assistance (IIC/BA) services are short term, intensive, community-based therapeutic interventions, rather than clinic or office-based, that are needs-driven, youth and family guided, and accessible. IIC/BA are aimed at engaging youth and families in a therapeutic process to reduce and stabilize challenging behavioral and emotional patterns and symptoms, introducing "replacement" skills, and developing parent skills for sustaining positive change and connecting to continued therapeutic supports when the need presents. This line of service is only authorized to youth involved with CMO or MRSS. CMO and MRSS request the service on behalf of the youth and family/CFT through their treatment plans. Services are provided to youth and families with moderate to high need; often the youth's immediate living situation is in jeopardy due to his/her behavior in combination with family needs. IIC/BA clinical criteria is located at: http://www.performcarenj.org/provider/clinical-criteria.aspx.

IIC services have two components:

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

BA services are adjunctive to IIC services. They are never stand-alone. BA services are delivered by a license-supervised individual who holds a bachelor's degree at minimum and has 1-year experience working with the population served. The BA is the agent of the IIC plan of care. The BA service provides direct youth and parent training, support, and intervention to maximize the potential of positive and sustainable change.

Evidence-Based Practices - The Children's System of Care is dedicated to providing behavioral health services that are based on the best evidence available and to improving outcomes and the quality of life for children, youth and young adults receiving services through the Division. With the introduction of Multisystemic Therapy and Family Functional Therapy, New Jersey embraces the nationwide trend to use research evidence to inform policy and program choices. The following independent organizations have verified MST as an evidence-based treatment: Blueprints for Healthy Youth Development; Office of the Surgeon General; SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP). FFT is based on scientific trials and methodology. The following independent organizations have verified FFT as an evidence-based treatment: Blueprints for Healthy Youth Development; SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP).

Licensed clinical staff at CSOC, as well as staff at Rutger's-UBHC, CSOC's Training and Technical Assistance Program, disseminate information from evidence-based, promising practices, and best practices. Licensed clinical staff at the CSA review and authorize the services as part of a child, youth or young adult's Individualized Service Plan (ISP). The CSA tracks utilization and outcome measurements of programs implementing "evidence-based" practices as part of their service delivery model. In accordance with the DCF Strategic Plan CSOC has prioritized building capacity to deliver additional evidence-based interventions and services.

Functional Family Therapy for Foster Care (FFT-FC) - CSOC in partnership with the Division of Child Protection and Permanency (DCP&P) and a local provider offer access to and service delivery of Functional Family Therapy – Foster Care (FFT-FC) through the CSOC Mobile Response and Stabilization Service and Intensive In-Community service lines. FFT is a relationally focused, trauma informed, evidence-based treatment model for youth in resource care that increases the likelihood of successful adjustment for youth in their resource placements as well as positive permanency outcomes. This treatment model is targeted toward youth aged 12-18 who are demonstrating behaviors that place them at risk of disruption in their resource care placement and are in the legal custody of the DCP&P and have the intellectual capacity to benefit from the treatment intervention. The model uses the relationally focused techniques of Functional Family Therapy (FFT) in a comprehensive and systemic approach adapted to helping youth and families involved with DCP&P to overcome individual and relational trauma to promote placement stability, increase youths' lifelong connections and improve youths' permanency outcomes.

Promising Path To Success, System of Care Expansion Grant - In October 2015, Children's System of Care was awarded a 5-year SAMHSA system of care expansion grant, to implement

trauma-informed care and provide workforce development to our system partners. The grant, which is called Promising Path to Success, utilizes the evidence-based practices of Six Core Strategies and the Nurtured Heart Approach to reduce restraint and seclusion, while additionally striving toward the goal of limiting out of home treatment to one episode of six to nine months in duration. The grant requires all system partners, including CSOC, to examine institutionalized practices and policies that could be trauma-inducing to achieve better outcomes for youth and families through improved system collaboration, policy creation, and the enhancement of youth and family voice. The· six core strategies are:

- Leadership Toward Organizational Change
- Use of Data to Inform Practice
- Workforce Development
- Use of S/R Prevention Tools
- Consumer Roles in Inpatient Settings
- Debriefing Techniques

Additional information on *The Six Core Strategies for Reducing Seclusion and Restraint Use* can be located via the following link: http://www.nasmhpd.org/docs/NCTIC/Consolidated_Six_Core_Strategies_Document.pdf

Wraparound - CSOCs care management services utilize the wraparound process. **Wraparound** is an evidence-based structured approach to service planning and care coordination for individuals with complex needs (most often children, youth and their families). Wrap Around is built on key system of care values: family and youth driven, team based, collaborative, individualized, and outcomes-based. Wraparound adheres to specified procedures: engagement, individualized care planning, identifying strengths, leveraging natural supports, and monitoring progress. Care Management Organizations (CMOs) organize and coordinate community-based services and informal resources through face- to-face care management at the local level for individual children and families with multi-service needs and multi-system involvement. The Wraparound Process User's Guide A Handbook for Families is available at the following link: http://www.nwi.pdx.edu/pdf/Wraparound_F amily_Guide09-2010.pdf

The Youth Guide to Wrap Around Services is available at the following link: http://www.nj.gov/dcf/families/csc/documen ts/YouthGuideWraparound.pdf

ARC-GROW Model - CSOC, through the Intensive In-Community (IIC) service line, in partnership with the Children's Center for Resilience and Trauma Recovery (CCRTR), and MRSS and CMO partners, offers access to and delivery of the ARC-GROW model. The ARC-GROW Model is an adaptation of the Attachment, Regulation, and Competency framework for intervention with youth and families who have experienced multiple and/or prolonged traumatic stress. The Attachment, Self-Regulation, and Competency (ARC) framework is a core-components treatment model, developed to provide a guiding framework for thoughtful clinical intervention with complexly traumatized youth from early childhood to adolescence and their caregiving systems. GROW is a caregiver skill building intervention designed to enhance resilient outcomes for families who are impacted by chronic adversity or stress (Kinniburgh et al. 2011).

Youth Outpatient Programs - Youth Outpatient program contracts moved over from the Division of Mental Health Services in SFY 2007 for youth under 18 years old as part of CSOC continuum of care development. Youth and families continue to access outpatient services by connecting directly with the agencies. Additionally, the CSA provides information and referral to families of youth when a review of a biopsychosocial assessment or clinical summary template yields outpatient treatment as the IOS determination. CSOC currently provides authorizations and utilization management for partial hospitalization services for youth younger than 18 years old. Outpatient substance use and mental health services covered under NJ Family Care are currently paid through fee for service for the child and youth population.

Outpatient - Outpatient treatment services provide behavioral health care to youth and families in a licensed community agency. Outpatient services are designed to support, enhance and encourage the emotional development of life skills to preserve or improve individuals' functioning, strengths and resources. Interventions may include individual, group and family therapy; and referral. Interventions are provided on maintenance, assessment and testing; outreach services; and referral. Interventions are provided on a long-term basis when necessary.

Partial Care/Partial Hospitalization - Partial Care/ Partial Hospitalization programs are highly structured, intensive (minimum 2 hours, 3 to 6 times per week) behavioral health services for youth with serious emotional challenges. Multi-disciplinary behavioral health interventions include rehabilitation programming such as activities for daily living, recreation, socialization, and community reintegration. Programs are typically located in, but not necessarily limited to, a community-based mental health or hospital setting (N.J.A.C. 10:37-12). Partial Care services assist in stabilizing youth with acute needs, either following or in lieu of hospitalization or other out of home treatment.

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

- Evaluating the local county policies and policies to understand and minimize the impact of local barriers to serving youth with behavioral and emotional health needs substance use and/or intellectual and developmental disabilities in their community.
- Identifying local strategies and mechanisms to promote the integration and coordination of county, State, or other resources serving youth with behavioral and emotional health needs, substance use and abuse, and /or intellectual and development disabilities.
- Assessing local systems needs using information received from DCF, the Contracted System Administrator (CSA), any child-serving agency identified by DCF, and other bodies to make recommendations regarding service and resource development priorities.
- Identifying and informing DCF/CSOC regarding gaps and barriers to local service effectiveness.

- Providing input to State, regional, and county entities regarding system performance and service need.

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

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

CSOC data have demonstrated a gradual decline in OOH utilization over the past several years, which is attributed to the success of maintaining more youth at home with community supports. Based on the analysis of utilization data, youth with high needs are requiring OOH intervention, whereas youth with low needs are more likely serviced in the community. Due to this decrease in utilization, as well as reduced lengths of stay, several OOH programs closed during FY 2018, resulting in a net loss of **132** beds. The Specialized Residential Treatment Unit (SRTU) provides administrative programmatic oversight of these programs and thus conducted a needs analysis to identify the types of OOH programs where additional capacity is needed. This analysis determined that only a small number of programs require replacement (SPEC-10 beds for girls, PCH-10 beds, RTC for older youth- 10 beds).

Key Principles of Out of Home (OOH) Treatment

- Child Family Team (CFT) decision to access out of home services
- Voluntary service (unless court ordered)
- Continuum of care is based on intensity, frequency, and duration of treatment
- Admission/eligibility is based on clinical review by the CSA. Clinical Criteria is posted at http://www.performcarenj.org/provider/clinical-criteria.aspx
- All-inclusive service based on contracted deliverables for specific Intensity of Service program
- Time-limited intervention (target is 9-12 months)
- One single episode of OOH treatment is optimal

- Holistic approach to care
- Engaging, safe, welcoming environment
- Trauma-informed
- Individualized services within each program, based on each youth's needs
- Stabilizes identified risk behaviors
- Small community-based settings
- Attendance to community schools whenever possible
- Actively engages families throughout entire course of treatment, through participation in treatment teams and Child Family Teams

Behavioral Health Out of Home Treatment Services

- IRTS (Intensive Residential Treatment Services) - Non-hospital treatment services provided to youth with a wide range of serious emotional and behavioral needs who require 24 hours per day care in a safe, structured environment with constant line-of-sight supervision.
- PCH (Psychiatric Community Home) - A community residential facility that provides intensive therapeutic services for youth who have had inpatient psychiatric care and/or children who may be at risk of hospitalization or re-hospitalization.
- SPEC (Specialty Bed Program) - Programs that provide intensive residential services for children who are presenting with very specific high-risk behaviors including fire setting, assaultive behavior, sex offending behavior predatory or non-predatory, and children who have experienced significant trauma from physical, sexual, or emotional abuse.
- RTC (Residential Treatment Center) - Programs that provide 24 hours per day care and treatment for youth unable to function appropriately in their own homes, schools and communities, and who are also unable to be served appropriately in smaller, less restrictive community-based settings.
- GH (Group Home) - Group home services provide up to 24 hours per day care and treatment to youth whose needs cannot be met appropriately in their own homes or in resource care, but who do not need the structure and intensiveness of a more restrictive setting.
- TH (Treatment Homes) - Programs that provide care and supervision by specially trained parent/caregivers in a family-like setting for typically one or two children with behavioral health needs who require a moderately high level of therapeutic intervention.
- CSAP-CW (Stabilization and Assessment Services for Child Welfare) - Short-term, highly structured, and nurturing environments with professional competencies to stabilize children engaged with or at risk of involvement with child welfare who are homeless and/or present with complex behavioral health challenges on an emergent basis, and who do not meet the need for an acute hospital setting. The intent is to stabilize crises in a soothing and trauma aware milieu while diagnostic assessments, services, and supports that meet the children's needs are conducted. The goal of this intervention is to identify and secure an appropriate living situation for the children (in home/out of home). Programs were developed in 2017-2018 specific to young children ages 5-12 involved with DCP&P.

Children's Crisis Intervention Services - Psychiatric inpatient hospital services, located in community hospitals, provide acute inpatient treatment, stabilization, assessment and short-term intensive treatment. The units are licensed by the Department of Health, following yearly

designation by CSOC. The Children's Crisis Intervention Service (CCIS) designation process ensures that CCIS units, established to meet the intent of the 1987 Children's Regional Plan, are following both the intent and spirit of the plan and comply with the Certificate of Need criteria for CCIS units (N.J.A.C. 8:33) and Hospital Licensing Standards (N.J.A.C. 8:43G). Nine CCIS units are located around the state and provide services to all 21 counties. There are currently 164 beds. They are funded through Medicaid and private insurance. Seven of the nine CCIS' receive additional support through a mental health subsidy ($15, 056 annual per bed) from the Division of Mental Health and Addiction Services.

Substance Use (SU) Treatment - The Children's System of Care offers an array of substance use treatment services for youth and young adult, including four withdrawal management beds, contracted outpatient/intensive outpatient services through 10 providers statewide, partial care services through one provider, short term out of home treatment through one provider with 22 beds, and long term out of home treatment through two providers – one with 36 beds and the other with 64 beds). In addition, residential treatment services for youth with co-occurring substance use needs and significant behavioral health needs can be accessed through the CMO from five providers with a total of 54 beds.

The South Jersey Initiative provides fee for service funding to 11 providers for outpatient and intensive outpatient substance use services for the eight southern counties. One agency, with a capacity of three beds, provides short term out of home treatment.

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

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

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

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

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

Types of substance use treatment services offered through CSOC

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

Supports and Services for Youth with Developmental Disabilities

DD Eligibility - As of January 1, 2013, CSOC assumed responsibility for determining eligibility for developmental disability services for children under age 18. This eligibility process for children, which was formerly completed by the Division of Developmental Disabilities, is required under New Jersey law to access publicly available developmental disability services. The CMOs and MRSS work with family members to make application for eligibility determinations. Although a family must submit the DD eligibility application, CMO and MRSS assist families with whom they are working in obtaining and compiling documentation needed to submit the eligibility application. DDD continues to determine eligibility for individuals aged 18 and over, and the Children's System of Care provides services to those youth. DDD and CSOC collaborate

through an established protocol to provide a seamless transition to adult services. During SFY 2018, **14,422** DD eligible youth were active with CSOC.

Intensive in Community – IIH Clinical/Therapeutic Supports

Intensive in community – Habilitation (IIH) clinical supports are intensive community-based, family-centered services delivered face-to-face as a defined set of interventions by a clinically licensed practitioner. The purpose of IIH services is to improve or stabilize the youth's level of functioning within the home and community to prevent, decrease or eliminate behaviors or conditions that may lead to or that may place the youth at increased clinical risk, or that may impact on the ability of the youth to function in their home, school or community.

The clinical and therapeutic services to be delivered are those necessary to improve the individual's independence and inclusion in their community. These services are flexible, multi-purpose, in-home/community, clinical supports for youth and their parents/caregivers/guardians. These services are flexible both as to where and when they are provided based on the family's needs.

Development of an integrated plan of care, which may include:

- Other assessment tools as indicated; clinicians must be familiar with the array of considerations that would indicate preferred assessment methods;
- Cognitive Behavioral Intervention -Individual, family and group counseling;
- Trauma informed counseling;
- Positive Behavioral Supports;
- Psycho-educational services to improve decision making skills to manage behavior and reduce risk behaviors;
    1. Instruction in learning adaptive frustration tolerance and expression, which may include anger management;
    2. Instruction in stress reduction techniques;
    3. Problem solving skill development;
    4. Social skills development

Family Support Services for children with intellectual/developmental disabilities - CSOC began to provide funding for family support services in 2013. These services provide a wide range of supports including, but not limited to, respite, assistive technologies, camps, and home and vehicle modifications for uncompensated caregivers of youth with developmental disabilities living at home. Family Support Services are federally mandated and detailed under NJ Statute. Family Support Services FAQ is available at http://www.performcarenj.org/families/faqs.aspx

Intellectual/Developmental Disability Out of Home Treatment Services

- SSH IDD (Special Skills Home) - Designed for youth who present with challenges in adjusting within their primary home setting or in a less intensive treatment setting. These homes are in private single-family homes. Youth are under the supervision of an agency trained mentor parent. There is no awake, overnight staff monitoring or supervision.

- GH-1 IDD (Group Home-Level 1) - Designed for youth who present with periodic behavioral difficulties that cannot be consistently managed in their primary home environment or in a less intensive treatment setting.
- GH-2 IDD (Group Home-Level 2) - Designed for youth who present with persistent challenging behaviors that cannot be safely and consistently managed in their primary home environment or in a less intensive treatment setting.
- RTC BH/DD (Residential Treatment Center for Intellectual/Developmental Disabilities) - Provides all-inclusive integrated programming with comprehensive therapeutic and clinical services in a 24-hour staff supervised, community-based setting for youth who present severe and persistent challenges in social, emotional, behavioral, and/or psychiatric functioning with a co-occurring intellectual / developmental disability.
- SPEC-IDD (Specialty IDD) - Designed for youth who present with challenges related to sexually reactive behavior. These specialty homes are in private single-family homes. Youth are under the supervision of an agency trained mentor parent. There is no awake, overnight staff monitoring or supervision.
- PCH-IDD (Psychiatric Community Home-IDD) - Provides supervised 24-hour care within an intensive treatment program for youth with intellectual/developmental disabilities who present with severe behavioral health challenges. PCH-IDD programs are designed for youth who have received inpatient services for behavioral health needs and who cannot be supported in their current living arrangement with a reasonable degree of safety.
- Intensive-IDD (Intensive Psychiatric Community Home -IDD) - Youth who are considered for admission present with complex challenging behavior(s) of such intensity, frequency, and duration that it prevents the youth's personal development and inclusion in family life and community. Challenging behaviors may be unusual responses to sensory experiences and recurring trauma, thus manifesting challenging behaviors that include but are not limited to: inappropriate/rule violations, noncompliance, self-injurious behaviors, destructive, aggressive and/or assaultive behaviors that require medical attention.
- RESP IDD (Respite for Intellectual/Developmental Disabilities) - Short term out of home respite services for youth and young adults with limited behavioral challenges.
- Stabilization and Assessment Services - CSAP IDD provides 24-hour care in a highly structured, community-based treatment setting with professional competencies and capabilities to stabilize youth with I/DD ages 6 to 20 years old (males/females) that are in crisis and unable to be safely supported in their current living situation. The primary goal upon stabilization is transitioning the youth to the community with wraparound services and supports, whenever possible. CSAP provides comprehensive diagnostic assessments that result in the identification of proper in-home services and supports that can meet the youth's habilitative and behavioral health needs upon transition.

Juvenile Justice - Reducing the number of Juvenile Justice commitments The Children's System of Care (CSOC) is fully accessible to youth involved with the juvenile justice system and the services coordinated by care managers help to keep youth out of detention centers. There has been a significant decrease in the number of detention center admissions resulting in the reduction of the number of county detention centers from seventeen to seven in the past few years (Union County detention center closed in February 2019).

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

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

Protocol for Court-Ordered Assessment of Children with Emotional and Behavioral Health Needs (14 Day Plan Protocol) between DCF/Children's System of Care and the New Jersey Judiciary, Family Division. - During 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 protocol exists

Biopsychosocial Assessments - The Juvenile Justice Commission requires, in the Manual of Standards, that all youth entering Detention receive the MAYSI (Massachusetts Youth Screening Instrument) within 24-48 hours of admission. CSOC has implemented an easily accessed clinical assessment process for any youth in a county juvenile detention center that may score on the MAYSI regarding possible mental health concerns or need for substance use treatment. This assessment is also utilized to expedite out of home treatment.

CSOC is represented on the New Jersey Council for Juvenile Justice Improvement. Diversion and the Reentry processes are discussed by the Access to Treatment and Racial Disparities sub-committees of the Council. Formal recommendations are presented to the full Council by the individual sub-committees.

DCF has established cooperative relationships with the Juvenile Justice Commission (JJC). In December 2004, the Department with the JJC signed a Memorandum of Understanding that outlines a distinct process by which youth in the JJC can be referred directly to what is now known as the Children's System of Care for services that will be implemented upon the youth's release from a JJC facility. Representation from both DCP&P and CSOC participate in the JJC and Annie E. Casey Foundation driven JDAI (Juvenile Detention Alternative Initiative) 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.

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/CSOC.

CSOC developed two out of home Detention Alternative Programs (DAP) with a total of 14 beds. The priority population is youth in DCF DCP&P custody awaiting DCF placement once their charges have been disposed. The CSOC liaison also refers youth in detention centers with mental health needs.

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

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

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

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

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

Suicide is the third leading cause of death for New Jersey's youth. CSOC is dedicated to the prevention of youth suicide. New Jersey's primary youth suicide prevention program is the Traumatic Loss Coalitions for Youth funded by CSOC. The Traumatic Loss Coalitions for Youth Program at Rutgers-University Behavioral HealthCare is an interactive, statewide network that offers collaboration and support to professionals working with school-age youth. This is accomplished through county, regional and statewide conferences, training, consultation, onsite traumatic loss response, and technical assistance. Since its inception, the TLC has trained thousands of individuals throughout the state with the purpose of saving lives and promoting post trauma healing and resiliency for the youth of New Jersey. The TLC website can be accessed at http://ubhc.rutgers.edu/tlc/

2ND Floor Youth Helpline - Accredited by the American Association of Suicidology, 2ND Floor confidentially serves youth and young adults (ages 10-24). Youth who call are assisted

with their daily life challenges by professional staff and trained volunteers. The 2nd Floor website can be accessed at http://www.2ndfloor.org/

Crisis Text Line – The Children's System of Care has developed an agreement with Crisis Text Line in New Jersey to provide another tool for constituents. Crisis Text Line is a free 24/7 support that connects anyone experiencing a self-defined crisis with a trained counselor. It can be accessed from anywhere in the United States. When texts are received, they are screened by an algorithm for severity, and texts that indicate imminent risk are placed at the top of the queue for faster response. Crisis counselors are trained to bring texters from "a hot moment to a cool calm" using empathic listening techniques. They collaboratively problem-solve to help the texter come up with a plan to stay safe. Calls are anonymous and confidential, unless referral to emergency services is necessary. DCF has a Memorandum of Understanding with the Crisis Text Line for sharing frequency data. For cell phone plans with AT&T, T-Mobile, Sprint or Verizon, texts are completely free and will not show up on the phone bill. For plans with another carrier, normal text rates will apply and will appear on the phone bill as 741741. Additional information about Crisis Text Line can be found at crisistextline.org.

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

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

The NJ CSOC/DMHAS partnership is well positioned to add services for youth and young adults at clinical high risk for psychosis to the already robust care continuum available throughout the state, as the program will utilize established behavioral health agencies who are currently providing treatment services for persons experiencing first episode psychosis (FEP). NJ PROMISE anticipates providing intervention to approximately 150 youth and young adults across three regions annually, and more than 600 youth and young adults over the four-year grant period. Through extensive outreach, coordinated care, the use of evidence-based, evidence informed, best, and promising practices as well as the expertise of a team of professionals, participants and their families will have the tools necessary to lead productive lives in their homes and communities.

The project's measurable goals are to:

- Reduce the percentage of youth/ young adults at clinical high risk for psychosis who become hospitalized.
- Reduce the prevalence of psychiatric symptoms that youth/ young adults at clinical high risk for psychosis experience.
- Increase the percentage of youth and young adults at clinical high risk for psychosis who adopt their collaboratively developed treatment plan, including all recommended medication.

- Increase the overall functioning of youth and young adults at clinical high risk for psychosis, as evidenced by increased participation at school, employment, and in their communities.

NJ FamilyCare Comprehensive Waiver (1115 Medicaid Comprehensive Waiver)

In 2012, the Centers for Medicare and Medicaid Services (CMS) approved New Jersey's 1115 Comprehensive Waiver for a five-year period with the goal of changing New Jersey's health care delivery to ensure a broader community base and person-centered continuum of care. Key changes for CSOC under the waiver authority included:

- Federal participation on behavioral health services for youth with severe emotional disturbance (SED);
- Targeted home and community-based services (HCBS) for populations of youth;
- In-home and community supports for children and youth with SED and/or intellectual and developmental disabilities(I/DD) and;
- Authority to provide and receive federal participation for services to youth with Autism under the Autism pilot.

In 2017, CMS granted New Jersey a five-year extension on the 1115 waiver (renamed NJ FamilyCare Comprehensive Demonstration) to include:

- Additional in-home supports for an expanded population of youth with intellectual and developmental disabilities;
- Needed services including HCBS supports for an expanded population of youth with severe emotional disabilities; and
- Needed services and HCBS for an expanded population of youth with co-occurring developmental/ mental health disabilities.

Children's Support Services Program (CSSP) SED

The Children's Support Services Program SED provides behavioral health, home and community-based services for youth under age 21 who have a serious emotional disturbance (SED) which places them at risk for hospitalization, out of home treatment, or at hospital level of care. For youth not eligible for Medicaid, this provides federal support for behavioral health services under the State Plan amendment, and home and community-based services that are authorized through the children's Administrative Service Organization (PerformCare, also known in New Jersey as the Contracted System Administrator, CSA).

The program also allows for Medicaid eligibility based on SED determination for youth who have a plan of care through CMO, irrespective of parental income. It also adds new services that have been found to be critical for the success of youth.

Highlights of the New Jersey Children's System of Care:

1. Keeping youth in NJ for treatment
    - In 2007, there were over 300 youth being served in behavioral health residential centers out of state
    - As of today, there is **1** youth in an out of state behavioral health program

2. Reducing the length of stay in residential treatment centers
    - In FY 2003, average length of stay was 407 days
    - In FY 2010, average length of stay was 349 days
    - In FY 2016, average length of stay was 267 days
    - In FY 2018, average length of stay was 256 days
    - A 37% reduction in length of stay in residential treatment has been achieved over the last fifteen years

3. Expanding community-based care management, in-home, and day treatment programs for children

    - In 2000, NJ served approximately 7,000 children, youth and young adults in community-based care management, in-home services and supports and day treatment programs
    - In 2010 NJ served 35,000 children, youth, and young adults in community-based care management, in-home services and supports, and day treatment programs, a 500% increase in a ten-year period
    - In 2018, NJ served approximately 56,000 children, youth and young adults in community-based care management, in-home services and supports, and day treatment programs, a 700% increase in an eighteen-year period
    - As of January 2019, 22% of the youth receiving care management are Developmental Disability (DD) eligible
    - As of January 2019, 23% of the youth receiving care management are involved with child welfare

4. Reducing the number of juvenile justice commitments:

    - The system of care is fully accessible to youth involved with the juvenile justice system and helps keep youth out of detention centers. There has been a significant decrease in the number of detention center admissions resulting in the reduction of the number of county detention centers from seventeen to seven in the past few years (Union County detention center closed in February 2019).
    - In 2004 there were approximately 200 youth, statewide, in detention awaiting residential treatment post disposition.[1] Today, it is rare to have even one youth awaiting residential treatment post disposition.

- The average waiting time to be admitted to a residential program is approximately 52 days (an increase from 40 days last year) across all levels of intensity for behavioral health. The waiting time increased this year due to increased demand for two co-occurring residential programs and specialty programs for girls. For youth in detention centers in need of out of home treatment, there are detention alternative beds that can be accessed on an emergent basis.

5. Creating a proactive safety net for youth:

- In 2003 40% of newly enrolled children were under 14 years of age; today that percentage has grown to over 50%
- This change in age distribution among youth served indicates that the system of care is effectively reaching youth at a younger age and thus able to engage youth and families to offer earlier intervention to address the child and family's needs.

6. Reducing the number of children in out of home (OOH) treatment settings:

- In FY 2007, there were almost 4,000 children in behavioral health OOH treatment settings. In the intervening 5 years, the numbers of children in OOH decreased substantially. Between FY 2012 and FY 2018, the number of youth in all OOH placement settings (behavioral health (BH), substance use (SU) and Intellectual and Developmental Disability (IDD) continued to decrease.

Year	**Children in OOH treatment settings**
FY2012	3,178
FY2013	3,100
FY2014	3,213
FY2015	3,114
FY2016	3,662
FY2017	3,430
FY2018	3,090

7. Providing immediate services to youth in crisis:

- Mobile Response maintains youth in crisis in their homes or current living situation, reducing disruptions for youth and their families and providing them with support and access to services during times of behavioral health instability.
- As of December 2018, over 97% of youth receiving Mobile Response services remained in the home or current living situation during the Mobile Response intervention.

8. The Children's System of Care continues to improve and continues to be the national leader and model for systems of care. NJ CSOC is frequently called upon by other states and

jurisdictions to offer strengths, lessons learned and insights on how best to develop a system of care in communities and serve youth and families. NJ CSOC has been of interest to other states seeking to implement FFA (Family First Act) strategies related to prevention of child welfare involvement through development of community-based treatment, decreased use of congregate care, and creation of a structure that supports clinically appropriate out of home treatment.

9. In October 2015, Children's System of Care was awarded a SAMHSA system of care expansion grant, to implement trauma-informed care and provide workforce development to our system partners. The grant, which is called Promising Path to Success, utilizes the evidence-based practices of Six Core Strategies and the Nurtured Heart Approach to reduce restraint and seclusion, while additionally striving toward the goal of limiting out of home treatment to one episode of six to nine months in duration. The grant requires all system partners, including CSOC, to examine institutionalized practices and policies that could be trauma-inducing to achieve better outcomes for youth and families through improved system collaboration, policy creation, and the enhancement of youth and family voice. SAMHSA representatives conducted a project site visit in December 2017. SAMHSA provided New Jersey with an exemplary exit report that recommended having enhanced youth voice within CSOC and the importance of supporting our Children's Inter Agency Coordinated Councils at the local level. In response to the report, the Children's System of Care recruited and hired its first Statewide Youth Ambassador, with lived experience from DCP&P as well as CSOC, in January of 2018. This Youth Ambassador has brought youth voice more prominently at the State Level into policies, program development and operations. Although youth voice was previously represented in the System of Care, having a Youth Ambassador employed by CSOC amplifies youth voice at the State level in a meaningful way and is true to the system of care approach.

Environmental Factors and Plan

19. Suicide Prevention - Required for MHBG

Narrative Question

Suicide is a major public health concern, it is the 10th leading cause of death overall, with over 40,000 people dying by suicide each year in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance abuse, painful losses, exposure to violence, and social isolation. Mental illness and substance abuse are possible factors in 90 percent of the deaths from suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, SAMHSA urges M/SUD agencies to lead in ways that are suitable to this growing area of concern. SAMHSA is committed to supporting states and territories in providing services to individuals with SMI/SED who are at risk for suicide using MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the M/SUD agencies play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

Please respond to the following items:

1. Have you updated your state's suicide prevention plan in the last 2 years? (●) Yes ( ) No

2. Describe activities intended to reduce incidents of suicide in your state.

Mental Health and Substance Use Disorder providers contracted and/or licensed by the Department of Human Services are required to report Unusual Incidents regarding individuals they serve. State Psychiatric Hospitals are also required to report Unusual Incident Reporting Management System (UIRMS) data regarding individuals they serve. According to the UIRMS data that the Division of Mental Health and Addiction Services (DMHAS) received, there were 324 suicide attempts and 48 deaths by suicide reported in calendar year 2018. DMHAS requires providers to intensely analyze each of these events to assess opportunities for improvement in their systems and processes. All reports of the providers involving deaths by suicide are reviewed by the DMHAS Mortality Review Committee for patterns and trends among agencies. Many of DMHAS consumers, who died by suicide, did not have an evidence-based suicide risk screening or assessment completed; consumers were often not appropriately linked to treatment; and often risk factors were overlooked. If indicated, members of the Mortality Review Committee, make recommendations for improvement, and follow-up on actions taken.

The Suicide Prevention Committee within DMHAS also continues to monitor and analyze data from the NJ Violence Death Reporting System (VDRS), Department of Health –New Jersey's detailed and timely surveillance system of all violent fatalities—as well as existing NJ data from other systems that capture non-fatal suicide attempts of individuals who received treatment through Emergency Department visits and inpatient hospitalizations.

During Suicide Prevention Week in September in 2017 and 2018, New Jersey Department of Human Services (DHS) in conjunction with Department of Health and other State Departments offered a Suicide Prevention Conference that attracted nearly 300 attendees from all walks of life. A variety of topics, one of them regarding Zero Suicide, were addressed. Several break-out sessions were tailored to specific interests, addressing different areas of concern. There was broad media coverage and the conferences were well received. This year's Suicide Prevention Conference is planned for September 10, 2019 with an increased focus on reaching primary care physicians.

In spring 2019, DMHAS created a position for a Suicide Prevention Coordinator within the Medical Director's Office at DMHAS. One full-time employee (Suicide Prevention Program Specialist), who started work on April 1, 2019 is principally involved with general suicide-related matters and specifically tasked with the organization and implementation of a statewide Zero Suicide approach. Funding in the amount of $500,000 for this purpose is included in the FY 2020 DHS budget.

Screening and Screening Outreach Programs are located within each of New Jersey's 21 counties. These programs are available to individuals in emotional crisis who require immediate attention and cannot wait for a regular appointment. Screening and screening services are typically located in a general hospital and available 24-hours a day, seven-days a week. An individual may walk in without an appointment, or be brought to the screening center by a parent, friend, spouse, law enforcement officials, mental health worker, or any other concerned individual. If the person in crisis is unable or unwilling to come to the Center, a screening outreach team may be sent to the person.

For information about adult mental health services, visit the Division of Mental Health and Addiction Services' website at http://www.state.nj.us/humanservices/divisions/dmhas/.

The National Suicide Prevention Lifeline (1-800-273-TALK (8255)) provides free and confidential emotional support to people in suicidal crisis or emotional distress 24 hours a day, seven days a week.

The SMHA continues to fund the NJ Suicide Prevention Hopeline, operated by Rutgers University Behavioral Health Care, which is

set up to accept calls 24/7 from individuals who are seeking information or assistance for themselves, friends or relatives who may be at risk of suicide. Calls are received from anyone of any age and are answered by a peer, a trained volunteer, or a clinical staff member. If a caller is assessed as being at serious risk of suicide, the caller can be "warm-transferred" to the appropriate local Psychiatric Emergency Service or other entity (i.e. DCF sponsored 2nd Floor Youth Crisis Line) that can provide emergency or other necessary services for that individual. In calendar year 2017 the Hopeline received a total of 26,619 incoming calls. This is an average of 2,218 calls per month. In the year 2018, the Hopeline received a total of 47,254 inbound calls, with a monthly average number of 3,938. Due to this enormous increase in call volume, DMHAS added funding for an additional 0.5 FTE position. The NJ Hopeline is an approved National Suicide Prevention Lifeline Crisis Center and provides back up to the Lifeline Crisis Center call system in NJ.

New Jersey Suicide Prevention Resources provided by Children's System of Care (CSOC):
Every life lost to suicide is a tragedy and the New Jersey Department of Children and Families (DCF) is committed to decreasing youth suicide. Suicide is the third leading cause of death for New Jersey youth between 10 and 24 years of age.

Hopeline
The Hopeline is New Jersey's peer support and suicide prevention hotline. It is staffed by mental health professionals and peer support specialists 24 hours a day, seven days a week. The service is available to all ages for confidential telephone support (except when a suicide attempt is in progress), assessment, and referral.

For individuals in crisis and need immediate help, please call the New Jersey Suicide Prevention Hopeline at 1-855-654-6735
Crisis chat is available through the website and the service can be reached at njhopeline@ubhc.rutgers.edu.
General information is available at: www.njhopeline.com.

Screening and Screening Outreach Programs
Available in each county 24-hours a day, seven-days a week to individuals in emotional crisis who require immediate attention. An individual may be seen without an appointment or be brought to the screening center by a parent, friend, spouse, law enforcement official, mental health worker, or any other concerned individual. For information visit the DHS Division of Mental Health and Addiction Services' website at
www.nj.gov/humanservices/dmhas/home/hotlines/MH_Screening_Centers.pdf.

Perform Care
When a child is facing challenges to their functioning and well-being, finding the right services and support can be overwhelming. Support from Perform Care for children and youth who are not in crisis is available here:
http://www.performcarenj.org/index.aspx.

Mobile Response and Crisis Screening
To access Children's System of Care (CSOC) Mobile Response services please call 1-877-652-7624. A listing of the Crisis/Screening Centers in New Jersey is available here:
http://www.performcarenj.org/families/emergency-services.aspx

2ND Floor Youth Helpline
Accredited by the American Association of Suicidology, 2ND Floor confidentially serves youth and young adults (ages 10-24). Youth who call are assisted with their daily life challenges by professional staff and trained volunteers. http://www.2ndfloor.org/

Traumatic Loss Coalitions for Youth Program
The Traumatic Loss Coalition aims to prevent suicide and provide trauma response assistance to schools following suicide, homicide, and death from accidents and illnesses.

Functioning as an interactive, statewide network, TLC offers collaboration opportunities and support to professionals working with school-age youth via education, training, consultation and coalition building to:
• reduce suicide attempts, suicide completions, and to promote recovery of persons affected by suicide and
• provide guidance and support in the response to a traumatic event

For more information and support related to suicide prevention visit http://ubhc.rutgers.edu/tlc/index.html.

New Jersey Youth Suicide Prevention Advisory Council
Established in the Department of Children and Families, the New Jersey Youth Suicide Prevention Advisory Council (Council). The Council is comprised of appointed New Jersey citizens and state government. The New Jersey Youth Suicide Prevention Advisory Council examines existing needs and services and makes recommendations for youth suicide reporting, prevention and intervention. It advises the development of regulations pursuant to N.J.S.A. § 30:9A-25 et seq.

New Jersey Strategy for Youth Suicide Prevention
The New Jersey Youth Suicide Prevention State Plan is available at:
https://nj.gov/dcf/documents/behavioral/prevention/preventionplan.pdf. DCF is dedicated to continuing to work to prevent youth suicides in New Jersey and this plan helps provide guidance

for this important task.

For more information, read DCF's Adolescent Suicide Report is available at: https://www.nj.gov/dcf/news/reportsnewsletters/dcfreportsnewsletters/New%20Jersey%20Youth%20Suicide%20Report%202017.pdf.

3. Have you incorporated any strategies supportive of Zero Suicide? (●) Yes ( ) No

4. Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments? (●) Yes ( ) No

5. Have you begun any targeted or statewide initiatives since the FFY 2018-FFY 2019 plan was submitted? (●) Yes ( ) No

If so, please describe the population targeted.

DMHAS added representatives from primary care, LGBTQ, and faith communities to our Adult Suicide Prevention Advisory Council and expanded on the voices of people with lived experience.

In June 2019, DMHAS revised Administrative Bulletin # 3:41: Screening, Assessment, Management, and Treatment of Suicidal and Non-Suicidal Self-Directed Violence that requires all NJ Psychiatric Hospitals to screen and/or assess all patients admitted to and discharged from state psychiatric hospitals. In addition, the Bulletin delineates the administration of evidence-based screening and assessment tools at various points of care to keep all patients safe during their hospital stay and mandates suicide specific treatments for patients identified with moderate or high suicide risk. Treatment modalities include Safety Planning and Cognitive-Behavioral Therapy for Suicide Prevention (CBT-SP). Training was held on August 14, 2019 for psychologists.

Please indicate areas of technical assistance needed related to this section.

DMHAS would like to receive technical assistance in relation to website development and the use of social media.

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Footnotes:

Environmental Factors and Plan

20. Support of State Partners - Required for MHBG

Narrative Question

The success of a state's MHBG and SABG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The SMA agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations;
- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with M/SUD 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 factors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and SUDs, 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, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead;
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's office of homeland security/emergency management agency and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in M/SUD needs and/or impact persons with M/SUD conditions and their families and caregivers, providers of M/SUD services, and the state's ability to provide M/SUD services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in M/SUD.

Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period? (●) Yes ( ) No

2. Has your state identified the need to develop new partnerships that you did not have in place? (●) Yes ( ) No

If yes, with whom?

Division of Mental Health and Addiction Services (DMHAS)

Strategic Prevention Framework-Partnerships for Success
The Division of Mental Health and Addiction Services (DMHAS) was awarded a second Strategic Prevention Framework-Partnerships for Success (SPF-PFS) grant in 2018 from SAMHSA (its first SPF-PFS grant was awarded in 2013). In this project, DHMAS will partner with the Department of Children and Families' (DHS) Children's System of Care (CSOC). DMHAS prevention coalitions will provide training on the basics of substance abuse prevention, and use of the SPF, with the CSOC's Children's Inter-Agency Coordinating Councils (CIACC) in each county. The CIACCs provide a forum where the system of services for children with special social and emotional needs can be developed, reviewed, revised and/or redirected through a collaborative decision-making process with the New Jersey Department of Children and Families (DCF) to promote optimal services provided in the least restrictive, but most appropriate setting possible. DMHAS will utilize current SPF-PFS funds for various prevention infrastructure developments and enhancements.

State Epidemiological Outcomes Workgroup
DMHAS 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 State Epidemiological Outcomes Workgroup (SEOW), comprised of individuals from various state departments including Health, Transportation, Education, Human Services, Juvenile Justice, county offices, universities, community provider agencies and statewide organizations. The SEOW continues to meet monthly to discuss ways to prevent the onset and reduce the progression of substance 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 (DOH) Division of Family Health, DOH Division of HIV, STD, and TB Services (DHSTS), Department of Military and Veterans Affairs (DMAVA), the NJ Poison Information and Education System (NJPIES), the New Jersey Hospital Association Behavioral Health Group, NJ Housing and Mortgage Finance Agency (NJHMFA), Office of Managed Health Care Behavioral Health Unit, Office of the Secretary of Higher Education (OSHE), representatives from the NJ State Police's Regional Operations Intelligence Center (ROIC), and representation from the Prescription Drug Monitoring Program which became operational in September 2011.

Moving on Maternal Depression (MOMD) Initiative
In August 2018, New Jersey was one of three states that received an award from the Center for Law and Social Policy (CLASP) through its Moving on Maternal Depression (MOMD) initiative. The 18-month initiative provides technical assistance, which is administered in the form of monthly calls with CLASP and other participating states; site visits with CLASP; and a conference with other states on promising practices toward serving populations with maternal depression. New Jersey's efforts under this initiative come from a collaborative which is co-lead by the Division of Mental Health and Addiction Services (DHS-DMHAS) and the Department of Health (DOH), and includes the Division of Medical Assistance and Health Services (DHS-Medicaid), the Department of Children and Families (DCF), and three maternal health consortia consisting of the Partnership for Maternal Child Health, Central Jersey Family Health Consortia, and South Jersey Perinatal Cooperative. The collaborative, known as the MOMD Core Team, has, as its focus, three individual goals for improving its ability to serve mothers with maternal depression. Each of these goals is the focus of its own subcommittee of core team members, which meets monthly to discuss progress, share insights, and discuss any questions or concerns arising from their efforts. The core team subsequently reports on these meetings to CLASP on monthly calls and receives feedback and consultation where necessary. The three goals comprising New Jersey's MOMD initiative consist of: 1) Enhanced Data Capacity related to examination of maternal depression in New Jersey; 2) Increased Access to Services related to maternal depression; and 3) Reduced Racial, Ethnic, and Socioeconomic Disparities in utilization of maternal depression services.

National Academy for State Health Policy Maternal and Child Health Policy Innovations Program Policy Academy
As a result of a collaborative application between DHS-Medicaid and DMHAS, New Jersey was selected for participation in a policy academy through the Maternal and Child Health Policy Innovation Program (MCH PIP), funded by the federal Maternal and Child Health Bureau, Health Resources and Services Administration (MCHB, HRSA). Through this program, the National Academy for State Health Policy (NASHP) will work with states and other state stakeholders, to support and advance innovative state-level policy initiatives that improve access to quality health care for the maternal child health population. As part of MCH PIP, NASHP is conducting a two-year policy academy for up to eight state teams comprised of representatives from state Medicaid agencies, public health agencies, mental health/substance use agencies, and other state stakeholders (e.g., child welfare agencies, provider groups, Medicaid managed care plans, etc.).

Participating state teams will identify, promote, and advance innovative state-level policy initiatives in order improve access to care for Medicaid-eligible pregnant and parenting women with or at risk of substance use disorder (SUD) and/or mental health conditions through health care delivery system transformation. The Policy Academy will emphasize policy strategies that promote integration of care and systems; align with state initiatives to transform how care is provided and paid for (e.g., Medicaid managed care, accountable care organizations (ACOs), value-based payment, etc.); and ultimately, improve health outcomes for pregnant and parenting women.

Children's System of Care (CSOC)

Strategic Prevention Framework-Partnerships for Success - NJ SOAR (Substance use, Outreach, Advocacy, Resources)
In September 2018, the Department of Human Services, Division of Mental Health and Addictions Services (DMHAS), in partnership with the Department of Children and Families' (DCF) Children's System of Care (CSOC), was awarded a five-year substance use prevention grant from SAMHSA. The grant award is for $2,260,000 annually.

NJ SOAR provides a statewide Strategic Plan Framework initiative to address underage drinking, marijuana use, and prescription medication/opioid misuse for youth ages 9 to 20. Through the grant, CSOC and DMHAS will partner to implement prevention strategies that include outreach, education and training services to communities and families throughout NJ. Leveraging the expertise of the established DMHAS County Prevention Coalitions throughout the State, Youth Prevention Specialists (YPS) within the coalitions will train their local CIACCs on effective prevention strategies. The CIACC membership will then infuse the prevention activities into their work.

NJ SOAR seeks to 1) Decrease youth underage drinking, marijuana use and misuse of prescription drugs/opioids by youth ages 9 to 20 throughout NJ, 2) Increase knowledge on the effects of underage drinking, marijuana use, and misuse of prescription medications/opioids among youth, families and youth-serving systems throughout NJ, and 3) Enhance the CSOC prevention

infrastructure to ensure that statewide prevention efforts reach youth.

Project goals are to strengthen and enhance the work of 21 County Prevention Coalitions, expand prevention data infrastructure and information systems capacity, and continue work in developing a unified statewide prevention planning and service delivery system that directly reaches youth-serving entities. CSOC and DMHAS will partner to implement prevention strategies that include outreach, education and training services to communities and families throughout NJ. Youth and young adults will benefit from early outreach and preventions strategies, to prevent the onset and reduce the progression of substance use and its related problems.

Community Programs for Outreach and Intervention with Youth and Young Adults at Clinical High Risk for Psychosis (CHR-P)
On September 30, 2018, SAMHSA awarded a four-year grant to the Children's System of Care to address youth and young adults at clinical high risk for psychosis. CSOC worked in partnership with DMHAS to develop the program, which will provide outreach and intervention for youth and young adults up to age 25, who may be experiencing prodromal symptoms of psychosis.

The NJ CSOC/DMHAS partnership is well positioned to add services for youth and young adults at clinical high risk for psychosis to the already robust care continuum available throughout the state, as the program will utilize established behavioral health agencies who are currently providing treatment services for persons experiencing first episode psychosis (FEP). NJ PROMISE anticipates providing intervention to approximately 150 youth and young adults across three regions annually, and more than 600 youth and young adults over the four-year grant period. Through extensive outreach, coordinated care, the use of evidence-based, evidence informed, best, and promising practices as well as the expertise of a team of professionals, participants and their families will have the tools necessary to lead productive lives in their homes and communities.

3. Describe the manner in which your state and local entities will coordinate services to maximize the efficiency, effectiveness, quality and cost-effectiveness of services and programs to produce the best possible outcomes with other agencies to enable consumers to function outside of inpatient or residential institutions, including services to be provided by local school systems under the Individuals with Disabilites Education Act.

See attached.

Please indicate areas of technical assistance needed related to this section.

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Footnotes:

20. Support of State Partners - Required for MHBG

3. Describe the manner in which your state and local entities will coordinate services to maximize the efficiency, effectiveness, quality and cost-effectiveness of services and programs to produce the best possible outcomes with other agencies to enable consumers to function outside of inpatient or residential institutions, including services to be provided by local school systems under the Individuals with Disabilities Education Act.

Division of Mental Health and Addiction Services (DMHAS)

Division of Medical Assistance and Health Services

The state remains 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 and other behavioral health issues. New Jersey has approval from Centers for Medicare and Medicaid Services (CMS) for one State Plan Amendment (SPA) to provide health home services to the SMI population in Bergen, Mercer, Atlantic, and Monmouth Counties. The Behavioral Health Homes (BHHs) are currently operational and reimbursed through Medicaid.

Of the original 12 BHH's, Atlanticare has dropped out due to low census. Behavioral Crossroads engaged in Learning Community 2 and are in the process to become a certified BHH. Learning Community 3 was completed in December 2018 for 10 additional providers in Burlington, Union, Somerset, Hunterdon and Warren counties.

The Division of Mental Health and Addiction Services (DMHAS) was selected to be one of the eight Certified Community Behavioral Health Clinic (CCBHC) demonstration states. This project is a collaboration between the Department of Human Services' Division of Medical Assistance and Health Services (DMAHS) and DMHAS and the Department of Children and Families (DCF). This demonstration is part of a national effort to integrate behavioral health with physical health care, increase consistent use of evidence-based practices, and improve access to high quality care for people with mental and substance use disorders. Populations to be served are adults with serious mental illness, children with serious emotional disturbance, and those with long term and serious substance use disorders, as well as others with mental illness and substance use disorders. There are seven behavioral health providers dually licensed in mental health and substance abuse participating as CCBHCs. The Federal Demonstration was extended to September 13, 2019 and the state partners are currently evaluating plans for sustaining some or all of the program in the state.

DMHAS and DMAHS have explored several models of integration, and continues to evaluate the needs of all populations. Together the two divisions received assistance through CMS State Innovation Model grant that includes integration as one of its priorities, and technical assistance from the National Academy for State Health Policy (NASHP) to assist with developing a more integrated system. As a result, the Department of Human Services, with assistance from a private foundation, has procured the Seton Hall Law School to review

Department of Health and Department of Human Services regulations to identify regulatory barriers and develop and implement strategies.

Partnership with other State and County Agencies in Mental Health Justice Involved Services

Justice Involved Services (JIS)

The SMHA has been funding JIS since 2000. The services work to divert from incarceration individuals whose legal involvement may have resulted from untreated mental illness or co-occurring mental health and substance abuse disorders. It is a short-term case management program designed to help consumers to successfully link to mental health or co-occurring and other services in order to stabilize and enter valued community roles reducing their incidence and length of incarceration. The program provides access to community-based mental health and substance abuse treatment services as well as critical social services. Through case management, clients receive treatment and psychiatric rehabilitation services, housing, employment, medications and health services. The SMHA is involved in very active collaborations with the Judiciary, Office of the Attorney General, local law enforcement, State Parole Board and Department of Corrections, and funds 15 JIS services and several other criminal justice initiatives. JIS is provided to a diverse mix of consumers, male and female as well as individuals of Caucasian, African American, Hispanic, Asian and Asian Indian backgrounds and from many different countries.

Pre-booking Diversion

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

Crisis Intervention Team (CIT)

DMHAS funds a Crisis Intervention Team (CIT) Center of Excellence through the Mental Health Association of Southwest New Jersey. The Center facilitated the development of new county CIT efforts. Presently 16 of 21 counties as well as the NJ State Police (NJSP) provide training to law enforcement, dispatcher and mental health staff in CIT. These counties offer the training to other counties and municipalities as well as their own. As of May 2019, 276 of 565 municipalities have at least one certified CIT officer. As of February 2019, 4,643 law enforcement and mental health provider staffs have been trained; 3,413 officers and 1,013 mental health staff.

Post-booking Diversion

Post booking diversion involves an intervention by a mental health staff person so that consumers are released from detention earlier than they otherwise would be; released on their own recognizance or released from jail with mental health intervention and treatment

conditions or helping to avoid detention altogether.

Superior Court

One form of post booking diversion that has been formally accomplished in NJ is through Prosecutor Diversion Programs. Prosecutor Offices identify a defendant who has a serious mental illness which is confirmed by the Mental Health JIS professional associated with the program. The JIS program arranges for mental health and related services. These become a condition of a plea bargain or dismissal of the indictment if the defendant successfully completes treatment and any conditions set by the Prosecutor.

The Union County Prosecutor's Office created and piloted this program, with DMHAS funds; however, the funds do not include treatment dollars. In 2014, the Office of the Attorney General (OAG) expanded the program by awarding two-year grants to Essex and Ocean counties for a prosecutor-led mental health diversion program on indictable offenses The grants had limited treatment dollars. In FY 2016, the OAG awarded three additional Prosecutor-Led Diversion programs: Warren, Hunterdon and Gloucester. The funding was only for two years, with the Prosecutor's Offices continuing as they were able after the funding expired. The SMHA continues to assist with services through local community mental health providers. There were no new grants awarded since 2016.

Atlantic County was awarded funds from the Office of the Attorney for a special Veterans Prosecutor Diversion Program. In conjunction with division funds, this program targeted Veterans whose charges are related to their behavioral health issues. The program coordinates with the VA Healthcare Systems and the New Jersey Department of Military and Veterans Affairs (DMAVA) to obtain needed services. With the Atlantic Veterans initiative, there are now seven funded prosecutor-led diversion programs or one third of the state. Necessary treatment and support services will continue to be a challenge. In 2017, legislation was signed that made the Prosecutor-Led Diversion Program for Veterans statewide, although no appropriation was made. There have been few referrals to this program as reported by the OAG as of January 1, 2019.

Municipal Court Liaison (MCL)

DMHAS funds a Municipal Court Liaison (MCL) Program which works directly with the Jersey City Municipal Courts; a case manager/municipal court liaison is stationed at the Municipal Court and provides individual consultations to the judges and attorneys, upon request. This often results in diversion to treatment which the liaison facilitates. DMHAS also funds a similar program for Atlantic City. The city of Newark a plea court which arranges for needed services post plea. Asbury Park has been funding a social worker who provides similar liaison services for many years.

The DMHAS, working with the Administrative Office of the Courts (AOC) has and continues to expand the availability of the MCL to include two to three municipalities within Passaic, Essex, Ocean, Monmouth, Mercer, Camden, Gloucester and Cumberland counties. The JIS programs will be providing the case management. The effort is ongoing with additional municipalities expected to be included as DMHAS resources are identified.

The PROMISE Parole Program & Parole Collaboration
This is a collaborative program of the State Parole Board, DMHAS and Housing and New Jersey Mortgage Finance Agency to assist parolees with serious mental illness to transition and integrate into their community and provide mental health and other wrap around services including employment and housing to reduce VOP. DMHAS funds a case manager to provide linkage and coordination.

Department of Corrections Max-out Pre-release Planning and Collaboration
This is a tri-monthly meeting with representative of DOC, Ann Klein Forensic Center (AKFC) and regional DMHAS representatives who review prisoners with serious mental illness coming up for max out who may need continued commitment at AKFC or community mental health services as an alternative.

The Veterans Assistance Initiative (VAI)
This is a combined effort of the Judiciary, the NJ Department of Military and Veterans Affairs (DMAVA) and the Department of Human Services, DMHAS. It uses existing resources of the participating state agencies to provide services to veterans/service members who get arrested and needs linkage and coordination with services through the local Veterans Service Offices (VSO) of DMAVA. All vicinages in New Jersey have the VAI.

The project was initially piloted in the municipal courts and in the criminal division of Superior Court and Municipal divisions in Atlantic. It formally provides a referral for behavioral health and generic services through DMAVA to those present and former military service men and women who become entangled with the criminal justice system. These individuals may come to the attention of the courts by police arrest documents, identification in jail or during the court process.

This program aims to connect service members with services that address physical, mental and personal issues through the local Veterans Service Offices of DMAVA. Local DMHAS funded mental health and justice involved services may compliment behavioral health available through the Veterans Health Administration. The program is geared toward providing services to veterans through referral, not diverting veterans from the courts, although this can happen when appropriate. Veterans who are charged with indictable and non-indictable offenses other than minor traffic matters, as well as veterans who are on probation, are eligible to participate in the program. The nature of the offense will not matter in the decision as to whether or not a veteran should be referred for services.

As of May 1, 2019, there have been 4,182 statewide referrals made to DMAVA Veteran Service Officers through the local courts since inception. The program is voluntary and although referrals are made, present and former service members may not take advantage of the opportunity.

Chief Justice's Interbranch Advisory Committee for Mental Health Initiatives
DMHAS has been represented on this committee since 2010. In 2012, the committee presented its report to the Supreme Court which accepted its recommendations which included among other things, the expansion of the Prosecutor-Led Diversion Program, Municipal Court

Liaison program and CIT. In December of 2014 the Chief Justice appointed the Interbranch Implementation Committee to begin to operationalize the report's recommendations. The committee is co-chaired by an individual from DMHAS and a Judge from the AOC. The Implementation Committee has been working to operationalize the 17 recommendation of the report. Much has been done in the educational area including mental health information and resources on the Judiciary webpage and knowledge transfer at Superior and Municipal court conferences and enclaves. The Prosecutor-Led Diversion Program and the Municipal Court Liaison program were discussed earlier.

Children's System of Care (CSOC) Juvenile Justice

Reducing the number of Juvenile Justice commitments

The Children's System of Care (CSOC) is fully accessible to youth involved with the juvenile justice system and the services coordinated by care managers help to keep youth out of detention centers. There has been a significant decrease in the number of detention center admissions resulting in the reduction of the number of county detention centers from seventeen to seven in the past few years (Union County detention center closed in February 2019).

In 2004, there were approximately 200 youth, statewide, in detention awaiting residential treatment post disposition.[1] In 2019, there are typically about three youth awaiting residential treatment post disposition.

The average waiting time to be admitted to a residential program is approximately 52 days (an increase from 40 days last year) across all levels of intensity for behavioral health. The waiting time increased this year due to increased demand for two co-occurring residential programs and specialty programs for girls. For youth in detention centers in need of out of home treatment, there are detention alternative beds that can be accessed on an emergent basis.

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

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

Medicaid/NJ FamilyCare

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

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

Protocol for Court-Ordered Assessment of Children with Emotional and Behavioral Health Needs (14 Day Plan Protocol) between DCF/Children's System of Care and the New Jersey Judiciary, Family Division

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.

Biopsychosocial Assessments

The Juvenile Justice Commission requires, in the Manual of Standards, that all youth entering Detention receive the MAYSI (Massachusetts Youth Screening Instrument) within 24-48 hours of admission. CSOC has implemented an easily accessed clinical assessment process for any youth in a county juvenile detention center that may score on the MAYSI regarding possible mental health concerns or need for substance use treatment. This assessment is also utilized to expedite out of home treatment.

When a court-involved youth held in a county juvenile detention facility is ordered by a Family Court judge to be assessed for an out-of-home treatment facility in lieu of incarceration, the youth should be transitioned from the juvenile detention center as quickly as possible. The biopsychosocial evaluation, which has a turn-around time of five business days, can be requested by the Social Services staff at the detention center. To accomplish this, CSOC developed a tracking system for children in county detention centers for whom a congregate care treatment program is being considered. The contracted system administrator's (CSA) management information system was also modified to incorporate information about legal status for system-involved children. The information in the CSA management information system identifies children for whom proactive treatment is initiated.

CSOC is represented on the New Jersey Council for Juvenile Justice Improvement. Diversion and the Reentry processes are discussed by the Access to Treatment and Racial Disparities sub-committees of the Council. Formal recommendations are presented to the full Council by the individual sub-committees.

DCF has established cooperative relationships with the Juvenile Justice Commission (JJC). In December 2004, DCF with the JJC signed a Memorandum of Understanding (MOU) that outlines a distinct process by which youth in the JJC can be referred directly to what is now known as the Children's System of Care (CSOC) for services that will be implemented upon the youth's release from a JJC facility. Representation from both DCP&P and CSOC participate in the JJC and Annie E. Casey Foundation driven JDAI (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 the case review process.

The Juvenile Justice Commission is responsible for operating state services and sanctions for juveniles and for developing a statewide plan for the effective provision of juvenile justice

services and sanctions at the state, county and local levels. To emphasize New Jersey's commitment to provide coordinated quality services and appropriate sanctions for youthful offenders while ensuring the public's safety, the JJC established the State/Community Partnership Grant Program. These Partnership Grants provide funding to 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/CSOC.

The Office of Special Needs oversees the SCRC, in terms of intra- and inter-agency planning. It is chaired by the Special Needs Assistant. Members include representatives from DCP&P, Office of Adolescent Services, Children's System of Care, the JJC Juvenile Parole and Transitional Services (JP & TS) Pre-Release Teams, Regional Court Liaisons/designees, the JJC Child Study Teams, JJC community residential homes, and 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, DCF maintains an existing Memoranda of Understanding (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 planning.

When juveniles in a JJC facility have permanency and treatment needs that require the intervention of DCF, the JJC Special Needs Review Committee will work with CSOC and DCP&P to make appropriate referrals prior to time of discharge. In circumstances where CSOC is unable to access a timely treatment plan in accordance with mandatory release dates, 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.

CSOC developed two out of home Detention Alternative Programs (DAP) with a total of 14 beds. The priority population is youth in DCF DCP&P custody awaiting DCF placement once their charges have been disposed. The CSOC liaison also refers youth in detention centers with mental health needs.

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

DCF/CSOC funds the Technical Assistance Center through Rutgers University Behavioral Health Care (UBHC) to provide training statewide. CSOC, through the UBHC 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
- Mobile Response and Stabilization Services (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
- Human Trafficking
- Substance Use and Abuse: Youth with Co-Occurring Developmental and Mental Health Challenges
- Substance Abuse 2: A Closer Look – Family and Addiction

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

Partnership with other State Agencies, Professional Organizations, Support and Advocacy Groups, and Consumer Organizations to Prevent Suicide in NJ

The NJ Adult Suicide Prevention Advisory Council was formed in December 2014 as an "State interagency committee." In addition to state agencies, professional organizations, behavioral health agencies, support and advocacy groups, consumer organizations, individuals with lived experience, and other stakeholders were part of it.

The Council was first tasked with prioritizing goals of the NJ Adult Suicide Prevention Plan and developing action steps and outcome measures for implementation. The focus of the Council work shifted from the Suicide Prevention Plan to increasing community collaboration and integration.

The membership of the Council also changed over the years and currently consists of approximately 56 members including of, but not limited to, state agency staff (e.g. DMHAS, DOH, DCF, State Police), community-based agencies, advocacy organizations, educational institutions, and persons with lived experience. Additional functions of the Council are:

- Serving as a forum for information sharing by state agencies and stakeholders;
- Providing input to the DMHAS on suicide prevention planning and other activities;
- Assisting with planning the annual Suicide Prevention conference through a subcommittee, including helping to identify themes, presenters and topics;
- Providing information and recommendations to the DMHAS on gaps in suicide prevention services in the community;
- Making recommendations to the DMHAS on how different entities (e.g. state agencies, community-based agencies) can collaborate to fill suicide prevention service gaps and respond to community needs. (Planning and policy decisions are retained by DMHAS executive leadership.)
- Evaluating the role of the Council and how it can best serve and promote suicide prevention activities.

Committee member representatives also collaborate with other states, and local and national organizations on Suicide Prevention.

State agency representation on the New Jersey Behavioral Health Planning Council / Citizens Advisory Board, includes the following: DMHAS, DMAHS (Medicaid), NJ Department of Corrections, the NJ Juvenile Justice Commission, the NJ State Housing Authority (New Jersey Housing and Mortgage Finance Agency-NJHMFA), the NJ Department of Health, the NJ Division of Vocational Rehabilitation, the NJ Division of Family Development (Social Services), the NJ Division of Aging Services, the NJ Department of Education, the NJ Board of Chosen Freeholders, and the NJ League of Municipalities. Some of the consumer and family members are representatives of consumer advocacy groups, including the National Alliance on Mental Illness in New Jersey (NAMI-NJ), County Family Support Organizations, Self Help Centers, Youth Development Council, and Statewide Consumer Advisory Committees (SCAC). Professional entities are represented on the council, such as The NJ Supportive Housing Association, NJ Hospital Association, the NJ Association of Mental Health & Addictions Agencies (NJAMHAA) and various other New Jersey partners.

On January 1, 2019, the Supportive Housing Connection (SHC) was transferred to the

Department of Community Affairs (DCA), Division of Housing (DoH). All direct care staff of the SHC were transferred to DCA, DoH as hourly employees as they were for HMFA. DCA, DoH employed an SHC supervisor and began recruitment for vacant positions within the SHC. The role and function of the SHC remains intact, the changes are in the physical location of SHC and its employees, now housed at the DCA. The Memorandum of Agreement (MOA) between the HMFA and the Department of Human Services (DHS) / Division of Mental Health and Addiction Services (DMHAS), expired December 31, 2018; the new MOA between DCA and DHS/DMHAS, has an effective date of January 1, 2019

In January 2019, the Department of Human Services/ DMHAS launched a partnership with the Department of Community Affairs (DCA) to administer housing subsidies to consumers receiving services from DMHAS. NJHMFA is responsible for the following tasks on behalf of the Division: Housing Search Assistance, Landlord Recruitment, Housing Inspections, Subsidy Processing, Rental Subsidy Administration, and Tenant/Landlord Inquiry Resolutions. The goal of this partnership is to increase community-based living, and enhance community tenure for consumers recently recovering from and/or at-risk for homelessness and/or placement in inpatient psychiatric settings.

CSOC Coordination with State and Local Entities

Children's Interagency Coordinating Council (CIACC)

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 compiles and analyzes data from available county-wide needs assessments to determine how CSOC community development funds should be allocated within that county.

CIACC Education Partnership

The mission of the CIACC Education Partnership is to promote, develop, and enhance collaborative efforts between school, behavioral health and child protective service systems and other interested parties to improve the well-being of children in Ocean County. The Partnership was conceived in 2006 by members of the CIACC who recognized a need for ongoing, standardized exchange of procedural information between local schools, the child protective service agency and children's behavioral health programs. The services and supports available for children are continually growing and evolving. Through this Partnership, professionals from each of the three systems are provided up-to-date, ongoing training and education on the services that are available and how to access and effectively coordinate with those services, which will help ensure that children receive the help that they need. Through enhancing the knowledge of and communication between professionals, Ocean County children may see the full benefit of these systems working together to meet their multifaceted needs.

Educational Services
The McKinney-Vento Act defines homeless children as "individuals who lack a fixed, regular, and adequate nighttime residence." This includes youth in out of home (OOH)/state facilities. The Department of Corrections, the DCF, the DHS, and the JJC are required to provide educational programs to students in State facilities ages five through 20 and for students with disabilities ages three through 21 who do not hold a high school diploma. Students must be able to receive high school credit.

In general State agencies are required to: provide a program comparable to the special education student's current individualized education program (IEP), and implement the current IEP or develop a new IEP; develop an individualized program plan (IPP), within 30 calendar days, for each general education student, in consultation with the student's parent, school district of residence, and a team of professionals with knowledge of the student's educational, behavioral, emotional, social, and health needs to identify appropriate instructional and support services; discuss the IPP with the student and make a reasonable effort to obtain parental consent for an initial IPP, including written notice; and, review and revise the IPP at any time during the student's enrollment, as needed, or on an annual basis if the student remains enrolled in the State facility educational program, in consultation with the school district of residence.

Attendance in educational programs is compulsory for all students, except for a student age 16 or above who may explicitly waive this right. For a student between the ages 16 and 18, a waiver is not effective unless accompanied by consent from a student's parent or guardian. A waiver may be revoked at any time by the former student. The actual number of days a student with a disability must attend the educational program shall be determined by the student's IEP.

Students with a Disability
Each State agency shall ensure all students with a disability in the agency's State facilities are provided a free and appropriate public education as set forth under the Individuals with Disabilities Education Act, 20 U.S.C. §§1400 et seq., and shall provide special education and related services as stipulated in the individualized education program (IEP) in accordance with the rules governing special education.

The State of New Jersey Department of Education Homeless Education link at https://www.state.nj.us/education/homeless/ provides additional links for information/resources.

Educational Stability for Youth in Out-of-Home Placement
In October 7, 2008, the federal government signed into law the Fostering Connections to Success and Increasing Adoptions Act (P.L. 110-351). This act required all states to arrange for children and youth in foster care to remain in their "school of origin" to ensure educational stability unless it is determined to be in a child's best interest to go to the new district where the Resource Family Home is located. New Jersey responded to this charge by passing the Education Stability Law on September 9, 2010, which established a system that supports the

act. The DCF, Department of Education (DOE) and Office of the Child Advocate (OCA) worked together to implement this law. For children, changing schools can affect their ability to thrive academically, socially, behaviorally and psychologically. This is especially true for children in resource family homes. For these children – who often suffer the lingering effects of abuse or neglect and the trauma of being removed from their homes and families – school can often be the most stable part of their lives.

Work continues to fully implement the requirements of coordination between the DCF and the local school districts. To support the continued progress "Improving the Educational Outcomes of Children in Out-of-Home Placements: An Interagency Guidance Manual" is available on the DCF website at https://www.nj.gov/dcf/families/educational/stability/GuidanceManual.pdf and on the DOE website at https://www.nj.gov/education/foster/outcomes.pdf. The guidance manual includes a model memorandum of agreement (MOA) and provides specific actions to reach the indicator and goals in the MOA.

Traumatic Loss Coalitions for Youth

Suicide is the fourth leading cause of death for New Jersey's youth. DCF/CSOC is dedicated to the prevention of youth suicide. New Jersey's primary youth suicide prevention program is the Traumatic Loss Coalitions for Youth funded by DCF/CSOC. The Traumatic Loss Coalitions for Youth Program at Rutgers -University Behavioral HealthCare is an interactive, statewide network that offers collaboration and support to professionals working with school-age youth. In 1999 the Traumatic Loss Coalitions for Youth Program (TLC) 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 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.rutgers.edu/tlc/

Training and Technical Assistance

The mission of Training and Technical Assistance Services for the Children's System of Care (CSOC) is to support learning the requisite knowledge and skills to provide services and support the unique needs and strengths of families and children with complex needs. The training and technical assistance effort draws on a commitment to competency-based curriculum design, training based on adult principles of learning and skill development, and development of local expertise and training capacity.

Rutgers University Behavioral HealthCare (UBHC), Behavioral Research and Training Institute, is responsible for all CSOC curriculum development, training and technical

assistance activities statewide. This includes all Information Management and Decision Support (IMDS) training and certification, as well as the provision of training contact hours for social workers and counselors. Additional information regarding the Training and Technical Assistance programs can be accessed at: https://nj.gov/dcf/providers/csc/training/.

Division of Child Protection and Permanency

The Division of Child Protection and Permanency (CP&P) is New Jersey's child protection and child welfare agency within the New Jersey Department of Children and Families (DCF). Its mission is to ensure the safety, permanency, and well-being of children and support families. CP&P is responsible for investigating allegations of child abuse and neglect and, if necessary, arranging for the child's protection and the family's treatment. The Child Abuse Hotline (State Central Registry) receives reports of child abuse and neglect 24-hours a day, 7-days a week. Reports requiring a field response are forwarded to the CP&P Local Office who investigates.

Clinical Consultants report to CP&P Area Offices and serve as liaisons, joined from the wraparound perspective, that translate system of care principles and values into case practice and planning and assist in the coordination of behavioral health services for youth involved in the child welfare system. The Care Management Organization (CMO) Clinical Consultant is a jointly owned and administered position between the CMO and CP&P. Clinical Consultants translate clinical information into user-friendly language identify mental health concerns regarding youth involved in the child welfare system and propose interventions to address underlying issues. Clinical Consultants serve as an advocate for youth in permanency and discharge planning, speaking on a clinical level with the Contracted Systems Administrator (CSA), PerformCare, and provider agencies and facilitating communication between care management entities. Clinical Consultants are required to be master's level clinician's licensed by the New Jersey Board of Marriage and Family Therapists or Board of Social Work Examiners.

Office of Adolescent Services (OAS)

The New Jersey Department of Children and Families' (DCF) Office of Adolescent Services (OAS) supports adolescents' transition to adulthood, achieve economic self-sufficiency and interdependence, and engage in healthy life-styles by:

- Ensuring services provided through DCF are coordinated, effective, meet best practice standards, are youth-driven, and adapt to the needs of families and communities,
- Developing linkages with other service providers to create a more equitable and seamless service system, and
- Providing leadership and policy development in the adolescent services field.

OAS work is guided by the principles that adolescent services should:

- Treat all youth with respect,
- Empower youth to engage in planning regarding their own lives, as well as service planning within their communities to the extent it is developmentally appropriate,
- Use a strengths-based and culturally competent approach,
- Assist youth to develop protective and positive attributes and reduce risky behavior,
- Be flexibly structured to meet the individual needs of youth,

- Promote healthy connections to family and other caring adults,
- Affirm the ability of all youth to succeed, but at their own pace and with support,
- Be coordinated and accessible and endeavor to meet established and emerging best practice standards, and
- Use data and focus on outcomes.

Youth Resources Spot (www.njyrs.org)
DCF supports various programs and services for adolescents and young adults including housing, life skills, mentoring, employment/training, educational support, youth advocacy, and healthcare. The New Jersey Youth Resource Spot provides information on local resources for youth. Users can search Child Protection and Permanency's (CP&P) policies, learn how to contact a CP&P worker, and email questions to the Office of Adolescent Services. Youth can also learn how to determine if they're eligible for Wraparound Funds, the Independent Living Stipend, and more.

This guide provides youth with valuable resources that will help their transition into adulthood: Helping You Transition to Adulthood: Resources for New Jersey's Youth at https://nj.gov/dcf/adolescent/YOUTHRESOURCEGUIDE2013.pdf.

Task Force on Helping Youth Thrive in Placement
DCF is committed to ensuring that children and youth, including those in out-of-home placement, remain connected to people important in their lives and fully participate in their schools, neighborhoods and communities. In essence, DCF wants children and youth to enjoy a normal childhood and adolescence regardless of their involvement in the child welfare system. DCF formed the Task Force on Helping Youth Thrive in Placement (HYTIP) to study and recommend ways these children can remain connected to their friends, schools, neighborhoods, and communities. Its interim report offered recommendation for change in several areas, and DCF responded by updating its regulations so children and youth can enjoy contact with family and friends and recreation, education, and employment opportunities within their home community. DCF continues to review and strengthen its practice culture, regulations, and contracting process to help children and youth enjoy a normal and fulfilling childhood and adolescence.

The Task Force on Helping Youth Thrive in Placement recommendations are available here:
https://nj.gov/dcf/adolescent/TaskForceHYTIP.pdf

The Youth Thrive Overview is available here:
https://nj.gov/dcf/providers/notices/nonprofit/YT.pdf

Youth Thrive Protective and Promotive Factors are available here:
https://nj.gov/dcf/providers/notices/nonprofit/YTdef.pdf

LGBTQ resources are available here: https://nj.gov/dcf/adolescent/lgbtqi/

Family and Community Partnerships (FCP)
DCF's Family and Community Partnerships' (FCP) promotes the health, well-being and personal safety of New Jersey's children and families. It works with parents, caregivers, organizations, and communities to ensure an effective network of proven support services, public education, and

community advocacy to prevent maltreatment.

Office of Family Support Services

The Office of Family Support Services (OFSS) provides leadership, support, and development to communities and family serving organizations in order to identify community strengths, needs, and community-based promising strategies that will improve the accessibility of support programs and improve the community context in which families live. OFSS is responsible for the long-term development of the Family Success Centers and the Kinship Navigator Program, so they can adapt, prosper and grow. OFSS works with community entities in an effort to coordinate and consolidate services provided to families and their children. Both programs provide wrap-around resources and supports for families.

Family Success Centers

A Family Success Center is a neighborhood gathering place, where any resident can go to for support, information, and services. The Centers provide family support services, encouragement and cross-generational relationships. They promote social connections that empower families and enhance the lives of children and adults alike. The Centers are guided by a Parent/Community led Advisory Board. Family Success Centers encourage families to take a leadership role, identify and build upon their own unique strengths and talents. A Family Success Center is not a community center or your traditional social services agency; it is a gateway to the Family Success Movement which embraces families and individuals in their quest to meet life goals they have set for themselves. New Jersey now has one of the country's only statewide systems of publicly-supported Family Success Centers. We have at least one Family Success Center in every County.

Family Success Centers help enrich the lives of children by empowering parents and neighborhoods with tools to strengthen their families and communities. Family Success Centers aim to keep families safe by addressing the impact of poverty and family violence, which can help prevent families from falling into crisis. These supports and services are available to the community, families, youth and children at no cost.

Ten Core Services for Family Success Centers

- Access to information on child, maternal and family health services
- Development of "Family Success" plans which help families set goals to overcome challenges and achieve success
- Economic self-reliance / employment related services/income security services
- Information & Referral Services (connection to off-site public and private resources)
- Life Skills training (budgeting, nutrition, etc.)
- Housing related services
- Parent education
- Parent-child activities
- Advocacy
- Home visiting

Kinship Navigator Program
Kinship caregivers are special people who have taken on the responsibility of caring for their relatives' children. These children might be the caregiver's siblings, nieces, nephews, or, most often, grandchildren. The children may be eligible for monthly payments through the federal Temporary Assistance for Needy Families (TANF) program as well as Medicaid health insurance.

Assistance
By dialing 2-1-1, eligible Kinship caregivers can get help addressing immediate problems, and they will also be referred to a local Kinship agency which will work with caregivers to access additional services.

The local Kinship agencies serve three functions. First, staff from the agencies helps caregivers "navigate" other forms of government assistance. Secondly, Kinship agencies determine if the caregiver's family is eligible for Kinship Navigator program benefits such as help with short-term expenses for the relative child, such as furniture, moving expenses and clothing. Finally, the Kinship agencies provide technical support and guide the family through the process of Kinship Legal Guardianship if the caregiver wishes to make a legal commitment to the child. The Kinship agency is there to help caregivers to access services.

Support services, available through numerous government and private agencies, include:

- referrals to grandparenting and family support groups
- help with getting medical coverage and services
- assistance with child support collection
- housing assistance
- help with paying for legal services/fees
- help to pay for furniture (for example, a bed, a computer, computer supplies for the child)
- tutoring services for the children in your care
- help with paying for summer camp for the child
- financial services

Wraparound Services
The Wrap Around Program provides caregivers with vouchers to pay for necessities that are not available through existing programs. For example:

- clothing for the child
- furniture for the child
- moving costs
- housing and legal fees
- summer camp costs
- tutoring

See Wrap Around Services fact sheet at:
https://www.state.nj.us/dcf/documents/prevention/support/kinship_wa.pdf.

Kinship Care - Legal Guardianship Program
This service assists caregivers who want to make a legal commitment to the child/children in their care. For more information, call toll-free: 2-1-1.

To obtain legal guardianship, the caregivers must have been:
a) caring for a child for at least one year;
b) willing to be responsible for the child until age 18 (21 if the child is disabled).

Caregivers who have legal guardianship may also be eligible for a subsidy.

Office of School-Linked Services
The Office of School-Linked Services coordinates the School-Based Youth Services Programs, Newark School-Based Health Services and the NJ Child Assault Prevention Project, in order to address the emotional, behavioral, and family problems encounter by children and youth that threaten their safety, well-being, and educational achievement.

School Based Youth Services Program (SBYSP)
The School Based Youth Services Program (SBYSP) is located in host schools and coordinate with existing resources in the community. All youth are eligible to participate, and services are provided before, during and after school. SBYSP services include: Mental Health Counseling; Employment Counseling; Substance Abuse Education/Prevention; Preventive Health Awareness including Pregnancy Prevention; Primary Medical Linkages; Learning Support; Healthy Youth Development; Recreation; and Information/Referral.

Prevention of Juvenile Delinquency (PJD)
Prevention of Juvenile Delinquency (PJD) is located in host schools to enhance the services and to collaborate with the Family and Community Partnerships (FCP) funded SBYSP. All youth enrolled in the host school where they display behaviors that can or have caused them to become involved in the juvenile justice system are eligible to participate. PJD services complement the SBYSP and focus specifically juvenile delinquency prevention strategies and self-regulation skills to prevent juvenile delinquent behaviors that can impede the student's achievement of their education and life goals. PJD services include: Case Management and Counseling Services; Collaboration with Local Law Enforcement, state and school and community-based agencies, Drop Out Prevention, Life and Coping Skills.

Adolescent Pregnancy Prevention Initiative (APPI)
Adolescent Pregnancy Prevention Initiative (APPI) is located in host schools to enhance the services and to collaborate with Family and Community Partnerships (FCP) funded School Based Youth Services Program (SBYSP) where available. All youth enrolled in the host school, where they display behaviors that could lead to an unplanned pregnancy, are eligible to participate. Youth involved in the program will gain increased pregnancy prevention skills to support the achievement of their education and life goals. APPI services complement the SBYSP program, where

available, and focus specifically on pregnancy prevention skills and knowledge to support the student's ability to achieve their education and life goals. APPI services include: Case Management and Counseling Services; Education and Awareness groups; Linkages to available services and resources; and Collaboration with school personnel.

Family Friendly Centers (FFC)
Family Friendly Centers (FFC) is located in host schools to enhance afterschool programming in elementary and middle schools. FFCs provide constructive academic, recreational, and social enrichment activities to students and their families. All FFC programs emphasize positive youth development, encourage parental participation, and seek to establish partnerships with school and community stakeholders to meet the unique needs of youth and their families.

Parent Linking Program (PLP)
Parent Linking Program (PLP) is located in host high schools to enhance the services and to collaborate with FCP-funded School Based Youth Services Program (SBYSP). PLP work to minimize/eliminate barriers expectant and parenting teens (including young fathers) face that can prevent them from completing their education. This is accomplished through the development and implementation of programs that strengthen pregnant and parenting teen's ability and access to complete their education (secondary and postsecondary); improve child and maternal health outcomes; improve pregnancy spacing and reduce the likelihood of repeat teen pregnancies; increase parenting skills for mothers, fathers, and families; strengthen positive young father involvement and co-parenting relationships, as appropriate, decrease intimate partner violence; and raise awareness of available resources.

NJ Child Assault Prevention (NJ CAP)
NJ Child Assault Prevention (NJ CAP) operate in all 21 counties to provide educational awareness training and effective strategies to handle and/or prevent child assault/neglect to children in grades pre-school through twelve, their parents/guardians as well as educators.

Newark School Based Health Centers (SBHC)
SBHC provides primary medical, dental and behavioral health care services to students and families (up to age 21) in the school where the health center is located and members of its surrounding community.

2NDFLOOR New Jersey Youth Helpline (2NDFLOOR)
2NDFLOOR is confidential, anonymous helpline that supports to NJ's youth (ages 10-24). Youth are provided with solutions and resources to the problems they face at home, at school or at play. Youth that access services receive quality service, support, and information from trained counselors, volunteers and interns. Trained Counselors are available to help youth make healthy decisions and find solutions to various worries they face such as: peer relationships, bullying, mental health issues, dating, sex/sexuality issues, etc. 2NDFLOOR services include: 24/7 Helpline; Interactive

web-site with an online Message Board; Text Support, Youth Advisory Council (YAC) and Information/Referral.

Office of Early Childhood Services
The Office of Early Childhood Services supports the development and implementation of programs and activities related to pregnancy and parent support for families with infants and children to age six.

Special Training series offered through Montclair State University Center for Autism and Early Childhood Mental Health -Keeping Babies & Children in Mind Workshops https://www.montclair.edu/center-for-autism-and-early-childhood-mental-health/.

New Jersey Home Visiting Initiative
Family and Community Partnerships (FCP) oversees the implementation of an array of evidence-based home visiting services to provide early support to families with infants and young children across the state. Eligibility criteria for home visitation services vary by model, but typically programs begin working with families during pregnancy and continue until the child is age two or three.

Home visitors provide pregnant women and new parents with health information, parenting education, and linkages to other resources that support child and family well-being. The directory provides information on all DCF-funded home visitation models that include:

- Healthy Families (HF-TIP) – pregnancy/birth to age three
- Nurse-Family Partnership (NFP) – first-time pregnancy to age two
- Parents As Teachers (PAT) – pregnancy/infancy to preschool
- Home Instruction for Parents of Preschool Youngsters (HIPPY) – age three to five
- Families: A Protective Factors Framework
  Strengthening Families is an evidence-based approach that provides training and guidance to childcare providers, who in turn engage and support parents/families of infants and young children who are enrolled in the child-care/family-child care setting. It focuses on building five Protective Factors that promote healthy development for children, better outcomes for families and reduce the likelihood of child abuse and neglect. The protective factors are:
  - Parental Resilience
  - Social Connections
  - Knowledge of Parenting and Child Development
  - Concrete Support in Times of Need
  - Social and Emotional Competence of Children
- The seven key strategies that have been identified to build protective factors with families are:
  - Facilitate
  - Friendships and Mutual Support

- Strengthen Parenting
- Respond to Family Crises
- Link Families to Services and Opportunities
- Value and Support Parents
- Facilitate Children's Social and Emotional Development
- Observe and Respond to Early Warning Signs of Abuse and Neglect

The Child Care Resource Referral agencies (CCR&R) in each county are the trainers who work with the childcare/family-child care providers to incorporate the five Protective Factors and seven program strategies in the program's daily activities. The child-care providers learn new approaches on how to partner with parents and families in protecting, educating and caring for young children while promoting their social and emotional development.

Community-Based Child Abuse Prevention Programs
Family and Community Partnerships (FCP) supports other community-based child abuse prevention programs throughout New Jersey. Examples include parenting education groups, fatherhood support, and programs that promote early childhood mental health and emotional well-being. These programs are funded through:

Community-Based Child Abuse Prevention (CBCAP) – federal formula grant funds issued to New Jersey by the Administration for Children and Families. The purpose of CBCAP is to support Community-based efforts to develop, operate, expand and enhance and coordinate programs and activities to prevent and reduce the likelihood of child abuse and neglect. In New Jersey, CBCAP funds are issued to support primary and secondary prevention services for diverse population needs across the state and within local communities. Grant funded programs are required to use evidence based/evidence informed practices in their work to prevent child abuse and neglect. Grants are awarded through a competitive process and funded for a three-year cycle. These projects are overseen by the Department of Children and Families, Division of Family and Community Partnership (DFCP), Office of Early Childhood Services. The DFCP provides technical assistance (TA) that builds program capacity in using evaluation for continuous quality improvement.

Children's Trust Fund (CTF) comes from a variety of sources, including voluntary state income tax check-off contributions. The New Jersey Children's Trust Fund (CTF) is a private/public partnership created by law in 1985 to fund child abuse and neglect prevention programs in New Jersey communities. The CTF supports local child abuse and neglect prevention programs that implement evidence-based and evidence-informed programs. Funds come to the CTF primarily from residents through the NJ state income tax check-off; surcharges on birth, divorce, or death certificates; state appropriations; interest from the Trust Fund; corporations and private foundations; and individual contributions and other private donor contributions. The funding priority for the current funding cycle, established by the NJTFCAN, is to promote positive parent-child attachment and support infant and early childhood metal health programs. Grants are awarded through a competitive

process and funded for a three-year cycle. These projects are overseen by the Department of Children and Families, Division of Family and Community Partnership (DFCP), Office of Early Childhood Services. The DFCP provides technical assistance (TA) that builds program capacity in using evaluation for continuous quality improvement.

Early Childhood Comprehensive Systems (ECCS)/ Help Me Grow NJ (HMG) Overview: ECCS / HMG is an early childhood systems integration initiative, working closely with state and local early childhood stakeholders ensuring a unified and coordinated approach to addressing the needs of pregnant women, infants and young children and their parents and families. ECCS/HMG works with public and private partners to facilitate linkages across programs, disciplines and sectors-prenatal/parent and child health, behavioral health, home visiting, Head Start, family support, social services, child care, preschool and elementary education, early intervention, special education, and child welfare. ECCS/HMG has a focus to expand the reach of early childhood developmental screening of children birth to age five. The focus is on increasing linkages to improve physical, social and emotional development during infancy and early childhood to support early learning and development, which in turn supports school readiness. ECC's goal is to eliminate the disparities to accessing early childhood services through system integration, collective impact and improving the quality and availability of services at the state and local level.

ECCS/HMG strategies for early childhood systems integration is to:

- Coordinate the expansion of infant/child developmental and social, emotional screening in early care and education setting statewide.
- Simplify connections for pediatric/health care providers with available community services for the families of infants and young children in their care.
- Assist families with linkages to medical homes, home visiting, early intervention, early childhood education, family support services and other community programs.
- Identify system partners (providers and parents), communication, training and support needs.
- Align ECCS/HMG with NJ Project Launch initiative in Essex County.
- Align ECCS/HMG early childhood priorities with the priorities of the NJ Council for Young Children's Infant Child Health Committee.

Project LAUNCH (Linking **A**ction for **U**nmet **N**eeds in **C**hildren's **H**ealth**)**
In 2013, the New Jersey Department of Children and Families received a five year federal grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) to help ensure that New Jersey's children are thriving in safe, supportive environments and entering school ready to learn and able to succeed. Project LAUNCH New Jersey's (PLNJ) focus is children from birth (including pregnancy) to age eight and their families in Essex County. PLNJ embodies a core population-based, public health approach with a broad perspective on infant and child health - addressing the physical, social, emotional, cognitive and behavioral aspects of well-

being. PLNJ builds on existing material and child health, pediatric primary care, home visiting, early intervention/special child health, childcare, early childhood education, and child behavioral health systems components at the state and local level.

The broad goals of Project LAUNCH are:

- Increase use of developmental screening and assessments in a range of child-serving settings to ensure that concerns are identified and addressed early.
- Improve early care education into primary care settings to ensure that primary care physicians identify and appropriately address behavioral health needs.
- Expand Evidence Based Practices (EBPs) that support parent-child interaction and young children development.
- Increase opportunities for family strengthening and parent/family leadership to help improve outcomes for young children, such as parent support groups, preventive interventions, peer-to-peer support, and parent leadership training.

Activities Related to this Section that the State would like to Highlight

On January 1, 2019, the Supportive Housing Connection (SHC) was transferred to the Department of Community Affairs (DCA), Division of Housing (DoH). All direct care staff of the SHC were transferred to DCA, DoH as hourly employees as they were for Housing and Mortgage Finance Agency (HMFA). DCA, DoH employed an SHC supervisor and began recruitment for vacant positions within the SHC. The role and function of the SHC remains intact; the changes are in the physical location of SHC and its employees, now housed at the DCA. The Memorandum of Agreement (MOA) between the HMFA and the Department of Human Services (DHS)/ Division of Mental Health and Addiction Services (DMHAS), expired December 31, 2018. The new MOA between DCA and DHS/DMHAS, has an effective date of January 1, 2019.

DMHAS and DCA entered into a MOA to have the Supportive Housing Connection (SHC), begin the process of paying the subsidies for individuals served by applicable DMHAS programs. Under this MOA, the SHC acts as fiscal agent and by agreement follows all DHS policy decisions. The SHC contracts with property managers and owners, completes all necessary apartment inspections makes subsidy payments to property managers and landlords. The SHC recruits landlords, provides training, assists with consumers completing paperwork and distributes welcome packets to afford a smooth transition for consumers. The SHC assists consumers in referrals for affordable housing units, administers DMHAS housing subsidies, and expands relationships for housing opportunities through developers and or other DCA housing projects. In the event of disputes between consumers and landlords, the SHC brokers disputes and contracting issues.

The Supportive Housing Connection (SHC) continues to manage supportive housing subsidies, conducting crucial related services such as apartment inspections and rental payments to landlords. The SHC responds to all submitted subsidy applications within one business day of receiving a complete package. The SHC provides apartment inspections

within five days of the provider's submitted request. The SHC also makes rental payments by the payment due date for all individuals with a subsidy managed by the SHC. The target compliance threshold for all of these requirements is 90%. These timeframes enable DMHAS and the SHC to maintain a low vacancy rate, with only new units or units becoming vacant as individuals move.

Environmental Factors and Plan

21. State Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application- Required for MHBG

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council to carry out the statutory functions as described in 42 U.S. C. 300x-3 for adults with SMI and children with SED. To meet the needs of states that are integrating services supported by MHBG and SABG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, SUD treatment, and recovery representation, referred to here as an Advisory/Planning Council (PC).SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance misuse prevention, SUD treatment, and recovery advisory council to ensure that the council reviews issues and services for persons with, or at risk, for substance misuse and SUDs. To assist with implementing a PC, SAMHSA has created **Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.**[69]

Planning Councils are required by statute to review state plans and implementation reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as an advocate for individuals with M/SUD problems. SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

[69] **https://www.samhsa.gov/sites/default/files/manual-planning-council-best-practices-2014.pdf**

Please consider the following items as a guide when preparing the description of the state's system:

1. How was the Council involved in the development and review of the state plan and report? Please attach supporting documentation (meeting minutes, letters of support, etc.) using the upload option at the bottom of this page.

a) What mechanism does the state use to plan and implement substance misuse prevention, SUD treatment and recovery services?

Substance abuse services are planned based on a needs assessment process completed by the State. State funding is allocated to counties based on a funding formula. Substance Abuse Prevention and Treatment Block Grant funding is allocated to third party contracts and fee-for-service contracts for prevention, early intervention, treatment and recovery services based on the needs assessment. As needs emerge, new Requests Proposals are drafted for contracts, which may be renewed annually, as needed.

b) Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work? (●) Yes ( ) No

2. Is the membership representative of the service area population (e.g. ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)? ( ) Yes (●) No

3. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

The functions of the NJ Behavioral Health Planning include: (1) to advise and review New Jersey's Federal Community Mental Health Services Block Grant and Substance Abuse Prevention and Treatment Block Grant plans each year before submission and to make recommendations for improving the plans to the Assistant Commissioner of the New Jersey Division of Mental Health and Addiction Services (the Division), (2) to serve as an advocate for consumers concerning State policy, legislation, and regulations affecting behavioral health, (3) to monitor, review, and evaluate the allocation and adequacy of behavioral health services in New Jersey, (4) to advise the Department of Human Services (DHS) and the Division of Mental Health and Addiction Services (as well as the NJ Department of Children and Families' Children's System of Care (CSOC)) concerning the need for, and quality of, services and programs for persons with behavioral health disorders in the state, (5) to advise the Assistant Commissioner concerning proposed and adopted plans affecting behavioral health services provided or coordinated by the Division and the implementation thereof, (6) as appropriate, to assist in the development of strategic plans for behavioral health services in the State and advocate for the adoption of such plans to other state departments or branches of government, and (7) to exchange information and develop, evaluate, and communicate ideas about mental health, substance abuse and co-occurring planning and services. In accomplishing these purposes the Council makes use of the State Planning Council Liaison and her staff (whom are all employees of the SMHA's Office of Olmstead, Compliance, Planning and Evaluation). The State Planning Council Liaison serves the council (and the public) by providing: logistical support for meetings, (including minutes & communications), networking to other state resources, support with navigating state bureaucracy and technical assistance in its advocacy efforts.

The Planning Council gathers input from people in recovery, families and other important stakeholders largely through its open, public, monthly meetings. Guests routinely join the meetings (both in-person and over the phone via a publicly-accessible conference call line) to ask questions or become more informed about behavioral health services in the State. The Planning Council advocates for individuals with SMI and SED in various ways, from presenting personal insights to presenters during the general meeting, to writing letters for/against programs. The Planning Council also has an Advocacy Subcommittee which focus on topics of interest.

At its core, the Planning Council is a tight, yet far-flung network of consumers, family members and advocates for behavioral health. The SMHA/SSA consistently reaches out to the Council to connect with consumers/family members on a range of issues. In the past year Council members have been invited by the SMHA to: serve as facilitators on its Statewide Suicide Prevention Awareness Conference (Spring 2018), to join the Governor's State Advisory panel on the DMHAS transition from deficit-based contracting, to Fee-for-Service (FFS) contracting, and to share with SAMHSA share their personal stories of recovery from SMI/SUD (June 21, 2018). The SMHA relies heavily on the members of the Planning Council for candid, open perspectives on lived experiences of behavioral health consumers, and their family members.

Please indicate areas of technical assistance needed related to this section.

Additionally, please complete the Advisory Council Members and Advisory Council Composition by Member Type forms.[70]

[70]There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) 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 (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

21. State Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application- Required for MHBG

1. How was the Council involved in the development and review of the state plan and report? Attach supporting documentation (e.g. meeting minutes, letters of support, etc...)

   The New Jersey Behavioral Health Planning Council (BHPC) / NJ Mental Health Citizens Advisory Board (CAB) is a full partner in the development and review of the MHBG and SABG. In SFY 2019 alone, the NJ Division of Mental Health and Addiction Services (DMHAS), which is both the Single State Authority (SSA) for substance abuse treatment and the State Mental Health Authority (SMHA)) hosted eight separate public presentations at the meetings of the NJ Behavioral Health Planning Council on the MHBG, SABG and related topics (See below, Section III., 22.1 for detailed descriptions, and the attached files). Whenever possible, the SMHA/SSA reviews all its submissions (e.g., Implementation Reports and block grant applications) with the Council, prior to submission. These discussions are held in open, public meetings that are accessible both in-person and via conference call. These meetings are announced via announcements published in four major newspapers as well as on the on the state website (https://www.state.nj.us/humanservices/dmhas/home/councils/bhpc.html).

2. Is the membership representative of the service area population (e.g. ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?

   Yes? ☐ No? ☒

   Although the BHPC is a diverse body, composed of volunteer members who represent many portions of the state, and its diverse demography, the SMHA/SAA continues to work to expand its membership to more fully include members from all parts of the state and additional ethnic, cultural and linguistic subgroups.

   At the July 11, 2018 meeting of the Council, the Membership Subcommittee solicited the Council members and general public for increased membership from families with young children with SED. Members of the Council indicated that soliciting voluntary participation of family members of young children with SED is especially difficult due to the fact that such families (already burdened with the standard time constraints such as work) have the added limitation of increased child care obligations directly related to their children's SED diagnoses. The SMHA/SSA (though its state partner, the NJ Department of Children and Families) can only promote and encourage participation in the Council among families who have young children with SED. The efforts of the SMHA/SSA to recruit such families is listed immediately below.

   At its September 12, 2018 meeting, the BHPC Membership Subcommittee reminded the Council that at least 51% of the Council must be composed of consumers and family members.

At the December 12, 2018 meeting of the Planning Council, the Membership Subcommittee shared its need to increase membership among family members of children with SED. In addition, it was shared that NJ Department of Children and Families' (DCF), Division of the Children's System of Care (CSOC) will be reaching out to the Family Support Organizations (FSOs), Care Management Organizations (CMOs), and county-based Children's Interagency Coordinating Council (CIACCs) to actively solicit membership to the Council among families with young children with SED. Outreach will be conducted via both mailings to families receiving services from CSOC, as well as through face-to-face interactions between CSOC staff and prospective families.

At the January 9, 2019 meeting of the Planning Council, the SMHA presented the BHPC with a review of the BHPC's Membership Subcommittee's efforts to solicit membership among families with young children with Serious Emotional Disturbances (SED) and to solicit additional membership from consumers representing diverse and underrepresenting ethnic, linguistic, and cultural groups (e.g., distribution of an updated membership solicitation letter from the DMHAS Assistant Commissioner, dated 1/9/19).

At the February 13, 2019 meeting of the BHPC the Children's System of Care reported to the Council its efforts in increasing the number of family members on the Council who have children with SED, through renewed outreach to its contracted system administrator.

State of New Jersey
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MENTAL HEALTH AND ADDICTION SERVICES
PO BOX 362
5 COMMERCE WAY
HAMILTON, NJ 08691

PHILIP D. MURPHY
Governor

SHEILA Y. OLIVER
Lt. Governor

CAROLE JOHNSON
Commissioner

VALERIE L. MIELKE, MSW
Assistant Commissioner

August 14, 2019

Valerie Mielke
Assistant Commissioner
Department of Human Services Division of Mental Health and Addiction Services
PO Box 362
5 Commerce Way
Hamilton, NJ 08691

RE: Support of the NJ Behavioral Health Planning Council for the 2019-2020 Block Grant Application

Dear Mrs. Mielke:

On behalf of the New Jersey Behavioral Health Planning Council, I am pleased to support the Division of Mental Health and Addiction Services (DMHAS) in its application for funding under the Substance Abuse and Mental Health Services Administration's (SAMHSA) 2019-2020 Community Mental Health Services Plan and Substance Abuse Prevention and Treatment Block Grant.

As the federally mandated planning body in the State, our membership is well aware of the need for continued enhancement of New Jersey's behavioral health system. This grant award will enhance the existing infrastructure and help individuals with Serious Mental Illness, Substance Use Disorders, and Serious Emotional Disturbances across the Garden State.

The Behavioral Health Planning Council is excited that New Jersey is seeking to continue its Block Grant funding to improve behavioral health services for the residents of New Jersey. I trust that SAMHSA will look favorably upon the State's application for funding.

Sincerely,

Darlema Bey

Darlema Bey
Chairperson (Acting)

New Jersey Is An Equal Opportunity Employer

Environmental Factors and Plan

Advisory Council Members

For the Mental Health Block Grant, there are specific agency representation requirements for the State representatives. States MUST identify the individuals who are representing these state agencies.

State Education Agency
State Vocational Rehabilitation Agency
State Criminal Justice Agency
State Housing Agency
State Social Services Agency
State Health (MH) Agency.

Start Year: 2020 End Year: 2021

Name	Type of Membership*	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Tonia Ahern	Family Members of Individuals in Recovery (to include family members of adults with SMI)		230 Route 50 Petersberg NJ, 08270 PH: 609-374-2526	tahern1128@aol.com
Cindy Aviles	Providers	NJ Assoc of Mental Health and Addictions Agencies	NJAMHAA Mercerville NJ, 08619 PH: 609-838-5488	CAviles@NJAMHAA.org
Julia Barugel	Family Members of Individuals in Recovery (to include family members of adults with SMI)		c/o NJ DMHAS Hamilton NJ NJ, 08625	barugel@optonline.net
Darlema Bey	Family Members of Individuals in Recovery (to include family members of adults with SMI)		507 Arch Street Glassboro NJ, 08028 PH: 856-701-2297	darlemabey@gmail.com
Harry Coe	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		152 Sunnymede St Englishtown NJ, 07726 PH: 732-851-4155	harrybcoe@gmail.com
Mary Ditri	Providers	NJ Hospital Association	760 Alexander Rd Princeton NJ, 08543 PH: 609-275-4279	mditri@njha.com
Maryanne Evanko	Family Members of Individuals in Recovery (to include family members of adults with SMI)		c/o NJ DMHAS Hamilton NJ, 08625	Maryanneevanko2@gmail.com
Christina Fagan	Parents of children with SED/SUD		9 Andrew Lane Kinnelon NJ, 07405 PH: 862-432-2776	achangefornick.cf@gmail.com
James Fowler	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		1227 East Front Street Plainfield NJ, 07062 PH: 908-251-8746	fowlerjames97@yahoo.com
Alice Garcia	State Employees	NJ Juvenille Justice Commission	NJ Juvenille Justice Commission Trenton NJ, 08625 PH: 609-943-5274	alice.garcia@jjc.nj.gov
			442 Rt 35	

Connie Greene	Providers	Barnabas Health Institute for Prevention	Eatontown NJ, 08754 PH: 732-837-9435	cgreene@barnabashealth.org
Joseph Guttstein	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		770 Anderson Avenue Cliffside Park NJ, 07010 PH: 201-224-9626	joe@joegutstein.com
Michael Ippoliti	Youth/adolescent representative (or member from an organization serving young people)		307 Wilson Avenue Edgewater NJ, 08010 PH: 609-217-3573	Michael.ippoliti@gmail.com
Barbara Johnston	Providers	Mental Health Association of NJ	MH Assn of NJ Verona NJ, 07044 PH: 973-303-1018	bjohnston@mhanj.org
Scott Kelsey	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		1113 Harrison Ave Roselle NJ, 07203 PH: 908-875-7042	Scott032464@gmail.com
John Loizzi	Others (Advocates who are not State employees or providers)	NJ County Drug and Alcohol Directors Assn	NJ County Drug and Alcohol Directors Assn Newton NJ, 07860 PH: 973-940-5200	nloizzi@sussex.nj.us
Phillip Lubiitz	Others (Advocates who are not State employees or providers)		NAMI - NJ North Brunswick NJ, 08902 PH: 732-940-0991	plubitz@naminj.org
Christopher Lucca	State Employees	NJ Department of Corrections	NJ Department of Corrections Trenton NJ, 08625-0863 PH: 609-298-0500	Christopher.Lucca@doc.state.nj.us
Michele Madiou	Others (Advocates who are not State employees or providers)	NJ Association of Mental Health Administrators	NJ Assoc of Mental Health Administrators Trenton NJ, 08625 PH: 609-577-3474	mmadiou@mercercounty.org
Tracy Maksel	Others (Advocates who are not State employees or providers)		Monmouth Co Board of Social Services Toms River NJ, 08754 PH: 732-506-5374	Tmaksel@co.ocean.nj.us
Patricia Matthews	State Employees	NJ Division of Aging Services	NJ Div. of Aging Services Trenton NJ, 08625 PH: 609-633-0411	Patricia.matthews@dhs.state.nj.us
Donna Migliorino	State Employees		NJ Div. of Mental Health and Addiction Services Trenton NJ, 08625 PH: 609-777-0669	Donna.Migliorino@dhs.nj.gov
Chris Morrison	State Employees	NJ Department of Health	NJ Dept of Health, Ancora NJ, 08037 PH: 609-567-7365	Chris.Morrison@doh.nj.gov

Lisa Negron	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		Freehold Community Wellness Ctr Freehold NJ, 07728	lnegron@cspnj.org
Joanne Oppelt	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		Contact We Care Westfield NJ, 07091 PH: 908-301-1899	joanne.oppelt@contactwecare.org
Damian Petino	State Employees	NJ Department of Education	NJ Dept of Education Trenton NJ, 08625 PH: 973-631-6475	Damian.Petino@doe.state.nj.us
Thomas Pyle	Family Members of Individuals in Recovery (to include family members of adults with SMI)		50 Basalm Lane Princeton NJ, 08540 PH: 609-924-7895	thpyle@gmail.com
Diane Riley	Providers	NJ Supportive Housing Assoc.	NJ Supportive Housing Association South Orange NJ, 07029 PH: 201-741-0755	Diane.riley@shanj.org
Jim Romer	Providers	RWJ/Barnabas Health	RWJ/Barnabas Health South Orange NJ, PH: 732-922-1042	Jim.Romer@rwjbh.org
Regina Sessoms	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		Brighter Day Self Help Center Brick NJ, 08723 PH: 732-477-4714	rsessoms59@aol.com
Suzanne Smith	Family Members of Individuals in Recovery (to include family members of adults with SMI)		Gloucester Co MH Board PH: 856-241-2166	STSSHS@aol.com
Marie Snyder	State Employees	NJ Div of Family Development	NJ Div of FFamily Development Trenton NJ, 08625 PH: 609-588-2176	
Pamela Taylor	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		162 Brighton Avenue East Orange NJ, 07017 PH: 973-943-5751	ptaylor@mhanj.org
Richard Thompson	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		11 Wolf Pack Road Hamilton NJ, PH: 609-462-7300	cureaut@yahoo.com
Cheri Thompson	State Employees	NJ Division of Vocatinal Rehabilitation Services	NJ Div of Vocational Rehabilitation Services Trenton NJ, 08625 PH: 609-292-7498	Cheri.thompson@dol.nj.us
Robin Weiss	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Consumer Provider Association of NJ	Consumer Provider Assoc of NJ Lindenwold NJ, 08021 PH: 856-956-6380	s.robin.weiss@me.com
Chain Winifred	Family Members of Individuals in Recovery (to include family members of adults with SMI)		21 Gateshead Drive Lumberton NJ, 08048 PH: 609-265-2079	winifredchain@gmail.com

*Council members should be listed only once by type of membership and Agency/organization represented.
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Footnotes:

The previous representative of the State Housing Agency (Bruce Blumenthal) has since retired from the NJ Housing and Mortgage Finance Agency (NJ HMFA). At the time of his retirement, his alternate was Julian Fowler--who has not attended the Council in many months. The SMHA is actively attempting to ascertain both Mr. Fowler's ability to resume his presence on the Council, and a replacement, if he is unable to do so.

Environmental Factors and Plan

Advisory Council Composition by Member Type

Start Year: 2020 End Year: 2021

Type of Membership	Number	Percentage of Total Membership
Total Membership	**36**	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	10	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	7	
Parents of children with SED/SUD*	1	
Vacancies (Individuals and Family Members)	0	
Others (Advocates who are not State employees or providers)	4	
Persons in recovery from or providing treatment for or advocating for SUD services	0	
Representatives from Federally Recognized Tribes	0	
Total Individuals in Recovery, Family Members & Others	**22**	**61.11%**
State Employees	8	
Providers	6	
Vacancies	0	
Total State Employees & Providers	**14**	**38.89%**
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	5	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	**5**	
Youth/adolescent representative (or member from an organization serving young people)	1	

* States are encouraged to select these representatives from state Family/Consumer organizations or include individuals with substance misuse prevention, SUD treatment, and recovery expertise in their Councils.

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Footnotes:

Environmental Factors and Plan

22. Public Comment on the State Plan - Required

Narrative Question

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. § 300x-51) requires, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?

a) Public meetings or hearings? (•) Yes ( ) No

b) Posting of the plan on the web for public comment? (•) Yes ( ) No

If yes, provide URL:

The attached Notice of Solicitation of Comment was posted on the Division of Mental Health and Addiction Services' website at: https://www.state.nj.us/humanservices/dmhas/provider/notices/ on July 11, 2019.

The Notice was also published on August 7, 2019 in the following newspapers: The Press of Atlantic City, Courier Post, Asbury Park Press, Bergen Record/Herald, and Trenton Times.

c) Other (e.g. public service announcements, print media) (•) Yes ( ) No

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Footnotes:

NOTICE OF SOLICITATION OF COMMENT

The Division of Mental Health and Addiction Services (DMHAS), within the New Jersey Department of Human Services, is soliciting comment on the Fiscal Year (FY) 2020 - 2021 draft Substance Abuse Prevention and Treatment and Community Mental Health Block Grant Application from any interested person, including any Federal or other public agency, during the development and after submission of the application to the Federal Substance Abuse and Mental Health Services Administration.

To view the document as it is drafted and posted online visit https://bgas.samhsa.gov/
Username: citizennj
Password: citizen

Written comments concerning the State application can be sent to DMHAS at the email or postal address indicated below.

New Jersey Department of Human Services
Division of Mental Health and Addiction Services
P.O. Box 362
Trenton, NJ 08625-0362

Electronic Mail: dmhas@dhs.nj.gov